WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1068/08

BEFORE: R. McClellan : Vice-Chair
V. Phillips : Member Representative of Employers
D. Broadbent : Member Representative of Workers

HEARING: May 1, 2008 at Toronto
Oral
No post hearing activity

DATE OF DECISION: June 20, 2008

NEUTRAL CITATION: 2008 ONWSIAT 1744

DECISION(S) UNDER APPEAL: WSIB ARO decision dated June 29, 2006

APPEARANCES:

For the worker: Mr. Richard Fink, Lawyer
Witness - worker's spouse

For the employer: Not participating

Interpreter: Italian

REASONS

(i) The appeal

[1] The worker appeals the decision of the Appeals Resolution Officer, Mrs. McPartland dated June 29, 2006. That decision concluded the worker did not have entitlement to an increase in the quantum of his 60% permanent disability award for psychotraumatic disability; and, the worker did not have entitlement to the personal care allowance on the grounds that he did not meet the entitlement criteria set out in Board policy of 100% Permanent Disability.

[2] The issues before the Panel are:

- whether the worker has entitlement to an increase in the quantum of his 60% permanent disability award for psychotraumatic disability; and,
- whether the worker has entitlement to the Personal-Care Allowance.

(ii) Background

[3] The worker, now age 63, was employed in a body shop beginning in 1968. He developed occupational asthma from exposure to isocyanate in the workplace and received compensation under a claim dated February 9, 1989. The worker received temporary partial benefits to March1990. In 1991, he was awarded a 5% permanent disability pension for isocyanate sensitization.

[4] The worker continued to work in body shops as a spray painter and in 1997 he experienced exposure symptoms and was unable to continue as a body shop worker. A new claim was established and vocational services were provided by the Board. The worker proved to be unable to benefit from vocational rehabilitation services and section 147(4) supplementary benefits were granted in November 1997.

[5] In 1997, the worker developed symptoms of mental illness with a diagnosis of depression and anxiety. Entitlement for psychotraumatic disability was denied at the claims level and denial was confirmed by an ARO's decision dated July 24, 2001, but psychotraumatic disability entitlement was allowed in Tribunal *Decision No. 208/04.*

[6] Following the Tribunal decision, the worker was awarded a 25% permanent disability pension for psychotraumatic disability for the period from October 1997 to December 1999 and as of December 4, 1999 the PD award for PTD was set at 60%, under the provisions of Board OPM Document #15-04-02, Category 4-Severe Impairment of total person (60%-80%).

[7] The worker has claimed entitlement to 100% permanent disability for his compensable psychotraumatic disability, based on reports from his psychiatrists as of April 7, 2001. The worker has been unable to testify at either the previous ARO appeal or the previous Tribunal hearing because of the severity of the psychiatric condition.

[8] In Tribunal *Decision Nos. 2018/03I and 2018/03* the panel summarized the medical evidence as follows.

Medical evidence

In February 1989, Dr. Chase, a respirologist, diagnosed the worker with isocyanate – induced asthma after a 15-year history as a spray painter. The worker was told to avoid further exposure and the worker became a prep man where he was no longer exposed to isocyanates at least on the same level as a painter. By August 1989, Dr. Hargreave reported that there was no evidence of impairment of ventilatory function but recommended some follow up because the worker was intermittently exposed to isocyanates even though he was no longer spray painting.

Follow ups were done in 1990 and 1991 where it was reported that the worker had no symptoms provided that there was no exposure.

There are no significant medical reports between 1991 and 1996. The worker started working with a new employer on September 16, 1996. Dr. Micelli's clinical notes are difficult to read but it appears that they start in the fall of 1996. The worker's son contacted the Board on November 20, 1996 regarding a worsening of his father's condition. The worker then had a severe episode of shortness of breath at work on December 16, 1996. In a conversation with the Claims Adjudicator, the employer confirmed that the worker started working as a prep person on September 16, 1996. He was applying primer and provided with charcoal filtered respirators.

The shop was completely renovated less than one year ago and there was a regular ventilation system. The worker's actual time spraying primer would be 10 to 15 minutes per day and maybe a couple of small jobs per day of two to three minutes. When not priming, the worker was taping, sanding and cleaning the dust off. The employer strongly contested the claim because they had heard from someone outside of the company that the worker had a problem prior to his employment with them. When they approached the worker about his problem, he stated that he was fine and liked working there. Nothing else was said and no complaints were made until December 16, 1996 when it was thought that the worker was having a heart attack. The worker was having problems breathing and was coughing a lot. The worker did not want to go to the hospital and left on his own. On December 18, 1996, the worker brought a doctor's note stating that he should not do that type of work. The employer then let him wash cars in a different building but by January 7, 1997, the employer did not have any other work for the worker and therefore let him go.

Even though the worker was removed from spray painting duties from December 18, 1996 to January 6, 1997, he reported on his Worker's Continuity Report that he had severe coughing at work on January 3 and January 6, 1997.

The worker was seen by Dr. Tarlo for assessment on January 23, 1997. Dr. Tarlo and her resident reported that the worker likely had occupational asthma secondary to isocyanates in the primer. The worker brought a bottle of the primer with him at his examination and it was confirmed that isocyanates were a component of the product. The worker's claim file also includes a letter from the maker of the primer confirming that it was a urethane-based primer that requires an isocyanate activator. The maker of the primer did not doubt that the worker was sensitive to the chemicals in the products but it was his opinion that the sensitivity and harm to his health was done earlier in his career. Dr. Kabir, a Board occupational hygienist apparently advised the Claims Adjudicator that 90% of Canadian body shops use primers with isocyanates to some extent and most would use it a lot.

Dr. Tarlo reassessed the worker on February 21, 1997. Review of his previous CT scan was unremarkable. Since he was last seen he continued to feel well but was not working. A methacholine challenge at the February 21, 1997 visit was entirely normal. The findings were consistent with the clearing of his symptoms since he stopped working with isocyanate exposure in early January. It was extremely likely that he had a recurrence of his asthma in relation to this exposure at work even though there was no

objective documentation of it. At present, there was no evidence of ongoing asthma but it was likely that it would recur if he again worked with isocyanates.

Dr. Micelli's clinical notes refer to anxiety as of January 30, 1997. In subsequent visits, the worker also reported being in "dire straits". By September 1997, Dr. Micelli felt that a referral to a psychiatrist, Dr. Gotkind, was in order.

A vocational rehabilitation caseworker first met with the worker on August 6, 1996. The worker was to identify alternative viable jobs. It appears, however, that vocational rehabilitation had barely started when as of September 22, 1997, the worker was unable to continue with rehabilitation due to anxiety.

On October 31, 1997, the worker was admitted to the mental health clinic of the Humber

River Regional Hospital due to increased dyspnea, anxiety and anger, because the worker found himself unable to work as a prep man any more. There were further visits to the mental health clinic on November 5, 1997, December 9, 1997 and December 19, 1997. The worker was seen by Dr. Gotkind, a psychiatrist at the Humber River Regional Hospital Mental Health Centre.

Dr. Gotkind's October 31, 1997 report provided a diagnosis of adjustment disturbance with anxiety and depressive features secondary to failing health. The patient's situation was made worse as his income declined and his son was recently laid off with bills piling up. Dr. Gotkind provided a further report on August 22, 1998 reporting that he had been following the worker for depression and anxiety escalated from his disablement. With respect to the etiology of the worker's psychiatric condition on April 17, 1999, Dr. Gotkind reported that he was unable to form any opinion as to the etiology of the worker's need for medical/psychiatric help for his anxiety disorder with panic attacks encompassing severe shortness of breath and secondary depression. Dr. Gotkind referred the worker to an Italian-speaking psychiatrist.

With respect to the worker's respiratory function, he was seen by Dr. Ritcey in November 1997 and March 1998. Dr. Ritcey reported that the worker's routine pulmonary function was normal although he tended to stop the peak flow with a bit of a hacking cough. The worker was exhibiting a very flat affect and depressed demeanour. The methacholine challenge was negative. Dr. Ritcey thought that the worker had a very mild asthma pattern with bronchial reactivity quite stable and controlled using Atrovent and Pulmicort at low dosages. His history suggested isocyanate idiosyncrasy and sensitivity but this was not an ongoing feature. His major problem was that of a severe depressive affective mood disorder. Dr. Tarlo also saw the worker in follow-up in 1998. She reported on October 20, 1998 that the worker's pulmonary function tests, although of poor quality, were essentially unchanged. She felt that the worker's current symptoms were not related to his symptoms from isocyanate exposure and that "his shortness of breath and cough may be unrelated to any respiratory problem at this time". She suggested another psychiatric opinion.

For reasons unknown, the worker started seeing another family physician, Dr. Sokol, at the same time as he continued to see Dr. Micelli. As a result, the worker was referred by Dr. Sokol to another psychiatrist, Dr. Arbitman. In a report dated February 5, 1998, Dr. Arbitman reported that at that time the worker was pleasant and cooperative during the interview. There was no evidence of thought disorder or delusional thinking. His sleep and appetite were poor. He was nervous and depressed. He had seen another specialist and had been prescribed medication.

Dr. Arbitman thought that the worker had an adjustment disorder with anxiety and depression.

He was to obtain the reports from the Board and Dr. Gotkind. On September 18, 1998, Dr. Arbitman reported that he only ever saw the worker on one occasion and never

received the reports from the Board or from Dr. Gotkind. At this time, the worker had not changed very much. He was still depressed, nervous and irritable.

It then appears that the worker did not continue with treatment with Dr. Gotkind or Dr. Arbitman and rather, started treatment with Dr. Canella, an Italian-speaking psychiatrist. In a report dated December 4, 1999, Dr. Canella opined that the worker was suffering from a major depressive disorder, which was chronic and had arisen as a consequence of injuries he suffered in the workplace. In a subsequent report dated April 7, 2001, Dr. Canella noted the isocyanate history and the 1996 layoff. The worker's respiratory problems had returned and it was found that he could no longer use the primers used in these shops. All the worker knew was bodywork and he had very little transferable skills that would help him find work in other industry sectors.

He was unable to find other work. His psychological state deteriorated and he had to confront his mortality and limitations with the ensuing loss of his role as a provider and contributing member of society. Financial difficulties contributed to his anxieties. As his condition worsened, it became self-perpetuating as the impairment resulting from his symptoms caused him further worry and despair about his future. On the basis of the medical information available, it appears that the worker had suffered from a major depressive disorder since at least early 1997. It was Dr. Canella's opinion that the worker's chronic condition had arisen as a consequence of the injuries suffered in the workplace. Dr. Canella supported the worker's claims for benefits from both CPP and WSIB. Dr. Canella continues to see the worker every two weeks. His medications are Lorazepam for anxiety and insomnia, Citalopram for depression and Pimozide for his worries, which Dr. Canella believes to be delusional in character. The prognosis is poor.

[9] Following the hearing, the Panel in *Decision No. 2018/03* referred the case to a Medical Assessor:

(iii) Medical assessor opinion

At the Tribunal's request, Dr. A. I. Margulies, a psychiatrist, provided a report on February 26, 2004 in response to our questions. Dr. Margulies prepared his report based on the documentary evidence and the information and findings contained in *Decision No. 2018/03I*. Dr. Margulies' opinion is as follows:

> On the basis of a review of the provided documentation, the likely diagnostic impression is that [the worker] is and has, for a number of years, been experiencing a major depressive disorder of moderately severe proportions. Symptoms thereof have included a generally depressed mood, crying, withdrawal, marked irritability, agitation, apparent feelings of uselessness, insomnia, fatigue, probable anorexia with uncertain weight loss, anergia, amotivation and non-specific cognitive difficulties. Overall, his psychiatric status would appear to have been little different than or possibly even more severe than what was noted by Dr. Canella at the time of initial evaluation in November, 1999 (and as outlined in a report dated December 4, 1999). More likely than not, this depressive illness had onsetted sometime during 1997 and, while initially relatively mild compared to current expression, had been apparent at the time of psychiatric evaluation by Dr.Gotkind in October, 1997 and Dr. Arbitman in February, 1998. The diagnosis of an adjustment disorder with anxiety and depression, made both by Dr. Gotkind and Dr. Arbitman, likely reflected what was considered to have been the reactive influence of environmental factors. By the time of evaluation by Dr. Canella in early 1999, a more obvious picture of a major depressive episode was apparently (details of which were noted above). [The worker] would appear to have been resistant to the therapeutic interventions undertaken by various health care providers, in particular Dr. Canella. His current status, while uncertain in view of

> the absence of the absence of contemporaneous reporting, has been assumed to be little different.
>
> Reasons for the development of this depressive illness are by no means clear. It has been indicated that in the past [the worker] had difficulties in coping with periods of unemployment and he is reported to have felt "nervous" in an unspecified manner, to have experienced sleeping difficulties, to have cried, to have become irritable and withdrawn, and to have developed coughing symptoms similar to that which had been manifest during asthmatic episodes secondary to isocyanates exposure and sensitivity.
>
> While in the absence of a more detailed account of his emotional state relative to periods of enforced unemployment, there is much to suggest, with the benefit of hindsight, that these were mild depressive episodes, likely reactive or secondary to unwelcome unemployment. Taking into consideration [the worker's] good work history, it is likely, but nonetheless, speculative to some degree, that his ability to work, to be the breadwinner for his family, was a major source of his self-esteem and that in order to maintain his role as a man, he had to be employed. When unable to do so, from whatever cause, there is much to suggest that he experienced mild depressive episodes, likely reactive in nature, and hence an adjustment disorder with depressed mood, to what he perceived to have been a threat to his integrity, self esteem and sense of self. Assuming that these factors apply to [the worker] it is noteworthy that the cause of his unemployment would be relatively unimportant in comparison to the fact of his unemployment. In an individual to whom his ability to work formed a major source of his self esteem and identity, any loss of work would have been a sufficient precipitant.
>
> There is nothing to indicate that exposure to isocyanates per se, or his sensitivity to it, would have been relevant to the development of what currently has become a depressive illness. To the best of my knowledge, there is nothing in the literature which suggests a cause and effect relationship between isocyanates and a mood disorder and while theoretically it may be possible, the likelihood is very remote.
>
> Perpetuating factors likely include the threat of an asthmatic attack if he were to be exposed to isocyanates, and, in all likelihood far more importantly, the fact of his appeal and the necessity that he prove himself to be disabled.

(iv) Additional opinion from the worker's treating psychiatrist, Dr. Canella

Following receipt of Dr. Margulies' report, Mr. Fink obtained an additional opinion from Dr. Canella who is the worker's treating psychiatrist. In his report dated March 26, 2004, Dr. Canella provided an update with respect to the worker's condition. Dr. Canella reported that the worker's symptoms have persisted and there has been little change from his initial presentation four and a half years ago. The worker continues to worry constantly and excessively about his health and future. He remains socially withdrawn, spending all day sitting alone and showing no interest in anything including his family. The worker presents as a frail, thin, psychomotor-retarded man who is anxious and depressed. For the most part, he is mute staring off in the air. Attempts to engage him usually result in his becoming agitated and weepy.

Dr. Canella also had the opportunity to review Dr. Margulies' report. With respect to that report, Dr. Canella opined:

> [Dr. Margulies] indicates that his review of the documentation suggests to him that the patient has been "experiencing a major depressive disorder of moderately severe proportions."
>
> It is unclear to me how one could use a qualifier "moderately" in this case. I would direct you to the accompanying copies of letters I have sent to the Workplace

> Safety and Insurance Board as well as consultation notes, copies of which were apparently also sent to the Board.
>
> With respect to the comments that a perpetuating factor is “the fact of his appeal and the necessity that he prove himself disabled.” I wish that this case were that simple. Please be aware that it was [the worker’s spouse] who applied for Canada Pension Plan Benefits and who has been the driving force behind the WSIB appeal. I wish to emphasize the fact that [the worker] has been completely oblivious to the process and that he showed absolutely no reaction when he was, in fact, granted a disability pension. Currently, he does understand that something is going on with “Compensation”, but his one and only concern, four and a half years after our initial meeting, remains that his “life is over.”

[10] Following Tribunal *Decision No. 2018/03*, the worker was assessed for pension purposes by Board psycho-social team coordinator Dr. Dudley. Based on a review of the medical file, Dr. Dudley recommended a stepped award, recognizing the deterioration in the worker's condition over time. He recommended a 25% permanent disability award from October 31, 1997 until December 4, 1999. As of the date of Dr. Canella’s assessment of December 4, 1999, the worker was found to be "severely impaired" and was rated by Dr. Dudley at 60%, at the low end of Category 4 - Severe Impairment.

[11] On March 26, 2004, Dr. Cannella provided a summary report to the worker's representative, stating that he had been treating the worker for a chronic and severe major depressive disorder since November 4, 1999 (summarized above). However, an extremely pertinent section of the report reads as follows:

> In accordance with the Guides to the Evaluation of Permanent Impairment of the American Medical Association, I would assess [the worker] as suffering from severe to extreme (4-5/5) impairment of his activities of daily living, extreme (5/5) impairment of social functioning, marked extreme (4-5/5) impairment of his ability to concentrate and see tasks to completion and an extreme (5/5) limitation in his ability to adapt to stressful circumstances.
>
> Diagnostically, using DSM criteria he suffers from:
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> | | |
> |---|---|
> | Axis I | Major depressive disorder, single unremitting chronic episode with psychotic features. Possible organic mental disorder. |
> | Axis II | none identified |
> | Axis III | pulmonary disease secondary to isocyanate toxicity. Given the severity and chronicity of the patient's cognitive difficulties it is also possible that he suffers from neurological sequelae of exposure to inhalants in the workplace. There is clear evidence of the toxic effects of solvents. With respect to isocyanate in particular there are studies that observed significant chronic psychological and neurological effects of the Union Carbide disaster in Bhopal. |
> | Axis IV | none currently |
> | Axis V | GAF-25 (current and highest in the past year). |

[12] The Case Record contains an excerpt from Kaplan and Sadock, *Synopsis of Psychiatry* 9th edition, describing at table 9-5 the Global Assessment of Functioning (GAF) scale.

[13] GAF in the range 30-21 is described as follows;

> Behavior is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment (e.g. sometimes incoherent, asked Grassley inappropriately, suicidal preoccupation) or inability to function in almost all areas (e.g. stays in bed all day; no job, home, or friends).

(iii) Testimony of the worker's witness

[14] The worker's witness testified that she was the worker's spouse, that the worker's psychiatric problems began in 1997/1998 and that his condition deteriorated significantly in 1998. She stated that by 1998, her husband was depressed, angry, and would no longer go out or socialize. She stated that his condition deteriorated between 2000 and 2002 and that by 2002, he was refusing to eat, neglected personal hygiene, refuse to socialize with anybody including family members and had basically stopped talking, except to express anger or to threaten to kill himself. The witness stated that by 2004 the worker required total care and she had to quit working to stay home and look after him. She stated that the worker requires total assistance with dressing, eating, washing and bathing, changing clothes and even cleaning his teeth. She stated that the worker refuses to sleep in a bedroom upstairs and sleeps downstairs by himself which requires her to sleep downstairs because of concern about his suicide threats.

[15] She stated that the worker also has auditory hallucinations.

(iv) Submissions of the worker's representative

[16] On the issue of a PD quantum, Mr. Fink reviewed the psychiatric and other medical evidence in detail, including the reports from Dr. Gottkind, Dr. Veidlinger, Dr. Tarlo, and treating psychiatrist Dr. Cannella. He submitted that the evidence was overwhelming that the worker was in the top end of Category 4, Severe Impairment of Total Person under the provisions of Board's Operational Policy Manual (OPM) Document #15-04-02. He specifically referred to the opinion from Dr. Cannella in his report of March 31, 2008, quoted below at paragraph 26.

[17] Mr. Fink submitted that this worker, with the extraordinarily low GAF of 25, is virtually mute, suicidal, suffers from the most severe form of depression, is totally withdrawn and socially isolated even from his own family, and requires total personal care. He concluded that the worker is entitled to a permanent disability rating at the top end of category 4 under the pre-1990 rating scale for Mental and Behavioural Disorders.

[18] On the issue of the worker's entitlement for the personal-care allowance, Mr. Fink referred to Tribunal Deci*sion No. 2220/07*. In that Decision the Vice-Chair cited correspondence dated June 26, 2000 addressed to a member of the provincial parliament from the Board's Vice-President, Policy and Research, on this same issue.

> *"Operational Policy Manual* Document No. 17-06-02, on the subject of "Independent Living Allowance," states, however, that severely impaired workers are entitled to an ILA to help them function independently and to improve their quality of life. The policy document goes on to provide guidelines which state that workers are considered "severely impaired" if their disabilities have been rated for either a 100% PD award or a 60% non-economic loss (NEL) award.
>
> In his submissions, the worker's representative has cited *Decision No. 1305/06* and *Decision No. 1673/10* for the proposition that it is appropriate in some circumstances to

award an ILA where a worker's PD award is less than 100%. The decisions suggest that when addressing entitlement to an ILA for an injured worker whose entitlement to benefits is governed by the *Pre-1985 Act*, a more liberal approach should be taken, given that that Act apparently prescribes a less stringent test.

I note, however, that in this case, even without the benefit of my decision herein, the worker's 60% PD rating falls within "Category 4 – severe impairment of the total person" as described in *Operational Policy Manual* Document No. 15-04-02. In that regard, the worker is "severely disabled", at least within the meaning of that policy document. It should be understood, however, that a worker who is rated in "Category 4– severe impairment of the total person" of *Operational Policy Manual* Document No. 15-04-02 should not necessarily, in every case, be considered "severely disabled" for purposes associated with entitlement to an ILA.

I also note that since the ceiling for the PD rating schedule for CPD is 80%, regardless of how severely a worker might be disabled by CPD, such a worker could never qualify for the ILA without the exercise of some discretion in applying the "guidelines" which indicate a 100% PD rating is required to attract entitlement to an ILA.

At the appeal hearing, the worker's representative referred to correspondence dated June 26, 2000, addressed to a Member of Provincial Parliament, from the Board's Vice-President, Policy and Research, at the time. The correspondence reviewed the eligibility rules for an ILA, as set out in the Board's policy documents. Near its conclusion, the document stated:

> Exceptions To The Threshold
>
> Under s.119(l) the WSIB is directed to consider the merits and justice of each case which means that the WSIB must take into account all the facts and circumstances of each ease.
>
> While s.119 does not allow the WSIB, to make exceptions to specific legislative provisions, the WSIB can depart from policy provisions if there are exceptional circumstances that justify doing so in a particular case. The WSIB recognizes that a wide variety of facts and circumstances can arise and that is not possible in advance to set policies to decide every conceivable situation.
>
> In the past, the WSIB has paid benefits, such as the PCA [personal care allowance], in cases where the workers did not meet the required threshold but in which there were exceptional circumstances. The WSIB remains committed to reviewing the details of each case when determining entitlement to benefits for severe impairments, and all other compensation benefits.

I agree that discretion should be used in awarding an ILA where the circumstances are exceptional. In my view, the worker's case represents exceptional circumstances. He is severely impaired according to the criteria set out in *Operational Policy Manual* Document No. 15-04-02.

My reasons, set out above, in relation to the worker's entitlement to an increase in his PD rating, provide details of the exceptionally severe nature of the worker's disability. As I have noted, as a result of the Board's rating scheme, without the exercise of some discretion, it appears impossible for a person who is severely impaired due to CPD to become entitled to an ILA.

[19] Given that the highest PD rating under the applicable rating schedule is 80%, Mr. Fink submitted the circumstances in the case before us are certainly exceptional, that the worker is severely impaired and that his spouse is basically a prisoner of care who urgently requires the kind of relief from her total care responsibilities by the provision of the personal-care allowance.

(v) Law and policy

[20] Since the worker was injured in 1989, the pre-1997 pre-1989 *Workers' Compensation Act* is applicable to this appeal. The hearing of this appeal commenced after January 1, 1998; therefore, certain provisions of the *Workplace Safety and Insurance Act, 1997* ("WSIA") also apply to the appeal. All statutory references in this decision are to the pre-1989 Act**,** as amended, unless otherwise stated.

[21] The relevant section of the pre-1989 Act states as follows:

> **45(1)** Where permanent disability results from the injury, the impairment of earning capacity of the worker shall be estimated from the nature and degree of the injury, and the compensation shall be a weekly or other periodic payment during the lifetime of the worker, or such other period as the Board may fix, of a sum proportionate to such impairment not exceeding in any case the like proportion of 90 per cent of the worker's net average earnings.
>
> …
>
> **(3)** The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent disability cases.
>
> **(4)** Where the impairment of the earning capacity of the worker does not exceed 10 per cent of the worker's earning capacity and the worker does not elect to receive compensation by a weekly or other periodic payment, the Board shall, unless the Board decides that it would not be to the advantage of the worker to do so, direct that such lump sum as may be considered to be the equivalent of the periodic payment shall be paid to the worker.
>
> **45(1)** Where permanent disability results from the injury, the impairment of earning capacity of the worker shall be estimated from the nature and degree of the injury, and the compensation shall be a weekly or other periodic payment during the lifetime of the worker, or such other period as the Board may fix, of a sum proportionate to such impairment not exceeding in any case the like proportion of 90 per cent of the worker's net average earnings.
>
> **(2)** Compensation for permanent disability is payable whether or not an award is made for temporary disability.
>
> **(3)** The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent disability cases.
>
> **(4)** Where the impairment of the earning capacity of the worker does not exceed 10 per cent of the worker's earning capacity and the worker does not elect to receive compensation by a weekly or other periodic payment, the Board shall, unless the Board decides that it would not be to the advantage of the worker to do so, direct that such lump sum as may be considered to be the equivalent of the periodic payment shall be paid to the worker.
>
> …
>
> **(11)** Where, at the time of a worker's death, the worker was in receipt of an award for permanent disability which the Board has rated at 100 per cent or, but for the death, would have been in receipt of an award for permanent disability at the rate of 100 per cent, a dependant of the worker is entitled to compensation from the time of the worker's death as if the death of the worker had resulted from the compensable disability for which the worker received or would have received the permanent disability award.

> **(12)** For the purposes of this section, "permanent disability" means any physical or functional abnormality or loss, and any psychological damage arising from such abnormality or loss, after maximal medical rehabilitation has been achieved.

[22] Pursuant to section 126 of the WSIA, the Board stated that the following policy packages are applicable to this appeal: In particular, we have considered Board Policy packages: 11; 104; 300.

[23] Board *Operational Policy Manual* Document #15-04-02 entitled "Psychotraumatic Disability," contains the rating schedule for pre-1990 CPD awards.

- **Category 1 - Minor Impairment of Total Person (10%)**

  In this category the injured worker's daily activity is slightly limited and no apparent difficulties are reported in personal adjustment. There is also some loss in personal or social efficacy and the secondary psychogenic aggravations are caused by the emotional impact of the accident.

  A mild anxiety reaction is 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. The disability, from the psychiatric point of view, is not expected to be permanent.

- **Category 2 - Moderate Impairment of Total Person (15% - 25%)**

  In this category, 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 the members of the family in all activities which take place outside the home. The worker demonstrates a moderate, at timed episodical, anxiety state, agitation with excessive fear of re-injury, nurturing strong passive dependency tendencies.

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

- **Category 3 - Major Impairment of Total Person (30% - 50%)**

  In this category the worker displays a severe anxiety state, definite deterioration in family adjustment, incipient 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 significant diminished stress tolerance. A phobic pattern or conversion will surface with some bizarre behaviour, a tendency to avoid anxiety-creating situations, with everyday activities restricted to such an extent that the worker may be homebound or even room-bound at frequent intervals.

- **Category 4 - Severe Impairment of Total Person (60% - 80%)**

  In this category, the worker clearly displays a chronic and severe limitation of adaptation and function in the home and outside environment.

  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 may be obvious loss of interest in the environment and the worker becomes extremely irritable, showing significant emotional liability, changes of mood and uncontrolled outbursts of temper. The worker may be severely depressed with outstanding features of psychomotor retardation and psychological regression. The worker is usually homebound or even room-bound.

[24] Mental disorders for claims after 1990 are rated for NEL purposes under Document No. 18-05-11, *Assessing Permanent Impairment Due to Mental and Behavioural Disorders.* The policy reads in part as follows:

Policy

Workers who have a permanent impairment due to a work-related mental or behavioural disorder are entitled to non-economic loss (NEL) benefits based on the severity of the impairment.

Guidelines
Rating impairment
The WSIB uses the NEL medical assessment completed by the roster physician (see 18-05-03, Assessing Permanent Impairment), and/or any relevant health information in the claim file, to determine the condition of a mentally or behaviourally impaired worker. The WSIB then rates the condition using the Mental and Behavioural Disorders Rating Scale, which combines elements of the *American Medical Association's Guides to the Evaluation of Permanent Impairment, 3rd edition (revised)*, (the AMA Guides) with the WSIB's Psychotraumatic and Behavioural Disorders Rating Schedule.

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Rating impairment
The WSIB uses the NEL medical assessment completed by the roster physician (see 18-05-03, Assessing Permanent Impairment), and/or any relevant health information in the claim file, to determine the condition of a mentally or behaviourally impaired worker. The WSIB then rates the condition using the Mental and Behavioural Disorders Rating Scale, which combines elements of the *American Medical Association's Guides to the Evaluation of Permanent Impairment, 3rd edition (revised)*, (the AMA Guides) with the WSIB's Psychotraumatic and Behavioural Disorders Rating Schedule.
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 liability, changes of mood, and uncontrolled outbursts of temper. The worker may be severely depressed, with outstanding features of psychomotor retardation and psychological regression.

Class 5, Extreme impairment (95%) - Impairment levels preclude useful function
There is such a degree of impairment of complex integrated cerebral functions that the worker is unable to care for himself or herself in any situation or manner. There is severe emotional disturbance that continually endangers the worker or others.

Application date
This policy applies to all decisions made on or after January 1, 1998, for accidents on or after January 2, 1990.
This policy is used in conjunction with Chapter 14 of the AMA *Guides, Mental and Behavioural Disorders*.

Board OPM Document 17-06-05, Personal care Allowance, reads as follows:

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.
>
> For a worker receiving both PD and NEL benefits, the WSIB combines all the impairments for review under the most appropriate rating schedule (i.e., either the PD or the NEL rating schedule) and determines if one of the above criteria for severe impairment has been met.

(vi) The Panel's conclusions

[25] On the issue of the worker's entitlement to a redetermination of the quantum of his permanent disability award for psychotraumatic disability, the Panel has carefully reviewed the medical and psychiatric evidence in the Case Record. The Panel in this case prefers the evidence from the worker's treating psychiatrist, Dr. Cannella, who is also Italian speaking and has been treating the worker twice a month since November 1999 for treatment of what he described as a chronic and severe Major Depressive Disorder.

[26] In his most recent report, dated March 31, 2008, Dr. Cannella`s DSM-IV diagnosis remains the same as stated in the report of March 26, 2004, with the same exceptionally low GAF score of 25. Dr. Cannella described the worker's mental impairment as follows:

> i) In accordance with *The Guides to the Evaluation of Permanent Impairment of the American Medical Association*, I would assess (the worker) as suffering from severe (4/5) impairment of his activities of daily living, severe to extreme (4-5/5) impairment of his social functioning, severe to extreme (4-5/5) impairment of his ability to concentrate and see tasks to completion and an extreme (5/5) limitation in his ability to adapt to stressful circumstances.
>
> ii) In accordance with the mental and behavior disorders rating scale utilized by the WSIB, I would assess (the worker) as being at the far upper end (85-90%) of Class 4, Marked Impairment. He clearly displays severe chronic limitation of adaptation and function. He does not leave the home without accompaniment. He is seriously withdrawn; he is forgetful and unable to concentrate. He needs continuous support emotionally, even within the home, and with the basics of self-care on personal hygiene. (The worker) can bring food to his mouth, but he needs daily reminders to eat. While he would lie on the couch all day unless encouraged to do otherwise, he is not confined to bed. He has demonstrated, at home and in my office and inability to complete the simplest tasks, reacting with marked agitation at minimal stress. You severely depressed, psychomotor retarded and regressed to the point of psychosis. There is significant emotional ability; he will weep loudly and uncontrollably at times, and others, he can become quite irritable and have outbursts of anger. Overall, there is extremely marked impairment, which significantly impedes an almost precludes useful function.

[27] The Panel accepts Dr. Cannella's assessment as determinative. His description of the worker's condition has been consistent since March 2004.

[28] The worker has a pre-1990 permanent disability award and therefore falls under the provisions of the rating schedule for behavioural and mental disorders sent out OPM Document #15-04-02. Again, the descriptor for category 4 reads as follows:

[29] Category 4 - Severe Impairment of Total Person (60% - 80%)

> In this category, the worker clearly displays a chronic and severe limitation of adaptation and function in the home and outside environment.

> 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 may be obvious loss of interest in the environment and the worker becomes extremely irritable, showing significant emotional liability, changes of mood and uncontrolled outbursts of temper. The worker may be severely depressed with outstanding features of psychomotor retardation and psychological regression. The worker is usually homebound or even room-bound.

[30] Based on the evidence from that worker's treating psychiatrist as well as the evidence of the worker's spouse, the Panel finds that the worker's permanent psychotraumatic disability should be re-rated at 80%, the top end of Category 4, Severe Impairment of Total Person. The worker's chronic and severe limitation of adaptation and function in the home and outside environment are explicitly delineated by Dr. Cannella. The severity of the worker's depression is evident from the medical reports and also from the evidence of the worker's spouse, that the worker experiences auditory hallucinations, which are the hallmark of a stage 5 Depression.

[31] The Panel finds that the worker is entitled to a redetermination of his permanent disability award for psychotraumatic disability, to be raised to 80%, effective the date of Dr. Cannella's report of March 2004.

[32] On the issue of the worker's entitlement to the Personal Care Allowance (PCA), the worker has been disentitled from receiving the PCA on the grounds that he fails to meet his threshold criteria for entitlement to the PCA, which is 100% permanent disability. The problem, of course, is that Board policy as set out in OPM Document #15-04-02, only allows a maximum permanent disability award for psychotraumatic disability of 80%. Therefore an injured worker with a mental health disability is evidently barred from receiving the personal care allowance, no matter how severe or disabling the disability. This is obviously an untenable situation which would appear to discriminate against injured workers with a mental health disability.

[33] However, a remedy has been identified and set out in Tribunal *Decision No. 2220/07* as discussed above, based on the finding of exceptional circumstances.

[34] In the case before us, the circumstances are clearly exceptional and warrant exception to the threshold criteria as set out in OPM Document #17-06-02. The worker in this case, with an 80% permanent disability award at the top end of Category 4, Severe Impairment, is totally dependent on his spouse for all aspects of daily living, including personal hygiene, dressing, bathing, toileting, access to medical care and even eating. She has been forced to quit her job to stay home to care for the worker and is under the unsustainable stress of providing care on a 24/7 basis.

[35] The Panel finds that, as a result of exceptional circumstances, the worker is entitled to the personal care allowance. The Board shall determine the extent of this entitlement.

DISPOSITION

[36] The appeal is allowed.

[37] The worker is entitled to a redetermination of his permanent disability award for psychotraumatic disability, to be raised to 80%, effective the date of Dr. Cannella's report of March 2004.

[38] The worker is entitled to the personal-care allowance. The Board shall determine the extent of this entitlement.

DATED: June 20, 2008

SIGNED: R. McClellan, V. Phillips, D. Broadbent