WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1249/17

BEFORE:	M. Crystal: Vice-Chair
HEARING:	April 21, 2017 at Toronto Oral
DATE OF DECISION:	May 18, 2017
NEUTRAL CITATION:	2017 ONWSIAT 1512
DECISION UNDER APPEAL:	WSIB ARO decision dated July 7, 2015

APPEARANCES:

For the worker:	Mr. O. Iacopini, Paralegal
For the employer:	Did not participate
Interpreter:	N/A

REASONS

(i) Introduction

[1] This appeal was heard in Toronto, on April 21, 2017. The worker appeals the decision of Appeals Resolution Officer (ARO) M. Palmieri, dated July 7, 2015. That decision determined that:

i) The worker is not entitled to benefits for injuries to his cervical spine or the left shoulder;

ii) The quantum of the worker's non-economic loss (NEL) award for a traumatic brain injury and for psychotraumatic disability has been correctly determined by the Board to be 57%, which is the "combined value" of the worker's 52% rating for a traumatic brain injury and the 10% rating for psychotraumatic disability the AMA Guides, 3rd Edition ("the *Guides*"), which is the prescribed rating schedule for NEL awards, directs that these NEL shall be "combined" pursuant to a mathematical formula. The combined value of two NEL rating values is typically somewhat less than the sum of the values);

iii) The worker is entitled to two hours of attendant home care services, three or four times per week, and the worker is not entitled to home care services 24 hours per day; and

iv) The worker is not entitled to receive benefits and services through the Board's Serious Injury Program (SIP), including entitlement to a Personal Care Allowance (PCA) or an Independent Living Allowance (ILA).

[2] The worker appeared and was represented by Mr. Ottavio Iacopini, paralegal. The employer did not participate in the appeal. The worker testified at the appeal hearing. Submissions were provided by Mr. Iacopini.

(ii) A synopsis of the case under appeal

[3] The worker sustained a traumatic brain injury as a result of workplace accident that occurred on October 26, 2010. At the time of the accident, the worker was employed as a truck driver by the accident employer, a plumbing supply company. The employer prepared an Employer's Report of Injury (Form 7), which is not dated, but appears to have been prepared late in 2010, which stated that the worker was delivering bathtubs to several subdivision lots, and that as he was removing one of the tubs, he fell about 48 inches off of the rear of the truck. The worker was 65 years old as of the date of accident.

[4] The worker was taken to hospital by ambulance, and the case materials included an Ambulance Call Report (ACR), dated October 26, 2010, which stated:

> [Patient] was unloading bathtub from back of truck when he lost his footing and fell [backwards] out of truck – 4 -5 ft. onto ground. Witnesses state [patient] fell onto back first then hit head. Brief [loss of consciousness] lasting [a few seconds]. [Patient] [alert and oriented] when awoke; sat up on his own.

[5] The ACR also indicated that the worker was experiencing pain at the left side ribs, and pain to the back of the head at the site of a laceration. The ACR also indicated that the worker did not have pain at the back or neck and that he did not have dyspnea (i.e., shortness of breath).

[6] At hospital, the worker underwent a CT scan of the head which disclosed that the worker had "subdural, subarachnoid and possible intraparenchymal hemorrhage in the frontal lobes bilaterally." The worker underwent a further CT scan of the head on October 27, 2010, the day following the accident, and the report on that CT scan stated that the "areas of hemorrhage anteriorly in the frontal lobes bilaterally are essentially unchanged" from the previous CT scan.

[7] The Board allowed the worker's accident claim and awarded the worker loss of earnings (LOE) benefits and health care benefits for the worker's injuries to his head and ribs. The worker was subsequently referred to Toronto Rehabilitation Institute (TRI) for assessment. The case materials included a report, dated May 13, 2011, from the Board's Neurology Specialty Clinic at TRI, prepared by an Assessment Team, led by Dr. Zeeshan Waseem and Dr. Marck Bayley, both physiatrists. The report stated that the worker's chief complaints at admission were, frontal headaches, dizziness, depression, shaky movements, trouble with meal preparation and activities of daily living (ADLs), poor appetite, poor sleep pattern and decreased balance and strength. The report indicated admitting diagnoses of traumatic brain injury with direct cerebral concussion, including a subarachnoid hemorrhage and frontal bilateral subdural hematoma, chronic post-traumatic headache and symptoms of depressed mood.

[8] A further Progress Report, dated October 4, 2011, from the Board's Specialty Clinic at TRI included information prepared by Dr. Lidia Domitrovic, neuropsychologist, which stated:

> [The worker's] behaviour and mood have been consistent throughout psychological treatment sessions and in Dr. Domitrovic's opinion reflect social-emotional changes secondary to traumatic brain injury. His presentation has been notable for restricted affect, save for mild irritability; limited eye contact; and terse yes/no responses to most inquiries. He also picks at his arms and fingernails in a perseverative fashion and demonstrates little awareness of this behaviour. Per [Ms T, the worker's caregiver], these features which he also demonstrates at home are a marked difference from his pre-accident mood and behaviour and have essentially remained unchanged since the injury. In concert with her reports of decreased behavioural initiation and motivation, such a presentation is consistent with the neuropathological inertia and loss of social interest that can be a component of executive dysfunction.

[9] The case materials also included a "Neurological Assessment Report", dated January 18, 2012, prepared by Dr. Robert D. Gates, psychologist, at TRI, which stated that the worker noted that Ms. T "has been helping him with bathing due to concern that he might fall" and that "she has told him that he is forgetful and is repeating himself." The report went on to state:

> The neuropsychological tests indicate that [the worker] has low average general intelligence, a finding in keeping with his educational and occupational history. His communicative abilities are intact at a basic level. His memory function, however, is significantly impaired, both over very short intervals (i.e., working memory) as well as longer intervals for more complex information, particularly in the domain of visual memory. In addition his processing speed is presently very slow.
>
> These impairments will have a significant limiting effect on his ability to perform most daily activities. He will be slow to take in information, and he will not reliably be able to recall it later. His decision-making will be slow and concrete. His fine motor skills are significantly limited, and he probably demonstrates a functional limitation of "hand

> skills" in everyday environments (e.g. buttoning or fastening clothing, using manual kitchen devices, opening and closing containers).

[10] The case materials also included a report, dated February 29, 2012, on an assessment of the worker carried out by Lan Nguyen, occupational therapist with TRI, which stated that the worker required assistance with some aspects of his personal care, including nail care, bathtub transfers, bathing, medication, transportation and all housekeeping and home maintenance activities.

[11] In a report, dated February 26, 2013, the worker's family physician, Dr. Randy Gordon, prepared a report for the Board which indicated that the worker had symptoms that included, headache, dizziness, decreased cognitive function and depression. In relation to the worker's depression, the report stated:

> Depression: he no longer socializes. He does not answer the telephone, he has decreased appetite, decreased sleep – mainly difficulty staying asleep. He has decreased self-confidence and decreased ambition. Antidepressant treatment helps a little.

[12] The worker was subsequently referred to Dr. J. Pilowsky, psychologist for further psychological assessment, which was sponsored by the Board. Dr. Pilowsky's initial report, dated January 21, 2014, stated in part:

> During the consultation, [the worker] reported the following psychological symptoms: depressed mood most of the time; occasional crying spells; passive suicidal ideation, but he does not have plans to kill himself; verbal outbursts of anger at times, but is devoid of violence; decreased appetite; sleep deprivation, in the form of initial and middle insomnia, mainly due to nightmares, headaches, and pain; nightmares, of which he is unable to recall, but awakens in an anxious state with shortness of breath and shaking; fatigue most of the time; frustration with his limitations; stress; irritability; loss of motivation; withdrawal from others; lack of interest in previously enjoyed activities; sensitivity to light and noise due to headaches; cognitive difficulties such as short-term memory, focus, and concentration problems; ruminations and intrusive images of the accident, and wishing the accident had not happened; anxiety including symptoms such as heart palpitations, perspiration, and cold sweats, among others; and feelings of uselessness and worthlessness.
>
> ….
>
> It is evident that [the worker] fits the criteria for psychological entitlement and without psychological treatment it seems that he is worsening. In my view, this man is in need of a psychological assessment to determine if this patient could benefit from psychological intervention geared to manage the psychological sequelae elicited by the accident.

[13] In a further report, dated June 25, 2014, Dr. Pilowski provided a DSM-IV multi-axial diagnosis, with diagnoses on Axis I of "Major Depressive Disorder. Severe", "Pain Disorder Associated with Both Psychological Factors and a General Medical Condition" and "Symptoms of Post-Traumatic Stress Disorder." On Axis V, the workers GAF (Global Assessment of Functioning) was estimated by Dr. Pilowsky to be 55.

[14] The Board awarded the worker a 52% NEL award for his neurological impairment which resulted from his traumatic brain injury. The rating date for this NEL award is March 4, 2013. Although the details concerning the calculation of this award is discussed below, it should be noted that the award was made essentially on the basis of "Central and Spinal Nervous System Disorders" as an organic impairment (the award also included a small component (i.e., 3%) for loss of smell, which was rated under the heading "Other Non-Scheduled Impairments").

According to a Board memo, dated July 6, 2012, the date of maximum medical rehabilitation (MMR) for the worker's traumatic brain injury was February 28, 2012, the date of the worker's discharge from TRI.

[15] The Board awarded the worker a further NEL award for "Major Depressive Disorder". The Board rated this impairment at 10%, reflecting a "Class 2 Mild Impairment (5 – 15%) – impairment levels compatible with most useful function". The rating date for this award is November 24, 2014. The MMR indicated in the NEL documentation is October 20, 2014, which is the date of the latter of Dr. Pilowsky's reports, referred to above.

(iii) Applicable law and policy

[16] The workplace accident which is the subject of this appeal occurred on October 26, 2010. Accordingly, the worker's entitlement to benefits in this appeal is governed by the *Workplace Safety and Insurance Act, 1997.*

[17] In this appeal, the worker is seeking an increase to the quantum of his NEL award for his diagnosis of "Major Depressive Disorder", which was rated under the Board's policy on psychotraumatic disability. The Board's policy on the subject of "Psychotraumatic Disability", is included in *Operational Policy Manual* Document No. 15-04-02, which 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.

…

[18] The rating schedule for impairment due to psychotraumatic disability is included in *Operational Policy Manual* Document No. 18-05-11, on the subject of "Assessing Permanent Impairment Due to Mental and Behavioural Disorders", which states, in part:

….

Mental and Behavioural Disorders Rating Scale

The following scale applies to the assessment of permanent impairment benefits for psychotraumatic disability, chronic pain disability, and fibromyalgia syndrome.

….

Class 1, No impairment (0%) - no impairment noted

Class 2, Mild impairment (5-15%) - impairment levels compatible with most useful function

There is a degree of impairment of complex integrated cerebral functions, but the worker remains able to carry out most activities of daily living as well as before. There is also some loss in personal or social efficacy and the secondary psychogenic aggravations are caused by the emotional impact of the accident.

There is mild to moderate emotional disturbance under ordinary stress. A mild anxiety reaction may be apparent. The display of symptoms indicates a form of restlessness, some degree of subjective uneasiness, and tension caused by anxiety. There are subjective limitations in functioning as a result of the emotional impact of the accident.

Class 3, Moderate impairment (20-45%) - impairment levels compatible with some but not all useful function

There is a degree of impairment to complex integrated cerebral functions such that daily activities need some supervision and/or direction. There is also a mild to moderate emotional disturbance under stress.

In the lower range of impairment the worker is still capable of looking after personal needs in the home environment, but with time, confidence diminishes and the worker becomes more dependent on family members in all activities. The worker demonstrates a mild, episodic anxiety state, agitation with excessive fear of re-injury, and nurturing of strong passive dependency tendencies.

The emotional state may be compounded by objective physical discomfort with persistent pain, signs of emotional withdrawal, depressive features, loss of appetite, insomnia, chronic fatigue, mild noise intolerance, mild psychomotor retardation, and definite limitations in social and personal adjustment within the family. At this stage, there is clear indication of psychological regression.

In the higher range of impairment, the worker displays a moderate anxiety state, definite deterioration in family adjustment, incipient breakdown of social integration, and longer episodes of depression. The worker tends to withdraw from the family, develops severe noise intolerance, and a significantly diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behaviour, tendency to avoid anxiety-

creating situations, with everyday activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

Class 4, Marked impairment (50 - 90%) - impairment levels significantly impede useful function

There is a degree of impairment of complex integrated cerebral functions that limits daily activities to directed care under confinement at home or in other domiciles. The worker clearly displays chronic limitation of adaptation and function, in the home and outside environment, that ranges from moderate to severe. The worker is withdrawn, forgetful, unable to concentrate, and needs continuous emotional support within the family setting. The worker is incapable of self-care and neglects personal hygiene.

There is a moderate to severe emotional disturbance under ordinary to minimal stress, which requires sheltering. There may be an obvious loss of interest in the environment with the worker becoming extremely irritable, showing significant emotional lability, changes of mood, and uncontrolled outbursts of temper. The worker may be severely depressed, with outstanding features of psychomotor retardation and psychological regression.

[19] The worker is also seeking entitlement to a PCA and to an ILA. The Board's policy on the subject of "Personal Care Allowance" is included in *Operational Policy Manual* Document No. 17-06-05, which states, in part:

Policy

Severely impaired workers who have difficulty with the activities of daily living are entitled to a personal care allowance (PCA) to hire attendants.

Guidelines

Severely impaired

Workers are considered severely impaired if their impairments are

- permanent and rated for either permanent disability (PD) benefits totaling at least 100%, non-economic loss (NEL) benefits totaling at least 60%, or
- likely to be permanent in the opinion of a WSIB medical consultant, and meet one of the criteria above

[20] The Board's policy on the subject of "Independent Living Allowance" is included in *Operational Policy Manual* Document No. 17-06-02, which states, in part:

Policy

Severely impaired workers are entitled to an annual independent living allowance to:

- help them function as independently as possible where they work, where they live and in society, and
- improve their quality of life

Guidelines

Severely impaired

Workers are considered severely impaired if their disabilities/impairments are

- permanent and rated for either permanent disability (PD) benefits totaling at least 100%, non-economic loss (NEL) benefits totaling at least 60%, or

- likely to be permanent in the opinion of a WSIB medical consultant, and meet one of the criteria above.

(iv) The issues under appeal

[21] The issue agenda for this appeal was discussed with the worker's representative at the commencement of the appeal hearing. The representative advised me that the worker wished to withdraw his appeal in relation to the issue of entitlement to benefits for injuries to the cervical spine and to the left shoulder. The representative indicated that he discussed the withdrawal of this issue from the appeal with the worker, and that the worker understood that it would be difficult to restore this issue to an appeal after it had been withdrawn. In the circumstances I agreed to allow the worker to withdraw this issue from the appeal. Should the worker wish to restore this issue to an appeal, he will be subject to the provisions of the *Workplace Safety and Insurance Act, 1997*, which impose time limits for appeals.

[22] The worker's representative also indicated that the worker's primary objective in this appeal is to obtain entitlement to a PCA and an ILA, and it was noted that the worker would be eligible for these allowances if he was in receipt of a NEL award rated at 60% or greater. It was also noted that, if, as a result of this appeal, the worker is awarded an increase to his NEL award for psychotraumatic disability, so that his total NEL award was 60% or greater, the issue of the number of hours of personal care to which he was entitled as a health care benefit, would be moot, because in that case, the worker would be entitled to personal care assistance through a PCA, and the extent of his entitlement to a PCA would be determined through a new assessment. On this basis, the worker's representative indicated that should the worker be entitled to a PCA as a result of this appeal, he should be deemed to have withdrawn his appeal in relation to the number of hours of personal care to which he was entitled as a health care benefit.

[23] For reasons that are provided below, I have determined that the worker is entitled to a NEL award rated at greater than 60%, and that the worker is entitled to a PCA and an ILA. Accordingly, the issues to be determined in this appeal are:

i) The quantum of the worker's NEL award; and

ii) Whether the worker is entitled to a PCA and an ILA.

(v) Analysis

(a) Quantum of the worker's NEL entitlement

[24] In this appeal, immediately prior to the appeal hearing, the worker was entitled to a 57% NEL award. This award is comprised of two main elements.

[25] In its rating of March 4, 2013, the Board awarded the worker a 52% NEL award for traumatic brain injury. This included a 51% impairment rating for "Central and Spinal Nervous System Disorders" and a 3% impairment rating for "loss of smell" which the Board allowed on the basis of "Other Non-Scheduled Impairments". These two ratings were combined to result in a rating of 52% for the worker's traumatic brain injury. At the hearing, the worker's representative indicated that he did not object to the quantum of this aspect of the worker's NEL award.

[26] The other element of the worker's NEL rating is for psychotraumatic disability. In its rating of November 24, 2014, the Board awarded the worker a 10% impairment rating for "Major Depressive Disorder". This rating falls within "Class 2, Mild impairment (5-15%) - impairment levels compatible with most useful function." The description for a Class 2 impairment which is included in the applicable policy document is set out above. When this 10% rating is combined with the worker's 52% rating, referred to above, the worker's total NEL award is 57%.

[27] It is apparent that, if the 10% rating is considered separate and apart from the worker's rating for his traumatic brain injury, the rating does not reflect the degree of psychological impairment that the worker experienced as a result of his work accident.

[28] From the medical information on file, some of which is included above, it is apparent that the worker's impairment is *not* "compatible with most useful function". The medical information on file indicates that the worker requires significant assistance with personal care, and is not capable of activities of daily living (such as cooking meals), without significant assistance and/or supervision. In April 2013, the worker was the subject of an assessment by the Community Care Access Centre (CCAC), and the report concluded by stating that "Patient will be able to remain at home provided that he receives 24 hour care and supervision." It is apparent from even a summary consideration of the worker's medical information that his level of psychological impairment does not fit the description for a Class 2 mild impairment which is consistent with a worker being capable of most useful day to day functioning.

[29] The reason for this apparent discrepancy is explained in the NEL documentation provided in connection with the worker's 10% award for psychotraumatic disability. The applicable NEL Evaluation document states, at the top of the second page of the document:

> In determining the degree of impairment, functional limitations that are caused by a work-related mental and behaviour disorder are differentiated from functional limitations and capabilities caused by physical or neurological impairments to avoid duplication.

[30] At the bottom of the same page of the document, it states:

> <u>Overall Impairment:</u>
>
> In reviewing all of the available and relevant evidence a Class 2 – 10% impairment best describes the worker's condition noting:
>
> - Impairment of complex integrated cerebral functioning, loss of personal and social efficacy have been captured in the previous neurological ratings of 2012/2013.
> - There is mild to moderate emotional disturbance and subjective uneasiness evidenced by his mood fluctuations, fatigue and worry about the future. Previous neurological rating has taken these issues into consideration.
> - The injured worker's anxiety reaction is noted within the current description of nightmares and the effects of decreased self concept, poor body image and loss of self confidence which appear to have contributed to his depressive state.

[31] I interpret this information to mean that the Board understands that the worker's impairment level for psychotraumatic disability is actually greater than 10%, but that the actual rating for psychotraumatic disability has been discounted to avoid double recovery by the worker. I interpret the information included in the NEL Evaluation document to mean that it is the Board's position that, elements of entitlement that would typically be included in a rating for psychotraumatic disability in the ordinary case, have already been awarded to the worker in the

context of his 52% neurological rating, and should therefore not be awarded again in the worker's rating for psychotraumatic disability.

[32] I agree that, in a case where a worker has been awarded a NEL benefit for a traumatic brain injury on an organic basis, and has also been awarded a NEL benefit for psychotraumatic disability in relation to the same injury, it is necessary to consider whether "duplication" or double recovery has occurred, and that steps should be taken to ensure that this does not occur. The concern with the approach taken by the Board in this case, however, is that it does not permit the worker to understand his "actual" level of impairment for psychotraumatic disability as determined by the Board, prior to the discounting which is necessary to avoid double recovery. The statement in the NEL documentation that "a Class 2 – 10% impairment best describes the worker's condition" is, if considered literally, obviously incorrect.

[33] In order to make clearer to the worker how his NEL award is calculated, I propose, as a first step, to rate the worker for psychotraumatic disability pursuant to the criteria included in *Operational Policy Manual* Document No. 18-05-11 without reference to the worker's neurological rating. This will reflect the worker's actual level of impairment for psychotraumatic disability. The second step of the process will be to consider the neurological rating and to determine whether there was an element of that rating which overlaps with the rating for psychotraumatic disability. If there is an overlap, the portion of the neurological rating which has been awarded for factors recognized in the rating for psychotraumatic disability, shall be deducted from the rating for psychotraumatic disability. The amount of the residual portion of the rating for psychotraumatic disability shall be an amount, which when combined with the portion deducted, results in the "actual" rating, previously determined.

[34] In my view, this approach will allow the worker to better understand his actual rating for psychotraumatic disability with analysis for why the rating was appropriate in terms of the criteria included in *Operational Policy Manual* Document No. 18-05-11. It will also allow the worker to understand the rationale for the quantum of the portion of the rating for psychotraumatic disability which has been deducted in order to avoid double recovery. This approach requires:

- A determination of a rating which reflects the worker's pre-discounted level of NEL entitlement for psychotraumatic disability ("step one");
- A determination of a rating which reflects the level of psychological impairment accounted for in the neurological rating, which should not be included in the rating for psychotraumatic disability ("step two");
- The determination of the residual portion of rating for psychotraumatic disability through the deduction of the amount determined in step two from the amount determined in step one. The residual portion of the rating for psychotraumatic disability, shall be an amount which when combined with rating deducted (i.e., the amount determined in step two), results in the pre-discounted rating for psychotraumatic disability.

[35] I find that the worker's pre-discounted level of impairment for psychotraumatic disability is best reflected by a 45% rating, which is the highest rating for "Class 3, Moderate impairment (20-45%) - impairment levels compatible with some but not all useful function".

[36] The Neuropsychological Assessment Report, dated January 18, 2012, from TRI indicated that the worker's "memory function… is significantly impaired" and that "these impairments will have a significant limiting effect on his ability to perform most daily activities." A further report from TRI, dated February 12, 2012, entitled "Attendant Care & Housekeeping Home Maintenance Assessment" indicated that the worker requires "basic supervisory care", and "co-ordination of care" noting that the worker "currently continues to experience limitation with his physical function and cognitive abilities (memory, safety, problem solving)" and that the assessor concluded that "he requires supervision throughout the day to ensure his safety within his home and the community."

[37] In addition, Dr. Pilowsky's report, dated January 21, 2014, stated that the worker had depressed mood most of the time with occasional crying spells, suicidal ideation, engaged in verbal outbursts of anger, had decreased appetite, sleep deprivation, nightmares, headache, fatigue, frustration with his limitations, withdrawal from others, lack of interest in previously enjoyed activities, sensitivity to light and noise due to headaches, cognitive difficulties such as short-term memory, focus and concentration, anxiety including symptoms such as heart palpitations, perspiration, and cold sweats, and feelings of uselessness and worthlessness.

[38] The final paragraph of the description for a Class 3 impairment that is set out in the rating schedule included in *Operational Policy Manual* Document No. 18-05-11 describes the characteristics of a worker who properly falls within the "higher range of impairment" for Class 3. These characteristics include:

- A moderate anxiety state;
- Definite deterioration in family adjustment,
- Withdrawal from the family
- Development of severe noise intolerance
- Phobic pattern or conversion reaction resulting in bizarre behaviour
- Everyday activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

[39] I find that the worker meets or exceeds all of these criteria. The medical information supports the conclusion that the worker experiences at least a moderate level of anxiety. He testified that he is divorced, and he rarely sees his children. His primary social contact is his caregiver. The worker testified that he develops severe headache from loud noise. Dr. Pilowsky and the assessors at TRI referred to the worker's verbal outbursts and anger, which amount to bizarre behaviour. The worker testified that he has ceased driving and that he is essentially homebound, and this is also supported by the medical information.

[40] I am satisfied that the worker meets most of the significant criteria associated with the highest range of a Class 3 level of impairment as described *Operational Policy Manual* Document No. 18-05-11. On this basis, I conclude that the worker's pre-discounted level of impairment for psychotraumatic disability should be rated at 45%.

[41] I now turn to the worker's neurological rating, to determine which portion of that rating is taken into account in the worker's 45% rating, determined above. I note that the neurological rating for traumatic brain injury includes three components:

- 3% for “Loss of smell”;
- 30% for “Station and Gait: Can stand but walks only on the level”; and
- 30% for “Brain Disorder Impairment”

[42] When combined, these three values result in the worker’s 52% neurological award. I find that the 3% awarded for loss of smell, and the 30% awarded for “station and gait” are not accounted for in the worker’s 45% rating, which I have determined is the appropriate pre-discounted rating for psychotraumatic disability.

[43] I find, however, that the 30% awarded for “Brain disorder impairment”, is reflected in the 45% award for psychotraumatic disability, and should be deducted from the award for psychotraumatic disability.

[44] Table 1 on page 109 of the *Guides* sets out “Spinal Cord and Brain Impairment Values”, and provides a range of values for “Language disturbances”, “Complex integrated cerebral function disturbances”, “Emotional disturbances”, “Consciousness disturbances”, “Episodic neurological disorders” and “Sleep and arousal disorders”. In the worker’s case, the Board determined that the worker should be rated at 30% for “Complex Cerebral Function Disturbances”, 20% for “Emotional disturbances”, and 30% for “Episodic neurological disorders”. The Guides state at page 104, under the heading “The Brain”, that “more than one category of impairment may result from brain disorders” and that “in such cases the various degrees of impairment from the several categories are not added or combined, but the largest value, or greatest percentage of the seven categories of impairment, is used to represent the impairment for all of the types.” It is on this basis that the worker was awarded 30% for “Brain disorder impairment.” As noted above, the worker has not objected to the Board’s rating of his neurological impairment.

[45] I find that the type of impairment captured by “Complex Cerebral Function Disturbances”, “Emotional disturbances”, and “Episodic neurological disorders” for which the worker was collectively awarded a 30% rating (30% being the greatest rating for any of these factors) is the same type of impairment that is typically included in an award for psychotraumatic disability. I note that “Emotional Disturbances”, which was rated at 20% in the context of the worker’s earlier neurological rating, and that “Complex Cerebral Function Disturbances” (which was noted to include “loss of personal and social efficacy)”, which was rated at 30% in the context of the worker’s earlier neurological rating, would typically be considered as factors in a rating for psychotraumatic disability.

[46] It follows that the worker should not receive the 30% for this type of impairment in both his neurological rating and in his rating for psychotraumatic disability, as this would result in double recovery for the same type of impairment. Accordingly, 30% should be deducted from the rating for psychotraumatic disability. The deduction should be performed so that if the residual rating for psychotraumatic disability were to be combined with the 30% (i.e., the amount to be deducted), the 45% rating for psychotraumatic disability is approximated. On this basis, I find that the residual rating for psychotraumatic disability is 20%. The combined value of 20% and 30% is 44%, which I find approximates 45%. This approach is also consistent with the Board’s practice of awarding ratings for psychotraumatic disability in multiples of five.

[47] I note that if the residual value for psychotraumatic disability were to be calculated by simple subtraction, with a result of 15% (i.e., 45% minus 30%), 15% combined with 30% results

in a value of 41%, which is significantly less than the 45% value of the worker's pre-discounted rating for psychotraumatic disability. If "combining" is applied in order to aggregate values, it follows that the reversal of combining, rather than simple subtraction, should be applied when amounts are being deducted from values, to ensure that the worker receives the approximate value of the 45% rating for psychotraumatic disability, after the deduction to avoid double recovery has been completed.

[48] On this basis I conclude that the worker is entitled to compensation for psychotraumatic disability consistent with a rating of 20%. When this 20% rating is combined with the 30% component of the neurological rating, which addresses the same type of impairment as is covered by psychotraumatic disability, the result is approximately 45%, which I have determined is the worker's appropriate pre-discounted rating for psychotraumatic disability.

[49] I have also considered the MMR date for the worker's 20% rating for psychotraumatic disability. I note that a Board memo, dated July 6, 2012, indicated that the Board determined that the MMR date for the worker's traumatic brain injury is February 28, 2012. I also note that the rating for the traumatic brain injury included a significant portion (i.e., more than half) of the worker's overall rating for psychotraumatic disability. The MMR date that the Board determined for its 10% award for psychotraumatic disability was October 20, 2014, the date of Dr. Pilowsky's second report. Given that the Board has determined that MMR date for the greater part of the rating for psychotraumatic disability is February 28, 2012, this is the MMR date which should be applied to the rating for the full psychotraumatic disability rating. It is not logical for the worker to have two different MMR dates for the different components of his psychological rating. The memo, dated July 6, 2012, stated that the Board had determined that the worker's condition (which included an element of his psychological condition) was "unlikely to improve" after February 28, 2012, and there is no persuasive medical information to support the conclusion that the worker's psychological condition improved after that date.

[50] Accordingly, I find that the appropriate MMR date for the worker's psychotraumatic disability award is February 28, 2012.

(b) Entitlement to a PCA and ILA

[51] For reasons that are provided above, I have determined that, in addition to the 52% NEL benefit awarded to the worker for a neurological injury, the worker is entitled to a further NEL award for psychotraumatic disability, rated as a 20% impairment of the whole person. When these awards are combined, the worker's total NEL award is 62%.

[52] The worker therefore meets the eligibility requirements for benefits and services under the Board's Serious Injury Program, and he is entitled to a PCA and an ILA. The Board is directed to carry out a new assessment of the worker to determine his needs and his level of entitlement to services and benefits in relation to a PCA and an ILA. The worker's entitlement to a PCA and an ILA is retroactive to February 28, 2012, which is the date when he became entitled to a NEL award greater than 60%.

[53] The worker's appeal in relation to the issue the number of hours of personal care to which he was previously entitled as a health care benefit is moot, and the issue is deemed to have been withdrawn by the worker.

DISPOSITION

[54] The appeal is allowed.

i) The worker is entitled to a NEL award reflecting a 62% impairment of the whole person.

ii) The worker is entitled to a PCA and an ILA, effective from February 28, 2012.

iii) The Board is directed to carry out a new assessment of the worker to determine his needs and his level of entitlement to services and benefits in relation to a PCA and an ILA.

DATED: May 18, 2017

SIGNED: M. Crystal