WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 2001/13

BEFORE:	M. Crystal	:	Vice-Chair
	M. P. Trudeau	:	Member Representative of Employers
	A. Grande	:	Member Representative of Workers

HEARING: October 28, 2013 at Toronto
Oral

DATE OF DECISION: February 24, 2014

NEUTRAL CITATION: 2014 ONWSIAT 401

DECISION UNDER APPEAL: WSIB ARO decision dated December 15, 2011

APPEARANCES:

For the worker: Mr. R. A. Fink, Lawyer

For the employer: Mr. M. Senicar, Paralegal

Interpreter: Ms. R. Osmakovski, Macedonian

REASONS

(i) Introduction

[1] This appeal was heard in Toronto, on October 28, 2013. The worker appeals, and the employer cross-appeals, the decision of Appeals Resolution Officer (ARO) V. Escobar, dated December 15, 2011. That decision determined that:

i) The worker is not entitled to benefits for psychotraumatic disability;

ii) The worker is not entitled to benefits for a permanent impairment of the left shoulder;

iii) The worker is not entitled to loss of earnings (LOE) benefits for the period subsequent to November 4, 2009; and

iv) The worker is entitled to LOE benefits for the period from December 25, 2008 to November 4, 2009.

[2] The worker appeared and was represented by Mr. Richard A. Fink, lawyer. The employer participated in the appeal, and was represented by Mr. Mark Senicar, paralegal. The worker testified at the appeal hearing. Submissions were provided by Mr. Fink and by Mr. Senicar. Ms. Rodna Osmakovski served as an interpreter of the Macedonian language.

(ii) The issues under appeal

[3] At the outset of the hearing, Mr. Fink indicated that the worker wished to withdraw his appeal in relation to the issue of whether the worker is entitled to benefits for a permanent impairment of the left shoulder, noting that it did not appear that the medical evidence supported such entitlement. Mr. Fink indicated that he discussed with the worker the question of whether to withdraw this issue from the issue agenda for this appeal, and that the worker agreed that the issue should be withdrawn. Mr. Fink indicated that the worker understood that if he wished to subsequently restore his appeal at the Tribunal in relation to this issue, the worker would be subject to the time limits imposed by the *Workplace Safety and Insurance Act, 1997*. In the circumstances, the Panel agreed to allow the worker to withdraw his appeal in relation to this issue.

[4] Accordingly, the issues to be determined in this appeal are:

i) Whether the worker is entitled to benefits for psychotraumatic disability;

ii) Whether the worker is entitled to LOE benefits for the period subsequent to November 4, 2009; and

iii) Whether the worker is entitled to LOE benefits for the period from December 25, 2008 to November 4, 2009.

[5] The first two issues, noted immediately above, are the subject of the worker's appeal. The third issue noted is the subject of the employer's cross-appeal.

(iii) The evidence

[6] The worker, who was 35 years old as of the date of the hearing, testified that he was injured as a result of an accident that occurred on July 28, 2008, while he was working for the accident employer, a company in the business of contracting for waste collection and disposal. The worker was employed by the accident employer as a driver/loader, driving a waste collection truck and collecting waste from private residences for recycling.

[7] The worker testified that the accident occurred when he was standing on the step at the side and to the rear of the truck, while his co-worker drove the truck. He testified that as the truck stopped at a corner, he felt a sharp pain in his left shoulder and he subsequently realized that he had been shot with a pellet gun by a person standing beside a residence. The worker completed a Worker's Report of Injury (Form 6), dated July 28, 2008, which provided the following description of the accident:

> On the 28.07.2008 I was work on the step at [municipal address]. Truck stop on the stop sign. As we made turn to left with truck, at that moment I felt the pain in the left shoulder. I started foling [sic - falling] down and I saw a man closing door. My shoulder popped out. I felt excruciating pain. I suspect that he shot me with some gun. Right away I called my supervisor and told her what happened. Resting my left arm in my right arm. I was in shock. My supervisor called police and they came very fast.

[8] At the hearing, the worker testified that he had been holding on to a rail at the side of the truck with both hands, but that after he was hit, apparently by a BB pellet, he let go of the rail with his left hand, but that he was able to hold onto the rail with his right hand, and that the lower half of his body was dragged along the pavement by the truck. He noted that there was a "STOP" button located near the railing, to alert the driver of the need to stop the truck, but that he was unable to push the button because his left arm was injured, and he was using his right arm to hold onto the truck. He stated that, after the incident, his boots were torn apart as a result of his legs and feet being dragged along the pavement by the truck.

[9] The worker testified that the police identified the person who fired a BB gun at him, and that this individual had explained to police that he was shooting at targets when the worker was struck accidentally. The worker testified that it was explained to him that he could seek benefits from the Workplace Safety and Insurance Board (WSIB) or alternatively, proceed with criminal charges. He stated that he applied for benefits through the Board and that he did not request that charges be laid against the individual, who apparently was given a warning by police. He stated that he applied to the Criminal Injuries Compensation Board for compensation for his injuries, but that he did not receive any award from that Board.

[10] The worker obtained medical treatment from Dr. F. A. Ibrahim on July 28, 2008, and Dr. Ibrahim prepared a Physician's First Report (Form 8) of that date. The Form 8 provided the following accident history:

> Got hit in [left] shoulder with object while working – working on stairs (holding onto stairs) instant reflex to turn hit [left] hand on railing and hit [left] shoulder.

[11] The Form 8 provided a diagnosis of "[left] shoulder strain", and stated that the worker was to remain off work for three days, after which he was to follow up with his family physician.

[12] The worker saw his family physician, Dr. Robert Shih, on July 31, 2008, who prepared a Functional Abilities Form for Timely Return to Work (FAF), dated July 31, 2008. The FAF stated that the worker had severe left shoulder stiffness with very limited range of motion. It

indicated that x-rays of the left shoulder were normal, but that an ultrasound report was pending. Physiotherapy was prescribed. The report stated that the worker could expect his injury to "last for 3 months." The case materials also included a report, dated August 8, 2008, on an ultrasound of left shoulder, which indicated a normal examination.

[13] The worker was seen by Justin Collins, physiotherapist, who prepared a further Form 8, dated August 11, 2008. This report indicated that the worker was injured "while holding onto garbage truck" when the worker was "shot in back by BB gun causing left arm to hyper abduct and [experience] immediate pain @ [left] shoulder." The report described the worker's prescribed physiotherapy treatment and stated that the worker was "unable to use his [left] arm" due to "severe pain, limitation and weakness." An x-ray report, dated August 14, 2008 indicated that the worker's x-rays of his cervical spine were normal.

[14] Physiotherapist Collins also provided a Health Professional's Progress Report (Form 26), dated September 2, 2008. The report stated that the worker "reports that he is experiencing pain in his neck, back, bilateral hamstrings and around his shoulder blades, and that he was experiencing numbness at the 4th and 5th fingers of his left hand." The report indicated that the worker was not to return to work for 2 weeks and that he was unable to use his left arm.

[15] Dr. Shih provided a narrative report, dated September 8, 2008, to the Board's Claims Adjudicator, which stated:

> As you are aware, [the worker] is a garbage collector. On July 28, 2008 while performing his duty he was shot with a BB gun on his left shoulder. At the time he was holding himself at the back of the garbage truck with his left arm. Due to this sudden attack he was forced to pull himself with the outstretched left arm in order to balance himself. As the result of this abrupt movement he suffers severe left shoulder pain.
>
> [The worker] was first assessed on July 29, 2008 at my clinic. He was wearing left arm sling at the time. Examination showed very limited left shoulder range of movement with stiffness around left glenohumeral joint and essentially tender throughout left shoulder and trapezius muscle. He was also showing sign of protective posture with his left elbow in flexed position even after the removal of arm sling.
>
> I have subsequently prescribed Percocet for pain control and arranged imaging studies of the affected area. Tests consisted of Cervical spine X-ray, left shoulder X-ray and ultrasound. Fortunately all tests were reported to be normal.
>
> Obviously [the worker] suffered left shoulder sprain as the result of the injury and as such I have prescribed him a course of physiotherapy on his follow up appointment on July 31, 2008. I am expecting improvement from 1 to 3 months and as such I have discussed with [the worker] about his return to work plan. He may be not able to perform his regular duty as garbage collector for up to 3 months. Modified duties were also discussed, but [the worker] is unsure what type of office duties he is able to perform. It appeared to me that [the worker] is doubtful of his credential as a new immigrant to Canada. He had been to Canada since 2004 and still has some language barrier.
>
> I will not have any objections if [the worker's] employer is able to offer modified work duties such as that of administrative filing, photocopying and other such clerical duties. This will certainly help his self-esteem as he recently had a new born at home and is very eager to return to work as long as his pain became more tolerable.

[16] After a few attempts to arrange a teleconference with the worker and an interpreter, the Board's Claims Adjudicator spoke with the worker on August 21, 2008, as indicated in an internal Board memorandum of that date. The memo stated that the worker indicated that the accident occurred when his "left arm swung backwards pulling the worker's left shoulder" and

indicated that the worker reported "not having any feeling in his ring and pinkie finger." The memo stated that the worker was aware that the employer had modified duties available for him and that the employer wanted the worker to come in to discuss the duties. The worker indicated, however, that his pain, lack of transportation and the fact that he was taking pain medication that made him drowsy, were barriers to his return to work. The memo indicated that the worker's claim would be approved for health care and lost time, and that the adjudicator would be discussing his referral to the Board's shoulder and elbow clinic with the Board's nurse case manager.

[17] In a further memo, dated August 21, 2008, the adjudicator confirmed that the worker's claim had been allowed, and was satisfied that the worker had barriers which had prevented him from returning to work at modified duties.

[18] The worker was subsequently assessed at the Board's Shoulder and Elbow Specialty Clinic, where he was seen by Dr. R.R. Richards on November 20, 2008. Dr. Richards report noted that the worker had limitations in range of motion in the left arm, but that radiological studies were normal. The report concluded by stating:

> I am not certain the cause of [the worker's] severe symptoms. [The worker] has a progressive neuropathy and/or RSD. I have asked for a total body bone scan looking for RSD and EMG and median and ulnar nerve conduction study. I will review [the worker's] file once his investigations have been completed. In the meantime [the worker] should be considered to be completely disabled with regard of the use of his left upper extremity. Stretching and strengthening exercises would be of benefit to [the worker]. I will review [the worker's] file once the above mentioned information is available.

[19] The worker was also assessed on November 20, 2008, by Dr. Michael Oosterhoff, psychologist. His report of that date reviewed the worker's accident history, and went on to indicate that the worker reported that his mood had been "frequently miserable" over the last month "because of pain, weakness and financial stress." The worker also reported "a few symptoms of Depression including some anhedonia, low appetite and energy and intermittent feelings of worthlessness, helplessness and hopelessness." The worker also reported "sleep disruption secondary to sleepwalking." He also indicated experiencing anxiety in relation to his financial situation, particularly in light of his newborn child. The worker denied any psychological history prior his accident, and the report reflected a normal psychological history during his formative years in his country of birth, in Europe.

[20] The report considered whether the worker had symptoms of post-traumatic stress disorder (PTSD), but concluded that "the presence of acute psychological symptoms could not be clearly determined." The report stated that although the worker "reported thinking about the accident, he did not report any reaction when he returned to work to talk to the manager or with co-workers over the phone" and that the worker indicated that "if physically better he could do the same job with no worries."

[21] The report concluded by stating that the worker had "symptoms of acute Pain Disorder and some symptoms of Depression and Anxiety." The report stated that the worker's depression and anxiety appeared "sub-threshold diagnostically" and appeared to be "related to adjustment issues and pain-related distress." It noted that the worker had limited acute symptoms associated with PTSD but that the worker might have "some specific cued symptoms with respect to the route or location where the accident happened" upon his return to work. Concern was also expressed in relation to the impact of the pain medication and benzodiazepine drugs that the

worker had been prescribed. The report recommended that the worker would benefit from a functional restoration program to address "the pain and functional issues along with psychological and [return to work] related challenges." The report provided the following DSM-IV Diagnostic Impression:

> Axis I: Pain Disorder associated with Psychological Factors and a General Medical Condition, Acute
>
> Axis II: Diagnosis Deferred
>
> Axis III: Continued injury recovery, continued pain at injury site
>
> Axis IV: Injury-adjustment related challenges
>
> Axis V: GAF 55

[22] The worker underwent a total body bone scan on December 8, 2008. The report on the scan indicated that the worker had "very mild arthritis in the left thumb" but "no evidence for reflex sympathy dystrophy." It stated that the appearance of the upper extremities thorax and shoulders was normal. The worker underwent electromyography (EMG) testing on December 18, 2008, which, according to a report of that date, disclosed "largely a normal study" although minimal findings were present which could reflect "a very mild ulnar neuropathy." Dr. Richards provided a report, dated January 19, 2009, which indicated that the worker's bone scan and EMG studies were essentially normal, and that "surgical treatment would not be helpful to him." Dr. Richards indicated that the worker 'evidently sustained a soft tissue injury" and that the worker would benefit from stretching and strengthening exercises. Dr. Richards also indicated that the Functional Restoration Program (FRP) "would be help to him."

[23] The worker was assessed by Dr. Tea Cohodarevic, at the Toronto Western Hospital FRP, on January 19, 2009, for the purpose of reviewing the worker's medications. The report recommended reducing the dosage for several of the worker's medications, but indicated that his dosage for Effexor, an anti-depressant and anti-anxiety drug, be gradually increased "since his symptoms of depression and anxiety are not yet optimally controlled."

[24] The worker underwent an interdisciplinary initial assessment at the FRP, that was carried out by a team consisting of Dr. Cohodarevic, a psychologist, an occupational therapist and a physiotherapist. The worker indicated interest in participating in the program, and the report recommended that he do so. The report provided a diagnostic impression of:

1. Pain Disorder associated with both Psychological Factors and a General Medical Condition (Chronic);
2. Major Depressive Episode – moderate;
3. Panic Attacks

[25] At the FRP, the worker also underwent a Comprehensive Psychological Assessment, conducted by Dr. Stacy Thomas, psychologist. Her report, dated May 29, 2009, provided a description of the worker's accident, as well as anxiety and panic attacks that he had experienced since the accident. In particular, the report indicated that the worker had anxiety about driving since his accident. He also reported disturbed sleep and night sweats.

[26] The report noted that the worker was near the end of his 6 week group based treatment program at the FRP, but that he needed more individualized intervention, and recommended that he work with a cognitive behaviour therapist to integrate relaxation technique to improve

management of "negative and irrational beliefs that are exacerbating and maintaining his distress." Treatment by a psychiatrist to manage his psychological impairments was also recommended. The report provided the following DSM-IV diagnosis:

> <u>Axis I: Clinical Disorders</u>
>
> - Posttraumatic Stress Disorder
> - Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, Chronic
> - Adjustment Disorder with Depressed Mood
>
> <u>Axis II: Personality Disorders</u>
>
> - Nil
>
> <u>Axis III: Medical Conditions</u> (according to patient report and file)
>
> - Chronic pain affecting his left arm, neck, back and right leg
> - Hypertension.
>
> <u>Axis IV: Psychosocial stressors</u>
>
> - Financial strain, uncertainty regarding occupational future, social isolation, lack of social support, lack of proficiency in English, stress related to WSIB
>
> <u>Axis V: Global Assessment of Functioning</u>
>
> - The GAF score does not include impairment due to physical limitations and is estimated to be 45 to 50.

[27] This DSM-IV diagnosis was also provided in a report, dated June 5, 2009, prepared by the worker's assessment team, at the completion of his FRP, and individualized treatment was again recommended to treat the worker's psychological issues and improve his functional abilities.

[28] According to an internal Board memorandum, dated July 7, 2009, the worker was referred to the Psychological Trauma Program (PTP) at the Centre for Addiction and Mental Health (CAMH) for assessment and a "second opinion". The case materials included an Occupational Therapy Assessment Report, dated September 1, 2009, prepared by Aron O'Brien, occupational therapist, at the PTP at CAMH. The report reviewed the worker's personal and accident history, and indicated that the worker reported persistent pain, very low mood, some suicidal ideation, and anxiety. In relation to PTSD, the worker reported persisting intruding thoughts about his accident, flashbacks to his accident, feeling uncomfortable in public places, disturbed sleep and decreased appetite. The report concluded by stating:

> SUMMARY & RECOMMENDATIONS
>
> [The worker] appears to be experiencing mood, anxiety and pain symptoms which appear to be directly related to the index incident, and appear to be negatively affecting his engagement in self-care, productive, and leisure occupations.
>
> However, the somewhat unusual nature of [the worker's] presentation and reporting make it somewhat difficult to precisely determine the severity of the symptoms and occupational dysfunction.
>
> Nonetheless, information gathered is sufficient to suggest that the issues do currently render [the worker] incapable of working in any capacity. A temporary psychological restriction for working with garbage trucks, also seems warranted.

> The prognosis for return to work is guarded for each of pre-accident or alternative work. Positive prognostic indicators include: young age; financial incentive to return to work; fair occupational skill set; and stable pre-accident functioning. While negative indicators include: possible worsening of symptoms; unusual physical and psychiatric presentation; prominent somatic focus and pain focus; symptom amplification; limited benefit from treatment to date; lack of improvement in symptoms; lengthening duration of disability; limited English; and chronic pain.
>
> Writer opines that although [the worker] has been seen at the Shoulder and Elbow Clinic, and is currently participating in the Functional Restoration Program, he has not yet received sufficient treatment for psychological and occupational issues noted above, and not reached maximum recovery in those areas. Barriers to recovery include: chronic pain; possible motivational factors; and limited English.
>
> [The worker] is a candidate for treatment at PTP due to the prominence of pain-related difficulties.
>
> Writer presently recommends a brief trial of individual treatment with a…psychologist who speaks [the worker's primary language] in the community to further clarify mood and anxiety symptom presentation, provide related treatment, and ascertain level of treatment engagement Recommendations for treatment continuation or cessation might then be made by that provider. In-home occupational therapy may also be useful in terms of clarification of symptom and day-to-day functional issues, and hands-on assistance addressing such.

[29] The case materials also included a report, dated July 28, 2009, from Dr. A. Bender, psychiatrist and Medical Director of the PTP at CAMH. The report reviewed the worker's personal and accident history in a manner consistent with information set out above. His report provided the following DSM-IV diagnosis, as well as answers to questions posed by the Board in relation to the worker's referral to the PTP. In these regards, Dr. Bender's report stated, in part:

Axis I	Pain Disorder associated with both Psychological Factors and a General Medical Condition, Chronic
	Major Depressive Disorder, Single Episode, (severity unknown) no mood incongruent psychotic features;
	Anxiety Disorder Not Otherwise Specified with features of Posttraumatic Stress
Axis II	No diagnosis
Axis Ill	Left shoulder sprain/strain, cervical myofascial sprain, left finger sprain
Axis IV	Financial problems, care-giving demands
Axis V	GAF=40

> ….
>
> **<u>Answers to referral questions</u>**
>
> **DSM-IV diagnosis**
>
> Please see above.
>
> [The worker] appears to be experiencing severe and persistent pain, anxiety, and depression following an unexpected shooting while working as a garbage collector in July 2008. Over the course of his disability he has had numerous assessments during which time he has exhibited extreme pain behaviours and self-limited functioning consistent with a Pain Disorder associated with both psychological factors and general medical condition. Concurrently he appears to be experiencing progressive depressive symptoms associated with reported auditory hallucinations, suggestive of a severe major

depressive episode with psychotic features. He is also reporting trauma-related symptoms including triggered and untriggered anxiety, recurrent flashbacks, nightmares and avoidance suggestive of a co-morbid posttraumatic stress disorder.

[The worker] denied any pre-existing psychological difficulties, personality disorder, or malingering. Overall he is reporting high and disproportionate levels of distress and exhibiting unusual physical symptoms which are generally inconsistent with the nature of his injuries. This is interfering with ability to clarify the true severity of his symptoms.

Comment on the relationship between the accident and its sequelae and the psychological condition

There is a direct relationship between the workplace accident and the development of the pain disorder, major depressive disorder, and the posttraumatic stress disorder. There is no evidence of pre-existing impairment.

Identify and comment on other contributants to the psychological condition

Other contributants include:

- Financial strain
- Loss of functioning

Is the client able to work in any capacity? If yes, provide specific precautions. If no, provide an explanation

[The worker] is currently unable to work in any capacity due to poor distress tolerance, persistent pain, and avoidance. He requires aggressive stabilization before considering return to work in a position with suitable physical restrictions.

Prognosis for return to work?

Overall, his prognosis for return to work in any capacity is guarded considering the following factors:

Positive

- Young age
- Good premorbid functioning
- Fair occupational skills set
- Financial incentive

Negative

- Severe symptoms
- Progressive symptoms
- Long duration of disability
- Limited response to treatment
- Chronic pain
- Avoidance behaviour

Barriers

- Self-limiting behaviour

Has the worker achieved maximum psychological recovery?

[The worker] has not reached maximum medical recovery.

….

[30] The worker was also assessed at the PTP at CAMH by Dr. Jason Bacchiochi, psychologist and Assessment Team Head at the PTP, and Lorena Hsu, psychology intern. Their report, dated July 29, 2009, stated that their assessment of the worker was based on interviews with him and a battery of psychological tests that were administered in July 2009. The report indicated, however, that the full battery of tests was not administered to the worker, due to limitations in his English language skills.

[31] The report provided a DSM-IV multi-axial diagnosis that was similar to that provided by Dr. Bender, as indicated above, however, the report indicated a GAF of 55 (as opposed to a GAF of 40, as indicated in Dr. Bender's report). The report went on to provide the following "Summary and Impressions":

> [The worker] is a 30-year-old man who was working as a loader/driver for [the accident employer] when on July 28, 2008, he was shot by a BB pellet in the left shoulder, and reportedly lost his balance and was dragged for 120 meters. As a result, he sustained multiple soft tissue injuries to his left shoulder, left upper extremity, head, neck and back. He has not returned to work since. He has gone on to experience significant pain symptoms, as well as symptoms of depression and anxiety. [The worker] has been seen at the Shoulder and Elbow Clinic, and is currently participating in the Functional Restoration Program. At the time of this assessment, [the worker] reported symptoms consistent with Pain Disorder Associated With Both Psychological Factors and a General Medical Condition; Major Depressive Disorder, Single Episode, R/O [rule out] Psychotic Features; and Anxiety Not Otherwise Specified with Features of PTSD and Panic Attacks.
>
> Although [the worker] reported a number of symptoms in the current psychological assessment, it is not possible to make a determination with respect to the true severity and nature of his symptoms given the questionable reliability of some of his self-report. Specifically, findings from the M-FAST, SIRS interview, and TOMM, instruments employed to assess the probability a respondent is malingering a psychiatric illness indicate that the information gathered from the current assessment may not be a valid and accurate reflection of [the worker's] current condition. It is possible that cultural or language factors, as well as the unstandardized administration of measures through the use of an interpreter may have played a role in his responses to measures, of malingering. However, there is also converging evidence based on inconsistencies in reporting that would support the notion that he may not be reliable in his report of symptoms. First, it appears that his description of the workplace accident was inconsistent with the initial accident report as well as the employer criminal report, as noted by his WSIB case manager during the case conference. As well, there were inconsistencies across the current assessment and a previous psychological assessment in November 2008 with regard to the onset of his symptoms of posttraumatic stress and panic disorder. Further, another previous psychological assessment in April 2009 had also noted the possibility that he was exaggerating his symptom presentation. Within the current assessment, [the worker] did not report any symptoms of posttraumatic stress or panic when asked about the main problems he is experiencing. Taken together, there is converging evidence to suggest that [the worker] may not have been reliable in his report of symptoms. As such, it is not possible to make valid determinations of the severity and nature of his current symptoms.
>
> <u>Relative Contribution of the Accident and Sequelae to Current Psychological Condition.</u> The workplace accident is a direct contributor to the pain disorder, symptoms of posttraumatic stress, and panic disorder, with onset shortly following the workplace accident in July 2008. The workplace accident is also a direct contributor to his depressive symptoms, with onset around April 2009.

> Other Contributions to Current Psychological Condition. Financial strain, loss of employment, reduced activity, marital and family stressors, and limited social support are likely contributing to his current psychological conditions.
>
> Prognosis and Ability to Return to Work. [The worker's] experience of pain and disability, as well as his symptoms of posttraumatic stress, panic disorder, and depression preclude a return to work to his pre-accident position at this time. As he continues to experience trauma-related symptoms associated with his work accident, psychological restrictions include working with garbage trucks. This restriction should be revisited with evidence-based treatment. His prognosis to return to his pre-accident position is guarded, and to alternative employment is guarded. Positive prognostic indicators include stable pre-accident functioning, relatively good previous workplace functioning, financial incentive, and young age. Negative prognostic indicators include heightened perception of disability, chronic pain, physical restrictions, limited social support, presentation style, and limited English fluency.
>
> Has Maximum Psychological Recovery Been Achieved? It does not appear that maximum psychological recovery has been achieved, given that he has not yet engaged in evidence-based psychological treatment.
>
> Barriers to Recovery. Barriers to recovery include [the worker's] experience of pain, heightened perception of disability, physical restrictions, and limited English fluency.
>
> Treatment Recommendations. Given [the worker's] presentation style, it would be important to continue to monitor his symptoms. It is recommended that he engage in six sessions of individual cognitive behavioural therapy focusing on his symptoms of depression and anxiety. This would involve psycho education about depression and trauma-related anxiety, behavioural activation to address his depressive symptoms, and graduated imaginal and in vivo exposure exercises to address trauma-related symptoms. He should be reassessed after two to three months to evaluate whether he is fully engaged in treatment. Treatment should be provided by a …therapist [who speaks the worker's first language].
>
> I trust this report has been of some assistance.

[32] The worker was discharged from the PTP at CAMH and the worker's assessment team prepared a Discharge Summary, dated September 1, 2009. Much of the information that was included in the Discharge Summary was similar to other information prepared by the team at the PTP, as indicated above. The report included a DSM-IV Axis I diagnosis that was similar to those indicated above, although the discharge report indicated that the diagnosis of "Major Depressive Disorder, Single Episode, Severe with psychotic features" was provided as a diagnosis to be ruled out. The report also noted that "it was not possible to establish the severity of depressive symptoms due to inconsistencies in his presentation and symptom reporting across assessments at PTP, and the changing report of symptomatology over time as documented in file information." The Discharge summary also made the following points in response to questions posed by the Board:

- The worker's accident was a major contributor to his psychological issues;
- Although no pre-exiting psychological condition was identified, co-existing contributors to the condition included "unusual physical symptoms that are inconsistent with the nature of the injuries, unusual course of psychiatric symptoms, possible symptom amplification, and financial strain";
- Given the severity of the worker's psychological issues he was not able to work in any capacity;

- The worker's prognosis for return to work was guarded. Positive and negative factors affecting this prognosis were stated, as noted in other PTP reports, set out above;
- The worker had not undergone sufficient treatment to have achieved maximum psychological recovery; and
- Barriers to recovery included chronic pain, possible motivational factors and limited English.

[33] At the hearing, the worker exhibited some unusual facial and gestural movements which appeared to be involuntary and could be described as "tics" or twitches. The case materials included a report, dated July 2, 2010, prepared by Dr. Susan Fox, neurologist. The report stated that the worker had been referred for "athethoid movements of the face". The report indicated that the worker reported that these movements "started rather abruptly [in May 2008] in the mouth area, and progressed to affect the whole facial and cervical area" and indicated that the worker "now presents abnormal movements of the aforementioned body areas." The report stated that "the abnormal movements are present constantly" including during sleep.

[34] The employer arranged for the worker to be the subject of an investigation that was carried out by a private investigation firm, and the investigation included video surveillance of the worker. The investigators also determined the worker's spouse was a subscriber to the "Facebook" social network, and a number of photographs that were obtained from the Facebook pages of the spouse's Facebook account were included as part of the evidence collected through the investigation.

[35] At the hearing, the worker testified that subsequent to his accident, he wore a sling to support his injured arm, but that on occasion, particularly at home, or when exercising, he took the sling off. At the hearing, it was noted that, in some of the photos that had been reproduced from the Facebook account of the worker's spouse, he was not wearing his sling. Some of the photos also depict the worker fishing apparently in a country setting, or at a cottage. At the hearing, the worker testified that, in or about Summer 2009, some friends had rented a cottage, and had invited his family to the cottage. He stated that these photos were taken at the cottage. The worker testified that he did not drive to the cottage, but that his family had been driven by friends.

[36] The worker also testified that he had intended to share the Facebook photos with family members who remained in his home country in Europe, and he did not want these family members to become worried about his welfare. He stated that for that reason, he had deliberately tried to have the photos depict himself as having a pleasant time at the cottage. He stated that he had not actually done fishing at the cottage, but rather, he had posed for a moment with a fishing rod for a photo that he hoped to share with family members in Europe.

[37] At the hearing, the Panel viewed the surveillance video, which was only a few minutes in length. The video was taken on September 5, 2009. It showed the worker casually dressed in shorts and a short sleeved shirt, wearing a sling which supported his left arm. Buildings are visible in the background of the video which appear to be part of a shopping centre or office complex. The worker was walking with a woman, apparently his spouse, who was carrying an infant. At the start of the video, the worker was smiling. Later in the video, the worker is observed driving a car.

[38] At the hearing, the worker testified that, in the moments before he is observed to be smiling in the video, before he exited the car shown in the video, his daughter had called him "Daddy" for the first time, and that this event caused him to smile. The worker also testified that, subsequent to his accident, he was able to drive short distances, not greater than about 10 km. He testified that when he was observed in the video, he was driving only a short distance.

[39] The case materials also included a report, dated May 23, 2011, prepared by Dr. J. Joel Jeffries, psychiatrist, who was retained by the worker's representative, to provide a comprehensive psychiatric evaluation of the worker, and to provide responses to questions posed by the representative. Dr. Jeffries was also provided with a copy of the worker's medical file, for review. The report also indicated that Dr. Jeffries observed the surveillance video, referred to above. Dr. Jeffries reviewed the medical evidence on file, and also included an account of the worker's accident and personal history. The report provided the following information in response to the questions posed by the worker's representative. The questions were included in italics in Dr. Jeffries' report, in the same manner as reproduced below:

> *You wanted to know the current DSM-IV diagnosis on all axes.*
>
> Axis I It is difficult to be sure. I believe what we are seeing is a conversion disorder 300.11. The criteria for this include A: "One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition." He has many such symptoms. Criterion B is that one judges psychological factors are involved because the symptoms are preceded by conflicts or other stressors. In his case the incident on the garbage truck was a stressor. Problematic however is criterion C, where we have to consider whether or not he is malingering or feigning. One has to give him a differential diagnosis of malingering V65.2, where the essential feature "is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives". Indeed he does have two of the criteria, which are "medico-legal context presentation" and "marked discrepancy between the person's claimed stress or disability and the objective findings." However, this is not enough in my mind to confirm malingering because one would find both these criteria being met in many people with chronic pain disorders. He lacks the other two conditions which are "lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen" and "the presence of antisocial personality disorder".
>
> Axis II I did not find any specific personality disorder.
>
> Axis Ill He does have hypertension which is presumably mild as it is not being treated. He also has gastric hyperacidity.
>
> Axis IV This is a difficult one for me to respond to because I generally find it unreliable. I cannot really pin down any psychosocial or environmental problems that have led to his current presentation.
>
> Axis V I would give him a GAF of 63. This is a difficult number to get to because one has to combine his presentation of somebody much sicker than this with the surveillance data, which suggests someone much healthier.
>
> *You asked about any restrictions or precautions that should be observed.*
>
> I have none to suggest.
>
> *You asked if any treatment is recommended*

> He really should be seeing somebody who takes him on with the premise that this is a conversion disorder and that his complaints are in excess of any tissue injury. Further medical investigations are contraindicated. One useful intervention might be to hypnotize him while filming him to see whether one can change some of the rather gross pseudo-neurological symptoms.
>
> *You asked me to comment about the surveillance which you were provided from the employer and all of the other medical reporting in the compendium you sent me.*
>
> There is of course a marked discrepancy between his presentation and what is in the video and the photographs and of course there have been discrepancies all along in his presentation and psychological tests. It is not easy to make sense of all this, but my impression based on the interview particularly, is that this fellow is role-playing what he thinks is a physical or psychological disorder. It is done in a rather primitive way and he persists in it despite confrontation, despite being told that there are obvious discrepancies. At times he rationalizes or denies what is plain for other people to see.
>
> *You asked about the relationship of any current "chronic pain/emotional difficulties to the accident at work on July 28, 2008.*
>
> Clearly all this is directly sprouting from that particular incident. It was, however, a rather minor accident and he has used this as an opportunity to take on a sick role despite the absence of any permanent injury.
>
> *You asked whether there are any other factors (possibly non-compensable) playing any role in the ongoing "chronic pain"/emotional difficulties [the worker] may be experiencing.*
>
> In any person who presents as sick there may be a secondary gain and by that I mean that dependency needs are met and other people take care of him. He has less responsibility and can blame any inadequacies he has on his "injury". He appears to have taken on a sick role. I am not able to do more than speculate about motivation here, though I wonder if being injured is an excuse for his lack of success vocationally.
>
> I will be pleased to elaborate or explain further upon request.

[40] After receiving the report from Dr. Jeffries, the worker's representative sent a further request for information, dated October 5, 2011, to Dr. Jeffries. The letter to Dr. Jeffries stated, in part:

> I notice on the one hand you feel that [the worker] does not fully meet the criteria for malingering, but on the other hand there is some role playing and secondary gain. I presume some of this is conscious. Perhaps you could provide me with a percentage as to conscious versus unconscious.

[41] Dr. Jeffries sent a further report, dated October 7, 2011, to the worker's representative, which stated:

> You asked me a supplementary question as to what percentage is conscious versus unconscious.
>
> This is a difficult problem. My estimate is somewhere between 5 and 20% is conscious in that he is thinking that he will present himself in a self-serving, false manner.
>
> You mention role-playing and secondary gain and these are significant issues but they are predominantly unconscious self-serving mechanisms.

[42] The worker testified that in or about Spring 2010, the worker began taking an English as a Second Language (ESL) course at a community centre. The case materials included a note, dated May 31, 2010, prepared by an ESL teacher who had taught the worker. The note stated that the worker had been enrolled for about two months in an ESL course that the author of the

note had taught. The note indicated that the worker had missed significant time from classes due to his appointments or his daughter's illness, but that he supported his absences with medical or other notes which explained his absences. The note also indicated that the worker had difficulty in participating or concentrating on his studies, due to the fact that "it seems he is constant pain."

[43] At the hearing, the worker testified that he took the ESL classes for one or two months, and that he improved his English language skills to an extent. He stated that he took the course five days per week, but that he rarely stayed at the class for more than one or two hours.

[44] The worker also testified that his condition improved somewhat by 2010, and that he looked for work beginning in 2010. The case materials included a "Job Search Summary" for the worker which listed 56 jobs for which the worker applied between October 2010 and January 2011. The "Job Search Summary", which the worker stated was prepared by himself in his own handwriting, indicated the date when the worker applied for each job, the position applied for, and the outcome of the application. Although the form on which the summary was prepared left a space to note the name of the potential employer, most of the entries did not include an employer's name, but stated that the worker applied for the job by email.

[45] At the hearing, the worker also testified that in or about October and November 2010, he performed some light work assisting a friend with tasks associated with renovation. The case materials included a note prepared by the worker which stated:

> I, [the worker], received $900 cash from [individual's name]. I received this money like renovations-helper on his apartment, for period of October and November.
>
> [The worker]

[46] The worker testified that in February 2011, he obtained employment cleaning and packing machine parts. He stated that in this employment, he earned $16.00 per hour, 40 hours per week, although, the case materials included a statement prepared by the worker in relation to this employment, which indicated that he worked 44 hours per week. The worker testified that by the time that he obtained this employment, he believed that his physical condition had improved by about 20 - 30%. He stated that, in relation to his psychological status, he had some good days and some bad days, and it was difficult to estimate his level of psychological recovery.

[47] The worker testified that he continued in this employment until about November 2012, when he was laid off from the employment, and that he subsequently received Employment Insurance (EI) benefits. He stated that he subsequently obtained other employment performing deliveries of medical products or materials, and that he was employed performing this work at the time of the appeal hearing, working between 3 to 4 hours on some days, and between 5 and 6 hours on other days, although he is required to pay the costs of operating the vehicle used for the deliveries.

[48] The worker testified that, at the time of the hearing, he was receiving ongoing psychiatric treatment from Dr. M. Zurowski, psychiatrist, and that Dr. Zurowski was prescribing psychiatric medications for him. He stated that he had previously seen Dr. Zurowski about once per month, but that at the time of the hearing, he was seeing his psychiatrist about once every two to three months, as directed by the psychiatrist.

(iv) Applicable law and policy

[49] The workplace accident which is the subject of this appeal occurred on July 28, 2008. Accordingly, the worker's entitlement to benefits in this appeal is governed by the *Workplace Safety and Insurance Act, 1997.*

[50] In this appeal, the worker is seeking entitlement to benefits for psychotraumatic disability. The Board's policy on such entitlement is included in *Operational Policy Manual* Document No. 15-04-02. That policy document states in part:

> **Policy**
>
> A worker is entitled to benefits when disability/impairment results from a work-related personal injury by accident. Disability/impairment includes both physical and emotional disability/impairment.
>
> **Guidelines**
>
> **General rule**
>
> If it is evident that a diagnosis of a psychotraumatic disability/impairment is attributable to a work-related injury or a condition resulting from a work-related injury, entitlement is granted providing the psychotraumatic disability/impairment became manifest within 5 years of the injury, or within 5 years of the last surgical procedure.
>
> Psychotraumatic disability/impairment is considered to be a temporary condition. Only in exceptional circumstances is this type of disability/impairment accepted as a permanent condition.
>
> Psychotraumatic disability/impairment resulting from organic brain damage is assessed as a permanent disability/impairment.
>
> **Psychotraumatic disability entitlement**
>
> Entitlement for psychotraumatic disability may be established when the following circumstances exist or develop
>
> - Organic brain syndrome secondary to
>   - traumatic head injury
>   - toxic chemicals including gases
>   - hypoxic conditions, or
>   - conditions related to decompression sickness.
> - As an indirect result of a physical injury
>   - emotional reaction to the accident or injury
>   - severe physical disability/impairment, or
>   - reaction to the treatment process.
> - The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socioeconomic factors, the majority of which can be directly and clearly related to the work-related injury.
>
> …

(v) Analysis

(a) Entitlement to benefits for psychotraumatic disability

[51] As noted above, in this appeal, the worker is seeking entitlement to benefits for psychotraumatic disability. The applicable Board policy document, excerpted above, provides that a worker may be entitled to benefits for a psychological injury as an indirect result of a physical injury, where the injury results from an emotional reaction to the accident or injury.

[52] In this case, the worker was apparently shot with a BB gun by a resident on the street while the worker was collecting recyclables in his employment with the accident employer. We accept that the worker was in fact shot by a BB gun, and that issue is not contentious in this appeal. Initial entitlement for the accident was allowed by the Board and has not been the subject of appeal.

[53] We do, however, question some of the aspects of the worker's account of the accident. In particular, we note that the initial medical report on the incident, dated July 28, 2008, prepared by Dr. Ebrahim, referred to the fact that the worker was hit by an object while working on the employer's truck, and that he hit his hand and shoulder on the railing of the truck. A few days later, Justin Collins, the worker's physiotherapist, prepared a Form 8, dated July 31, 2008, which indicated that the worker's injury occurred when his being shot caused his left arm to hyper abduct, causing a shoulder strain. Dr. Shih, the worker's family physician, prepared a further report, dated September 8, 2008, which indicated that the "due to this sudden attack he was forced to pull himself with the outstretched arm in order to balance himself" and that "as a result of this abrupt movement he suffers severe shoulder pain."

[54] When the worker was seen by the assessment team at the FRP, their report in January 2009, indicated that at the time of the accident the worker "fell from the truck and his feet hit the road." When the worker was interviewed in the course of his comprehensive psychological assessment for the FRP in May 2009, the report on the assessment, dated May 29, 2009, stated:

> He explained that "I was hanging on with just one arm and my legs were dragging on the road and I thought that I was going to go down under [the truck]…

[55] At the hearing, the worker maintained this version of his accident history, indicating that his work boots were torn apart in the course of being dragged by the truck 150 to 200 metres, while he held on to the railing of the truck with only his right hand.

[56] In our view, although we accept that the worker was shot by a resident with a BB gun (it appears that this was confirmed by police investigation), we find it improbable that the worker was dragged 150 to 200 metres on the paved road while he was hanging on to the truck with only his right arm. We find it improbable that the accident occurred in this manner, first, because the worker's initial reports of the incident did not refer to the worker being dragged in any manner by the truck. The worker did not provide this version of events until about late 2009, more than a year after the accident.

[57] In addition to the fact that the worker did not report being dragged by the truck until well after the accident, in our view, had the worker been dragged in this manner, we expect that the worker would have sustained some injuries, at least superficially, to his lower body that was being dragged, or to his right arm that was holding on. Dr. Ebrahim, who saw the worker on the date of accident did not report on such injuries, and neither did the worker's physiotherapist, who saw him soon after. Dr. Shih's report, dated September 8, 2008, stated that the worker pulled himself with his outstretched left arm "in order to balance himself", and if the worker balanced himself, presumably he was not dragged on the pavement.

[58] As we have indicated above, initial entitlement for the accident that occurred on July 28, 2008 is not in dispute in this appeal, and we accept that the accident occurred, notwithstanding our finding that it is improbable that after being shot by the BB gun, he was dragged more than 150 metres. The importance of our finding that the accident did not involve

the worker being dragged by the truck, is that it is evidence that the worker exaggerated his accident history. It is not possible for us to discern whether the worker deliberately exaggerated the history, or whether he has reconstructed events in his mind so that, at the time of the hearing, and subsequently, he believed that the accident occurred in this manner. In either case, we conclude that, when the accident occurred, the worker was not dragged along the pavement for 150 to 200 metres by the truck, while holding on with one hand, as the worker testified at the hearing.

[59] In addition to the worker exaggerating the severity of his accident history, we also find that it is probable that the worker exaggerated his psychological or psychiatric symptoms. We note that when the worker was being assessed at the Shoulder and Elbow Specialty Program, the FRP, and at the PTP at CAMH, the psychological and psychiatric reports appear to question whether the worker was exaggerating his symptoms. For example:

- The report prepared by Dr. Oosterhoff, dated November 20, 2008, at the Shoulder and Elbow Specialty Program, stated that the worker exhibited “prominent pain behaviours, tendency to report his pain in ways that emphasize its severity, a perception of significant disability, self-limiting behaviours, adoption of the patient role, and a primary focus on pain” which were impediments to recovery;
- The report, dated May 29, 2009, prepared by Dr. Stacy Thomas, at the FRP, stated that the worker “did tend to use dramatic language to describe his symptoms and demonstrated significant pain behaviour suggesting a tendency to present an exaggerated symptom picture”, although noting that “there is no evidence to suggest that this represented a conscious attempt to exaggerate his complaints.”; and
- The Psychological Assessment Report, dated July 29, 2009, prepared by Dr. Bacchiochi at the PTP at CAMH, stated that “the information gathered from the current assessment may not be a valid and accurate reflection of [the worker’s] current condition”, that “the description of the workplace accident was inconsistent with the initial accident report” and that “there is converging evidence based on inconsistencies in reporting that would support the notion that he may not be reliable in his report of symptoms”.

[60] It should be understood, however, that the reports on the comprehensive assessments conducted in relation to the worker from the Shoulder and Elbow Specialty Program, the FRP and the PTP at CAMH, did not indicate that the worker was malingering, or that he had fabricated his injury or symptoms. To the contrary, the reports provided established DSM-IV Axis I diagnoses, and confirmed that there was “a direct relationship” between the workplace accident and worker’s psychological disorders (see Dr. Bender’s Psychiatric Assessment Report). Nevertheless, we conclude that, either implicitly or explicitly, the medical reports in the worker’s claim file indicate that the worker probably was exaggerating his symptoms.

[61] This point was ultimately emphasized most explicitly in the report, dated May 23, 2011, by Dr. Jeffries. As excerpted above, that report stated that the worker demonstrated “a marked discrepancy between his presentation and what is in the video and the photographs”, “discrepancies all along in his presentation and psychological tests”, and indicated that the worker was “role-playing what he thinks is a physical or psychological disorder… in a rather primitive way…despite being told that there are obvious discrepancies… [which are] plain for

other people to see." Dr. Jeffries also acknowledged that "all this is directly sprouting from [the workplace accident]" but indicated that the accident was "a rather minor accident and he has used this as an opportunity to take on a sick role despite the absence of any permanent injury."

[62] In response to this report, the worker's representative asked Dr. Jeffries to estimate "what part of the Worker's conversion disorder is conscious and intentful, and what part of his conversion disorder is unconscious and without intent." Dr. Jeffries indicated in his report, dated October 7, 2011, that "this is a difficult problem" but that he estimated that "somewhere between 5 and 20% is conscious in that he is thinking that he will present himself in a self-serving, false manner."

[63] The issue of how a worker's exaggeration of symptoms should affect entitlement is addressed in the Tribunal's *Decision No. 1541/05*, which stated, at paragraph 28:

> We note that the issue of exaggeration of symptoms was addressed in one of the Tribunal's leading decisions, *Decision No. 915* (7 W.C.A.T.R. 1). The Panel in that decision noted that there are frequently reasons for a worker to exaggerate symptoms, such as the avoidance of anticipated pain from a physical examination. It was also noted, at page 222 of the decision, that a patient may exaggerate symptoms because the patient would be "motivated to make sure that the doctor made no mistake about the seriousness of the…disability." The decision refers to exaggeration in this context as "honest exaggeration."
>
> At page 153 of *Decision No. 915,* the Panel distinguishes, however, between "honest exaggeration of symptoms" and "dishonest exaggeration." In this regard, *Decision No. 915* states:
>
>> In working out the application of these general principles to the facts in the particular case at hand, the Panel has come to appreciate the probability that in many chronic pain cases there is likely to be found evidence of honestly motivated conscious exaggeration of symptoms. In the Panel's view, such exaggeration would be properly taken into account in the process of determining the nature and degree of the disability. The evidence of disability would be discounted to a degree reflecting the Panel's uncertainty as to the amount of the disability.
>>
>> Dishonest exaggeration, or what we have referred to earlier as partial malingering, is obviously a more serious problem. The identification of dishonesty in any aspect of a worker's conduct or testimony will give a panel cause to approach the whole claim - particularly one of this nature - with justified skepticism. And in a case of the nature of a chronic pain case, where such skepticism may not find the reassurance of objective medical findings, that skepticism may lead to a rejection of the whole claim on the basis of the Panel failing to be satisfied on the issue of genuineness.
>>
>> However, we must also recognize that we are not operating in an ideal world. In some cases a panel will be able to identify a degree of improperly motivated conscious exaggeration without feeling that the genuineness of the basic claim has been totally undermined. In such cases, as in cases of honest conscious exaggeration, the exaggeration could be taken into consideration through a discounting analysis at the point of determining the nature and degree of the disability….

[64] *Decision No. 1541/05* also noted (at paragraph 30) that the issue in *Decision No. 915* was entitlement to benefits for chronic pain disability (CPD), but that the discussion of exaggeration of symptoms in the decision was equally applicable where the issue under appeal was entitlement to benefits for psychotraumatic disability, as it is in this case.

[65] We agree and adopt the reasoning of *Decision No. 915* as reflected in *Decision No. 1541/05* that "in some cases a panel will be able to identify a degree of improperly motivated conscious exaggeration without feeling that the genuineness of the basic claim has been totally undermined." We conclude that, in this case, although the worker exhibited "a degree of improperly motivated conscious exaggeration", this fact does not cause us to conclude that the "genuineness" of his claim has been entirely undermined.

[66] We have arrived at this view, taking into account the full body of psychological evidence available to us, and in particular, the evidence provided by Dr. Jeffries. We interpret the evidence from the Shoulder and Elbow Specialty Clinic, the FRP and the PTP at CAMH to mean that the worker had a genuine psychological disorder, notwithstanding his tendency to exaggerate both the accident history and his subsequent pain and psychological symptoms. This was recognized by Dr. Jeffries who diagnosed the worker with a genuine conversion disorder. He stated that he could not conclude that the worker was "malingering or feigning" because he lacked two criteria that would be associated with malingering, namely, a "lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen" and "the presence of antisocial personality disorder". It is apparent from the information provided by the FRP that the worker co-operated in his evaluation and treatment, and none of the psychological reports indicated that the worker had a pronounced personality disorder.

[67] The analysis provided by Dr. Jeffries went further however. We interpret his report, dated October 7, 2011, to mean that the worker was consciously feigning 5% to 20% of his presentation. It is implicit in this analysis, however, that 80% to 95% of the worker's presentation was not feigned. Although we are not able to conclude that this reflects a genuine organic disability, we are able to conclude that, to about this degree, the worker was not consciously fabricating his psychological symptoms, and in that sense, the worker's psychological symptoms were genuine and arise from the subject workplace accident.

[68] In conclusion, we find, based upon the full body psychological and psychiatric evidence before us, that the worker sustained a psychological injury, diagnosed by Dr. Jeffries as Conversion Disorder, which arose from the workplace accident that occurred on July 28, 2008. We make this finding notwithstanding the fact that it is apparent to us that the worker has presented his condition with an element of conscious exaggeration. The Panel in *Decision No. 915* noted that it was possible for decision makers to "identify a degree of improperly motivated conscious exaggeration without feeling that the genuineness of the basic claim has been totally undermined", and we are able to do that in this case.

[69] Accordingly, the worker is entitled to benefits for psychotraumatic disability. The issue of the nature and extent of his entitlement to benefits for psychotraumatic disability is remitted back to the Board for determination.

(b) Entitlement to LOE benefits

[70] In the circumstances of this appeal, the Board allowed entitlement for the accident that occurred on July 28, 2008, and awarded him LOE benefits until November 4, 2009. In correspondence, dated November 12, 2009, the Board advised the worker that "there is sufficient evidence dating back to December 25, 2008 to support [he had] misrepresented [his] level of impairment", and that LOE benefits paid to the worker for the period from December 25, 2008 to November 4, 2009 had "been inactivated". The same correspondence advised the worker that,

accordingly, a debt owed by the worker to the Board had been created in the amount of $21,478.26.

[71] The ARO decision, dated December 15, 2011, which is the subject of this appeal, determined, however, that the worker was entitled to full LOE benefits previously paid to November 4, 2009, restoring LOE entitlement during the period from December 25, 2008 to November 4, 2009. The decision also determined, however, that although LOE benefits were restored up until November 4, 2009, the worker was not entitled to further LOE benefits, beyond that date. In this appeal, the employer has appealed the ARO's determination that the worker is entitled to full LOE benefits during the period from December 25, 2008 to November 4, 2009, and the worker has appealed the ARO's determination that the worker is not entitled to LOE benefits during the period subsequent to November 4, 2009.

[72] We note that the worker obtained full time employment in February 2011, but at a lower rate of remuneration than he was paid by the accident employer prior to his accident. We also note that the worker was laid off from this employment in or about November 2012. The worker subsequently received E.I. benefits, after which he obtained other employment, which he performed on a part time basis.

[73] Considering first the period from December 25, 2008 to November 4, 2009, we confirm the ARO's decision that the worker is entitled to full LOE benefits during this period. According to a memo, dated December 22, 2008, prepared by the Board's registered nurse, the worker was referred to the FRP at Toronto Western Hospital on about that date. The worker was assessed at the FRP in early 2009. A report from the FRP, dated May 8, 2009, prepared by Sobia Sheikh, physiotherapist, indicated that the worker had completed his assessment at the FRP and that the worker's treatment had begun. The report stated that the worker "reports motivation to change his situation and has reported interest in continuing in the program." There was no indication that the worker was not co-operating in the program. A further report, dated May 29, 2009, prepared by Dr. Thomas, psychologist, stated that the worker was not capable of returning to work.

[74] The Discharge Summary, dated September 1, 2009, from Dr. Bender, at the PTP at CAMH, stated that the worker had been referred to the PTP on June 17, 2009. The report stated that the worker's accident was a major contributor to his psychological symptoms and that his psychological symptoms would not allow him to work in any capacity. There was no significant medical information relating to the worker's psychological condition prepared between September 2009 and November 2009, when the Board rescinded the worker's LOE entitlement from December 2008. In particular, there was no persuasive information to indicate that the worker's psychological condition improved to an extent commensurate with his being capable of returning to employment.

[75] We also note that the Discharge Summary, dated September 1, 2009, stated that "it was not possible to establish the severity of depressive symptoms due to inconsistencies in his presentation and symptom reporting across assessment at PTP" and that it is apparent from the case manager's memo, dated November 4, 2009, that it was this statement (or a similar statement in an earlier PTP report) which caused the Board to rescind the worker's LOE entitlement.

[76] Taking into account our analysis in relation to entitlement to benefits for psychotraumatic disability, notwithstanding our finding that the worker exaggerated the extent of his psychological symptoms, we have found that the worker sustained a psychological injury as a

result of his accident. We also find that, during the period from December 25, 2008 to November 4, 2009, the worker co-operated in the assessments and treatment in which the Board sponsored him. We note that the mental health professionals who advised the Board that they could not establish the severity of depressive symptoms due to inconsistencies in his presentation and symptom reporting, also concluded, at the same time, that the worker was not capable of returning to work. In these circumstances we conclude that it is appropriate to confirm the ARO's determination that the worker is entitled to full LOE benefits during the period from December 25, 2008 to November 4, 2009.

[77] As for the period subsequent to November 4, 2009, there was no persuasive evidence before us to indicate that the worker's psychological condition resolved as of November 4, 2009. The only significant medical information concerning the worker's psychological condition after November 4, 2009, is the report provided by Dr. Jeffries. In that report, Dr. Jeffries indicated that the worker continued with a DSM-IV Axis I diagnosis of Conversion Disorder, which supports a finding of ongoing psychological disability.

[78] We find that after November 4, 2009, the worker continued to experience psychological symptoms, although we recognize that the worker was exaggerating his symptoms. In keeping with the PTP Discharge Summary, which apparently recognized that the worker was exaggerating his symptoms, we also find that the worker was not capable of returning to work as of November 4, 2009. At that time, however, the Board discontinued the worker's treatment. Given our finding that he continued to have a psychological disability as of November 2009, we conclude that the worker would have had difficulty mitigating his circumstances after the Board withdrew its treatment and support of the worker.

[79] The case materials included clinical notes for the period from October 2009 to July 2010, which disclose that the worker saw his physician regularly during this period, usually once or twice per month, and that the notes indicate that the worker was continuing to be prescribed anti-depressant medication, and that he continued to report experiencing pain. There is evidence that the worker studied ESL in Spring 2010, and that he performed some light renovation work in October and November 2010, for which he received remuneration of $900.00. There is also evidence of the worker's job search from October 2010 until the end of January 2011, when he obtained employment.

[80] In these circumstances we find that the worker is entitled to full LOE benefits from November 4, 2009 to February 2011, when he obtained new employment. We make this determination noting that:

- For reasons provided above, we have found that the worker has ongoing psychological entitlement beyond November 2009. The Board's Appeals Branch found that the worker was entitled to full LOE benefits up until November 4, 2009, and there was no persuasive evidence that the worker's condition resolved or changed at that time;
- The worker continued treatment with his family physician after November 4, 2009, including treatment with psychotropic medication, notwithstanding the Board's withdrawal of sponsorship for treatment as of November 2009; and
- In 2010, the worker attempted to mitigate his employment circumstances by taking an ESL course, performing some light work in the field of renovation; and

searching for employment, which resulted in the worker obtaining employment in February 2011.

[81] In these circumstances, we find that the worker is entitled to full LOE benefits during the period from November 4, 2009 to February 2011, taking into account the $900.00 that the worker earned in employment during this period.

[82] We note that, apart from Dr. Jeffries' report, there is little medical or other information available to us describing the worker's ongoing condition, his earning capacity, or the type of employment that the worker was capable of performing after February 2011, when he obtained full-time employment, but with earnings that were less than in his pre-accident employment. Accordingly, the issue of the worker's level of ongoing LOE entitlement subsequent to February 2011, is remitted back to the Board for determination.

DISPOSITION

[83] The worker's appeal is allowed, in part.

[84] The employer's cross-appeal is denied.

i) The worker is entitled to benefits for psychotraumatic disability. The Board is directed to determine the nature and extent of the worker's entitlement to benefits for psychotraumatic disability.

ii) The worker is entitled to full LOE benefits during the period from December 25, 2008 to November 4, 2009.

iii) The worker is entitled to full LOE benefits during the period from November 4, 2009 to February 2011, less $900.00 earned in employment during this period.

iv) The issue of the worker's level of ongoing LOE entitlement subsequent to February 2011, is remitted back to the Board for determination.

DATED: February 24, 2014

SIGNED: M. Crystal, M. P. Trudeau, A. Grande