SUMMARY

DECISION NO. 525/99

Consequences of injury; Psychotraumatic disability; Bipolar disorder.

The worker suffered two compensable accidents in 1985. In the first accident, he suffered an ankle injury. In the second accident, he was struck by a car when it backed into him, causing knee, ankle, neck, elbow and back injuries. The worker appealed a decision of the Board denying entitlement for psychotraumatic disability.

The worker was suffering from bipolar disorder. The Panel found that the worker did not suffer a head injury in the compensable accidents. Since he did not suffer a head injury, the Panel could not relate the emergence of the bipolar disorder in 1990 to the compensable accidents. Even if the worker had suffered a head injury, the Panel did not see any causal relationship to his condition. Symptoms of a head injury would emerge immediately (within a few weeks) and would not deteriorate over time.

The worker's psychiatric condition was not related to the compensable accidents. The appeal was dismissed. [19 pages]

DECIDED BY: Keil; Klym; Young
DATE: 09/04/2001 NUMBER OF PAGES: [19 pages]
ACT: WCA

WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 525/99

[1] This appeal was heard in Toronto on March 17, 1999, by a Tribunal Panel consisting of:

M.F. Keil : Vice-Chair,
B.M. Young: Member representative of employers,
P. Klym : Member representative of workers.

Post-hearing work was completed in May of 2000.

THE APPEAL PROCEEDINGS

[2] The worker appeared and was represented by his lawyer, K. Sargeant, from McCarthy Tetrault. (Another lawyer from the same firm, M.C. Chambers, provided final written submissions during the post-hearing process.) The employer was present in the person of its coordinator for workers' compensation services and was represented by his lawyer, J. Bruce, from Hicks, Morley, Hamilton, Stewart, Storie. The worker's wife attended to give testimony and the worker's son was present as an observer.

[3] On January 1, 1998, the *Workplace Safety and Insurance Act* (WSI Act) took effect. This legislation amends portions of the *Workers' Compensation Act*, which continues to apply to injuries occurring before January 1, 1998. All references to "the Act" in this decision mean the Workers' Compensation Act as it read on December 31, 1997, unless otherwise indicated.

[4] The Appeals Tribunal is now required to apply Board policy in accordance with sections 112 and 126 of the WSI Act. While the Tribunal previously considered and applied Board policy in deciding appeals, this was not specifically required by the Act. In addition, the jurisdiction of the Appeals Tribunal is now described by section 123 of the WSI Act, with necessary modifications.

[5] Post-hearing work in this appeal was concluded well over six months ago and the Panel wishes to apologize to the parties for the delay in issuing this decision. We realize that this matter is of concern to both sides and regret any distress that may have been caused.

THE RECORD

[6] The Panel had before it as exhibits the Case Record and one Addendum prepared by Tribunal Counsel Office. We also had two letters (one with enclosures) from Ms. Sargeant. At the end of the hearing, the Panel announced it would be obtaining additional information. This documentation is contained in three post-hearing Addenda, containing the family physician's clinical notes, a report from the Tribunal medical assessor and written submissions by Ms. Chambers and Mr. Bruce.

THE ISSUE

[7] The Panel must determine if the worker has entitlement for a psychotraumatic disability claimed to have resulted from his compensable injury on May 2, 1985.

THE REASONS

(i) Background

[8] Although the extent of the worker's injuries on May 2, 1985, are in dispute, much of the relevant background information is a matter of record that can be summarized as follows:

- The worker was born in 1945 and became employed as a police officer in 1970. In March of 1985, he sustained a compensable right ankle injury. He received temporary total disability benefits for a couple of months until he returned to regular work on May 2, 1985. The first day of his return he was involved in another compensable accident. On this occasion, the worker was struck by a police car when it backed into him. According to the employer's Form 7, the worker sustained injuries to his back, left knee and left ankle. The worker saw his family physician, Dr. Choudhury, the following day. The doctor noted flexion/extension injuries to the neck, bruising of the right elbow and left ankle, as well as a lumbo-sacral strain. The worker was sent to hospital for cervical x-rays and obtained a neck brace at that time. X-rays were normal. There is nothing in the contemporaneous documentation to suggest that the worker sustained a head injury. It should be noted that the worker's progress report of May 22, 1985, indicated that he had been experiencing some headaches since the accident.
- The worker was seen on June 28, 1985, by Dr. Martin-Smith, with complaints of tingling in his left arm, numbness in the fingers and some "vague left chest discomfort." The doctor noted that the worker was vague and was not clear whether this "represents a personality change." On physical examination, the worker was vague and anxious; the doctor found that he could reproduce the worker's left arm tingling by turning his head and putting pressure on the top of it. The EGG was normal and the worker was given Amitriptyline.
- By July of 1985, the worker's progress note was mentioning dizzy spells and chest pains, as well as back and neck aches. He was admitted to Downsview Rehabilitation Centre in September of 1985 and discharged a month later as having a resolving sprain of the lumbar and cervical spine. While the worker was at Downsview, the doctors made some mention of apprehension, overprotection and over-reaction.
- The worker returned to modified work in October of 1985 and to regular work in January of 1986. Following, he received a 5% permanent disability award for his right ankle (referable to his first compensable injury). The worker had a number of recurrences in 1986, 1987 and 1988 relating to his right ankle, left ankle and low back pain.
- In July of 1990, the worker resigned from the police force and took a one year buy-out. In April of 1992, the worker was referred to psychiatrist, Dr. M. Aziz, for paranoid and depressed behaviour. Over the next few years, the worker was admitted to the Clarke Institute on several occasions. Initially, it was thought that the worker was suffering from

a major depressive disorder (Dr. R. Cooke in his letter of August 25, 1993). By October of 1993, it was thought that the worker was suffering from bipolar affective disorder (Dr. G. Hasey's report of October 14, 1993). In March of 1994, when the worker was again admitted, another Clarke psychiatrist, Dr. P. Collins, suggested that the worker suffered from a "delusional disorder which, at face value, appears to be a Paranoid or Delusional Disorder but may very well be, given his history, a component of a Bipolar Disorder or Schizoaffective illness."

- A CT scan of the worker head was taken in April of 1994 and this showed no evidence of previous trauma or any other abnormality. At the time of the worker's discharge from the Clarke in late April there was a discharge diagnosis of "delusional disorder, possibly of organic etiology." In July of 1994, neurological studies – a SPECT scan and MRI – were normal and neurologist Dr. M. Gawel, suggested that there was no significant brain damage, although he did note that the worker's sleep study showed significant apnea.
- In October of 1994, psychiatrist Dr. L. Martin wrote to the Board and set out the following analysis:

> [The worker] presented with what I feel is a diagnosis of a Delusional Disorder, with the onset of his difficulties following the accident on May 2, 1985, when he was struck by a police cruiser. Following this incident, there is a clear history of both altered behaviour, with [the worker] showing increasing difficulty managing our day-to-day cognitive tasks related to his work, a task which had previously given him no difficulty… Both his own and his family's description is one that strongly supports there having been a head injury during this accident with secondary impairment of cognitive function. [The worker's] behaviour also began to change following this accident….
>
> While at the Clarke, psychological testing was undertaken to investigate possible organic basis for [the worker's] psychiatric difficulties and this testing showed altered cognitive function which was compatible with the previous head injury and which appeared to be of organic basis. A review of [the worker's] previous use of alcohol indicated a very moderate consumption and there appeared to be no clear other basis for explaining his altered status than the motor vehicle accident of 1985.

- The worker's claim to the Board for psychiatric entitlement was denied throughout the internal levels. Most recently the Appeals Officer concluded that there was no objective evidence to indicate that the worker had sustained a head injury at the time of his compensable injury. Therefore, the Appeals Officer could not find that the worker's subsequent psychological problems were causally related to his compensable motor vehicle accident.
- Since the time of the Appeals Officer decision, Ms. Sargeant has submitted two additional medical reports. One is from psychiatrist Dr. G. Bartolucci. This psychiatrist treated the worker when he was admitted to the Acquired Brain Injury Program at the Hamilton Psychiatric Hospital in the mid 1990's. Dr. Bartolucci put forth the following analysis:

> [The worker] is indeed showing periods of manic mood with delusional thinking and periods of lethargic depression and has responded reasonably well to the use of mood stabilizers, currently lamotrigine, since he had a severe allergic reaction to valproic acid and clozapine which has been used because of its mood stabilizing properties as well as the neuroleptic effect which corrected any residual delusion.

> Cyclic affective disturbances are seen following brain injuries and may be precipitated or caused by it, although the evidence in this respect is not final. I cannot state unequivocally that there were no other possible causes for the onset of [the worker's] psychotraumatic disability. Nonetheless, a few factors must be taken into consideration in making a tentative decision about the attribution of his disorder. Bipolar affective disorders usually show an early onset in the patient's very early youth. [The worker] developed his bipolar symptoms well into his middle age and his first symptom was a chronic depression, the state in which I first saw him, which began at the time of accident and went on unrelentingly for years. Only after adequate treatment of the depression, the bipolar course emerged. The late appearance of his symptoms and the chronological relationship of the accident must be taken into consideration. There was no evidence of any affective symptoms prior to the accident itself.
>
> I suggest that, in fairness to your client, and because of the atypical time of onset with a chronological relationship to the accident exhibited by [the worker's] bipolar symptoms, the trauma should be considered, at least, as a significant precipitating factor. It should be considered a necessary but not sufficient cause for the development of his symptoms and given this role, [the worker] should be considered for at least partial compensation for his handicaps.

- Dr. Aziz, in his letter of February 4, 1999, took the following position:

> The other issue of his [the worker's] initial presentation as being of organicity with symptoms of depression, lethargy, poor concentration, memory impairment, as well as difficulties in activities of daily living, is clinical, even though evidence he does suffer from a brain injury CT scan, the EEG findings as well as Spect Scan and MRI investigations at Sunnybrook Hospital is negative.
>
> Further neuropsychological testing at the Clarke Institute does reveal evidence of closed brain injury that can be correlated directly to his current symptoms, however, it is possible that he may have a neuronal injury. The secondary complex that he presents are (sic) consistent with the diagnosis of an organic brain syndrome a secondary diagnosis of bipolar illness.
>
> ….I cannot, therefore, find any other reasons that his current psychiatric disorder has some other biological factor contributing to his mental state other than the past psychotraumatic injury.

- The worker now brings the issue of psychotraumatic disability to the Tribunal for a final decision.

(ii) Testimony

(a) The worker

[9] The worker testified that on May 2, 1985, he had arrived at the scene of an accident, where an impaired driver had struck a pole. Another police car was already present and the worker volunteered to walk up and look out for traffic. The police car backed up and the next thing the worker knew he "was up on the trunk of the car and then flying through the air." He landed on his hands, elbows, stomach and head. Although the worker felt dizzy and his back ached, he told the other officers that he was fine. The worker explained that he had just returned to duty from a previous compensable injury and felt "like an accident waiting to happen." As a result, he did not want to make a big fuss.

[10] The worker went back to the police station, reported the injury and went home. He had a bump on his head and felt as though he were in shock. The next morning, the worker's back was very sore, as was his right ankle. He still felt dizzy, as well as having a headache. He went to see his family physician, Dr. A. Choudhury, who sent him to the hospital for x-rays. At the

hospital, he received a neck brace. The worker stated he was not thinking about his head when he went to the hospital because it was his back that was really bothering him at that point.

[11] Over the next few months, the worker stated that he did very little. His ankle and back were bothering him "like crazy" and he still had dizzy spells, with intermittent headaches.

[12] When the worker returned to work, he saw someone he had known for 15 years whose name he could not remember. He had trouble remembering where streets were, even though he had been familiar with his area before the accident. He got lost one morning making a run he had done 50 times before. The worker started experiencing problems preparing reports and would ask his partner to fill out the more difficult ones. He began driving aggressively and rudely. Because he was having difficulty remembering names, he started calling people "Bud" and would write their names down on his memo pad.

[13] The worker had four anxiety attacks, all following the compensable injury, with the first one being in June of 1985. He also described a hunting trip he had been on in 1986 with fellow police officers, where he had been in the Winnebago by himself and, upon hearing some shots, became convinced that someone was trying to kill him. This episode only lasted a little while and he did not mention it because he was embarrassed.

[14] The worker testified that, following the accident he became less social, not wanting to go out as much and acting in a withdrawn manner. He had been a volunteer fire fighter in the town where he was living but, after the accident, he experienced difficulty running the pumper on the fire truck, so he had quit. He began to feel that his job was too much for him "too much of a strain" and that if he quit, he would feel better. He told his wife about it a month ahead of his actual resignation and then just went ahead. He stated that he "was tired of being confused." The worker thought that he had received annual performance appraisals and could not recall having any difficulties in that regard.

[15] The worker had raised animals but, after he quit the force, he found they were too much for him and he got rid of them. He had thought he might build a house but he never pursued that plan. Instead the worker "just laid around the house and got depressed." He agreed that he had bought a used Jaguar when he retired; he did a little body work on it and tried to paint it.

[16] Around 1992, the worker experienced his first sustained paranoid episode. He thought the Mafia was following him and that his house was bugged. He took to carrying around his shotgun and hired people to sweep the house looking for electronic surveillance equipment. During this period, he also began to believe his wife was running around on him. He bugged the telephones and taped her car, watched her, and even hired a private investigator to follow her. The worker explained that he tried to hide some of his actions but the "wife got wise to me" and called the doctor.

[17] The worker was admitted to the Clarke on several occasions and then was admitted to the Acquired Brain Injury program at Hamilton Psychiatric Hospital. For a period of time, his symptoms improved. His last delusional episode began in June of 1998, when he thought people were trying to kill him. He was committed to Peel Memorial Hospital but signed himself out after three months and then "went missing" for a few weeks. After he was found, he went to

Peace Ranch, a "country home for people with mental disorders." In February of 1999, he began living in a group home (affiliated with Peace Ranch) with two other men. He takes medication twice daily, provides for himself, but receives supervision from counsellors and a caseworker on a regular basis. He still sees Dr. Aziz once a month. He is driven to these appointments, as his licence is under medical suspension. The worker was seeing his family physician once a week when he first got out of hospital, but not on so regular a basis currently.

[18] When asked why he had waited so long to mention his symptoms to anyone, the worker replied that he had been embarrassed – he felt "stupid" and did not want to talk about it. The only other accident he had had outside of work was when he had dislocated his shoulder playing hockey for the police department. He did not sustain a head injury at that time.

[19] The worker testified that his father and uncles drank heavily on the weekends but not during the week. He thought that both sides of his family probably drank "too much" but were not alcoholics. The worker stated that he did not drink. He also agreed that his mother had become confused in her 70's and did "not see things the way other people do".

[20] The worker was asked when and how he had come to associate the 1985 accident with his psychological problems. He replied that Dr. Martin had asked him about any injuries and then told him that the car accident must have been the start, since it was unusual for a man his age to be experiencing the type of psychological symptoms he was having.

(b) The worker's wife

[21] The wife testified that she and the worker had been married since 1966. Until the accident, they had enjoyed a stable, compatible and "good" relationship. She had not seen her husband the night of the accident because he was working the late shift. When she woke up in the morning, he was already awake, complaining about his neck and back. He also told her he had felt dizzy at the time of the motor vehicle accident and had seen "stars." The wife encouraged him to go the hospital where x-rays where taken and a neck brace was prescribed. Following the injury, the worker would say that he did not feel right, and would mention his back, neck and ankle.

[22] The wife noticed that, subsequent to the accident, the worker did not go out of the house; he stayed inside and told his wife that WCB investigators would be checking up on him. When the worker did return to work, he complained about the drive in and stated that senior officers were "barking" at him. He began to talk about work in a negative way. To his wife, the worker seemed more anxious – he started having anxiety attacks and would fuss about minor things.

[23] In 1990, he told his wife he was quitting work and he did not care what she thought. This was not how they had planned their retirement, as they were both about five years away from early retirement at that stage. The wife was upset because they had always talked about things together. She explained to the Panel that, in retrospect, it was possible to see a pattern of behaviour but, in isolation, as things occurred, she would rationalize his behaviour. She noted that he became distant and stopped participating in activities that had formerly given him pleasure – volunteer fire fighting and raising animals. The wife described her husband as a man who had built two houses but, after the accident, could not be convinced to fix a leaky faucet. She experienced the worker's withdrawal as a gradual onset. He did not do much the first year

after he quit policing, although he would talk about building a house. At the time, the wife was frustrated but thought maybe he was going through a "mid-life crisis."

[24] She portrayed the worker as becoming more withdrawn from friends and family. He was thoughtless in behaviour and would get lost while driving familiar routes. He would forget items when he went to town and have to make a second trip. In 1992, the worker started manifesting dangerous and paranoid behaviour. He was carrying his shotgun and told her he would catch the men who were sleeping with her. Although the wife was terrified by this behaviour, she thought it would be humiliating for him to have the police called in, so she contacted the family physician and he arranged for the worker to start seeing Dr. Aziz. Later, there were periods of hospital committal.

[25] According to the wife, the worker has manifested a pattern of behaviour: cycles of delusional behaviour – usually accompanied by a period of committal in hospital – are followed by a more stable period, and then succeeded by a progressively more lethargic and depressed state. When the worker was in a paranoid state, he would think people were following him and that his wife was in with a gang, engaging in drugs and illicit sex. He would "boobytrap" the house to catch those members of the gang, tape her car and bug the house.

[26] The wife testified that her husband had initially done much better at the Acquired Brain Injury program in Hamilton, but that the facility had subsequently been closed down. The worker's last delusional episode had been in June of 1998; this resulted in another hospitalization. The worker had briefly gone missing after he checked himself out and was currently living in a structured group home setting.

[27] The wife had not known what was wrong with her husband and it was not until she talked to Dr. Martin that the association had been made with the work injury. Once the psychiatrist had suggested that motor vehicle accident was a trigger, she had contacted the police association for help registering a claim with the Board. The wife confirmed that the worker had experienced no other head injuries and that his only other non-compensable accident had been a separated shoulder in 1975 while playing hockey. She also stated that the worker had been fine after his right ankle injury in March of 1985, but had been despondent following the May 1985 accident.

(iii) Post-hearing information

[28] At the close of the hearing the Panel determined that it required more information prior to rendering a decision. We concluded it would be desirable to have some questions put to a Tribunal assessor but before this were to take place, the Panel wanted some gaps filled in – if at all possible. To that end, by way of a post-hearing memorandum dated March 18, 1999, we directed Tribunal Counsel Office to arrange for the following:

1. Ms. Sargeant was to provide the soliciting letters she wrote to Drs. Bartolucci and Aziz. We requested her to provide documentation as to the date the worker stopped his volunteer fire fighting duties with the town of Caledon.
2. The employer was to attempt to locate any and all reports of the May 1985 accident – internal investigations and descriptions, statements by co-workers, etc. The employer was also to provide copies of the worker's performance appraisals over the years and his

attendance records. This would include the dates the worker was absent for re-occurrences of his compensable accidents. The worker agreed to authorize disclosure of this information.

3. We requested the clinical notes from Dr. Choudhury for the worker – one year prior to 1985 and following. If the doctor had any independent recollection of the worker ever voicing complaints of dizziness, anxiety or fuzziness following his accident, we asked for any information the doctor could provide in that respect. Lastly, we asked the doctor to outline his/her procedure for eliciting details about possible head injuries at the time of an accident. In this regard, was there any contemporaneous reporting by the worker concerning a head injury or bump to the head?

4. We requested that Dr. Aziz to be contacted and asked when he first connected the worker's psychological problems to the 1985 accident. If this did not occur for some time, to what did the doctor originally attribute the worker's problems?

[29] Ms. Sargeant provided copies of her soliciting letters to the two physicians in correspondence dated March 22, 1999. In a letter dated April 16, 1999, Ms. Sargeant advised that the worker had ceased his volunteer fire fighting duties in September of 1988.

[30] The employer sent a copy of the worker's personnel file by way of correspondence dated May 27, 1999. The performance evaluations are set out in the following chart for ease of reference:

YEAR	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
Dec. 1982			26	5	
Jan. 31/83		11	20		
Dec. 18/83	9	10	12		
Dec. 31/83	6	7	18		
Feb. 2/85	7	3	21		
Feb. 3/85	6	21	4		
Dec. 23/85			17	13	1
Dec. 23/85		2	24	3	1
Feb. 8/87		14	17		
Feb. 15/87	1	14	18		
Dec. 27/87		19	13		
Dec. 30/87	2	23	7		
Jan. 29/90		4	28	1	
Feb. 17/90		5	25	3	

[31] The employer contacted the investigating sergeant at the time of the worker's accident. The sergeant (now retired) located his memo book, which stated that worker was "struck from rear – injuries to left side and neck – did not request medical at that time." The sergeant stated the worker had not mentioned falling down or striking his head or losing consciousness. The constable who struck the worker recollected he was backing up at approximately 5 kms/hr. but could not remember if the worker fell down or if he complained about head injuries at the time of the incident.

[32] Dr. Aziz sent a letter to the Tribunal, dated April 27, 1999, in which he advised that the worker's difficulties since 1985 (as he had not seen the worker until April of 1992), were brought to the psychiatrist's attention by the worker's wife. She had asked if there were any evidence that the worker's current symptomatology was related to his compensable injury. The psychiatrist also suggested that, "even though it appears to me there may not be direct relationship, it is convincing evidence in my mind that [the worker] has had some brain trauma that may lead us to explain his current symptomatology especially relating to his frontal lobe injury."

[33] In correspondence dated May 6, 1999, Dr. Choudhury informed the Tribunal that he had no independent recollection as to whether the worker complained of dizziness, anxiety or fuzziness following his compensable accident. However, based on his clinical notes and report sent to Dr. Hancock, there was no history of head injury or loss of consciousness following the incident of May 2, 1985. The physician's clinical notes for May 3, 1985, discuss cervical and low back pain; no loss of consciousness is noted. There are nine other notations for 1985 but no mention of dizziness or anxiety. There are occasional notations of neck and ankle pain.

(iv) The assessor's report

[34] The Panel reviewed the post-hearing information obtained. We asked Tribunal Counsel Office to choose an assessor who was to review all the relevant documentation and respond to the following questions:

1. Given the kind of injury the worker suffered on May 2, 1985, would you expect the medical attention he received shortly afterwards to have considered the possibility of a head injury?
2. What kind of symptomatology would have alerted the doctors to the possibility of a head injury in May of 1985?
3. Is it possible to sustain an organic head injury with few or no symptoms? As a follow up, is loss of consciousness a necessary corollary to there being a head injury?
4. In reviewing the family physician's clinical notes between 1985 and 1990, as well as other contemporaneous medical reporting, are there any medical indicia of the worker's suffering from an organic head injury?
5. If the worker's compensable accident significantly contributed to his paranoid episodes starting in the 1990's and following, why would this have taken this amount of time to develop? We note the testimony on the point that there was altered behaviour shortly following the accident which progressed in severity until it manifested itself in the first

delusional episode. Are head injuries progressive or are there instances in which the symptoms develop over time?

6. If there had been an organic brain injury in May of 1985, would you have expected to see a change in the worker's performance appraisals over the following years and, if so, of what kind?

7. What is the significance of a negative CT scan, a negative SPECT scan and a normal MRI as far as confirming or ruling out a head injury is concerned?

8. Some of the treating psychiatrists have suggested that the worker's delusional behaviour (first diagnosed in 1992) is related to his work injury in May of 1985. If this is accurate, would you expect this to have been diagnosed earlier? Is it medically feasible that the worker's delusional thinking would have come on in the gradual manner described in his and the wife's testimony with the first sustained paranoid episode not taking place until 1992?

9. If such a development is plausible, could you explain why the head injury would take this amount of time to manifest itself in the manner it did?

10. The worker underwent neuropsychological testing which Dr. Martin and Dr. Aziz stated demonstrated altered cognitive function compatible with the previous head injury and appeared to be of an organic basis. How can one know from such testing whether there is altered cognitive function in the absence of other tests done before the work injury? In other words, how can one know from testing in the 1990's whether the altered cognitive functions are of a recent origin? The Panel would appreciate any relevant background information you could provide on this subject.

11. The Panel would also appreciate an explanation of how one determines if there is an organic basis for the results of psychoneurological testing? If the testing does demonstrate an organic basis for the worker's altered behaviour, is there any kind of clinical testing that would demonstrate some type of injury?

12. Drs. Bartolucci and Dr. Aziz have related the worker's delusional thinking and manic moods at least in part to his work injury. In your view, are there other medical explanations for the worker's condition? If so what are they?

13. Any other medical comments that you have which may be of assistance to the Panel in reaching a fair and considered opinion would be welcome.

[35] Psychiatrist Dr. A. Margulies provided a report dated October 20, 1999. He provided the following description of bipolar disorder:

> Bipolar disorder is characterized by recurring episodes of mood disregulation – depression and/or mania – with, generally, full remission with a return of functioning during the inter-episode intervals which can be of highly variable duration. A small percentage of individuals, however have a less than total remission and go on to experience chronic symptoms of mood instability, interpersonal or occupational difficulties and cognitive impairment may eventually become dysfunctional. With increasing age, the interval between episodes, which are often found to be increasingly resistant to treatment, tends to diminish. While the average age of onset of bipolar disorder is in an individual's twenties, later onset, over the age of 50, is by no means

> unheard of and while forming a small percentage of cases, its emergence at that age in no way negates the diagnosis.

[36] The psychiatrist observed that in view of the "chronic symptomatology and, even more significantly, the general unreliability of a post-hoc history of an individual who has undergone a number of bipolar episodes, it would not be helpful to undertake a psychiatric examination of the worker."

[37] Dr. Margulies commented that there was no compelling evidence to suggest the worker sustained a head injury at the time of the motor vehicle accident. "Had he done so, signs thereof would have been immediately apparent and, with the passage of time and physiological healing, resolved to a greater or lesser degree." He noted that the "symptomatic effects of brain damage do not have a period of latency to become apparent months and years following the purported trauma or intensify with the passage of time." Dr. Margulies also provided specific answers to the questions posed by the Panel:

> 1. On the basis of the provided data, there would have been no reason to consider that [the worker] had sustained a head injury as a result of the accident of May 2, 1985. All recorded complaints were primarily soft tissue in nature involving his musculoskeletal system and what more general symptoms, such as headaches and dizziness, were also noted, are very often associated with such injuries…
> 2. Had [the worker] sustained a head injury, one would have anticipated a history of some alteration in his level of consciousness ranging, according to the severity, from a stunned or dazed feeling to an absolute loss of consciousness of whatever duration. The common denominator throughout is one of some alteration, howsoever brief, of the individual's level of consciousness as it reflects a decrement in brain functioning. Generally speaking, very mild alterations, considered mild concussions, while reflective of cerebral dysfunction, are not associated with any permanent brain damage.
> 3. …There are some schools of thought which subscribe to the notion that a head injury with underlying injury can occur with no apparent clinical symptoms. This hypothesis is by no means generally accepted and by the same token is extremely difficult to prove or disprove.
> 4. No. I can find no documentation of any symptoms which would be suggestive of a head injury.
> 5. Had any injury sustained by the worker in 1985 contributed to what is now considered to have been a bipolar illness, it would be expected that the chronology would be much shorter and involve a matter of weeks rather than the five to seven years as would appear to be the case with [the worker]. As noted above, the effects of traumatic head injury are immediately apparent and improve, to a greater or lesser degree with the passage of time. They are not progressive and there is no latent period, measured in this instance in years, for symptoms to develop.
> 6. …One's expectation, had [the worker] sustained a brain injury in May of 1985, would have been a deterioration of his abilities and which, presumably, would have been noted upon performance appraisals. This would have taken the form of general deterioration in his overall work, difficulties in his relationships with his peers, moodiness, irritability and emotional dyscontrol and some indications of impaired memory.
> 7. Each of these investigative procedures represents a different form of visualizing pathology in the suspect organ (in this instance the brain). While none are infallible, the MRI is, by far, the most sensitive test to detect indications of alteration in brain

> structure. In view of the negative findings upon all parameters of investigation as well as the clinical history, which is also negative for any indications of head injury…it is not unreasonable to conclude that [the worker] did not sustain a head injury.
>
> 8. It is generally agreed that [the worker's] delusional thinking and behaviour have been functions of an atypical bipolar disorder…had this bipolar disorder been manifest prior to 1992, evidence thereof would have been readily apparent and, presumably, appropriate action undertaken. A six or seven year gradual development is completely out of keeping with the known episodic nature of bipolar disorder which, historically, did not become apparent until 1992 or, possibly, late 1991.

[38] Dr. Margulies went on to state the worker's development was totally inconsistent with the recognized clinical course of head injury. With respect to neuropsychological testing, the psychiatrist pointed out that the results had to be interpreted and one also had to take into account the psychological/emotional state of the individual at the time of the evaluation and other parameters such as educational level, history of learning disability, language, culture and other factors. He noted that it appeared at the time of the worker's testing he "was experiencing a manic episode with paranoid features. Such being the case, it would not be surprising to find that his performance… would be impaired and to interpret the results as indicative of brain damage" would be a "very slippery step".

[39] The psychiatrist concluded by noting that bipolar disorder such as experienced by the worker had a lifetime prevalence of 0.5 to 1.6%. Its etiology is not known but familial/ biological/genetic factors are considered relevant. While a family history is often found, many individuals suffering from bipolar disorder do not have a positive family history. This is a form of severe mental disorder which is known to occur without necessary antecedent in a certain percentage of the general population.

(v) Relevant law and policy

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

> **3(1)** Where in any employment, to which this Part applies, personal injury by accident arising out of and in the course of employment is caused to a worker, the worker and the worker's dependants are entitled to benefits in the manner and to the extent provided under this Act.
>
> **(2)** Where a worker is entitled to compensation for loss of earnings because of an accident, the employer shall pay to or on behalf of the worker the wages and benefits that the worker would have earned for the day or shift on which the injury occurred as though the injury had not occurred.
>
> **(3)** Where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment and, where the accident occurred in the course of the employment unless the contrary is shown, it shall be presumed that it arose out of the employment.
>
> **(4)** In determining any claim under this Act, the decision shall be made in accordance with the real merits and justice of the case and where it is not practicable to determine an issue because the evidence for or against the issue is approximately equal in weight, the issue shall be resolved in favour of the claimant.

[41] Board Operational Policy Document No. 03-03-03, entitled "Psychotraumatic Disability", states that a worker is entitled to benefits when disability results from a work related personal injury by accident; this includes both physical and emotional disability. The policy goes on to note:

> If it is evident that a diagnosis of a psychotraumatic disability is attributable to a work-related injury or a condition resulting from a work-related injury, entitlement is granted providing the psychotraumatic disability became manifest within five years of the injury, or within five years of the last surgical injury.
>
> Psychotraumatic disability is considered to be a temporary condition. Only in exceptional circumstances is this type of disability accepted as a permanent condition.
>
> Entitlement for psychotraumatic decision 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, or
>
> ⇒ reaction to the treatment process
>
> - The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socio-economic factors, the majority of which can be directly and clearly related to the work related injury.

(vi) Submissions

(a) Ms. Chambers

[42] Ms. Chambers submitted that the worker was suffering from a psychotraumatic disability caused by a head injury sustained on May 2, 1985, during a workplace accident. As a consequence he should be entitled to a permanent disability award for that disability, temporary and/or supplementary benefits from the date that his psychotraumatic disability caused him to stop working in 1990 and appropriate medical and rehabilitation costs.

[43] Ms. Chambers submitted that there was contemporaneous documentation to substantiate that the worker sustained a head injury on May 2, 1985. These documents would include: Dr. Choudhury's report of May 3, 1985; May 3rd notation from J. Ronan, R.N.; two more May 1985 reports from Dr. Choudhury; a June 18, 1985, report from Dr. McDonald (as well as a follow-up report from July 24th); a June 28, 1985, report from Dr. Martin-Smith; and, reports from Downsview Rehabilitation Centre in the fall of 1985.

[44] Ms. Chambers submitted that Dr. Choudhury's assumption that the worker did not sustain a head injury was unfounded and he clearly had no recollection of whether he had carried out any clinical tests to see if that were the case. Ms. Chambers pointed out that the worker testified

that, at the time of the May 2, 1985 accident, he had passed out for a few moments , was dizzy and had a bump over his right eye. He also testified that he began to experience personality changes following the accident in terms of increased agitation, poor memory, social agitation and a significant narrowing of his interests. This testimony was corroborated by his wife. Since the worker was the only reliable witness to the event in question on May 2, 1985, his testimony should carry great weight.

[45] Ms. Chambers argued that the worker's performance appraisals demonstrated a significant fall-off following his work injury and confirmed that the worker was having memory loss and confusion.

[46] Ms. Chambers also argued that the weight of medical evidence favoured a causal relationship between the work injury and the worker's psychotraumatic disability. She alluded to Drs. Aziz, Martin, Brooker, Hasey and Bartolucci as supporting the thesis that the worker had suffered brain damage as a result of the work injury, resulting in psychological difficulties.

[47] Ms. Chambers then turned to the report from the Tribunal's medical assessor, Dr. Margulies. She suggested that he had an inaccurate understanding of the facts and had never examined the worker. She enumerated the psychiatrist's factual errors, amongst which were his comments that the performance appraisals demonstrated the worker was adequate, ignoring in her view the very favourable ones he received in 1984. She took issue with Dr. Margulies' contention that the worker's symptoms did not become manifest for several years by stating that the worker had anxiety, headaches and dizziness immediately following the accident. She also claimed that Dr. Margulies was in error when he stated the worker did not lose consciousness following his accident.

[48] Ms. Chambers also submitted a report (presumably solicited by herself, although a copy of the soliciting letter was not copied to the Tribunal) from psychologist Dr. B. Willer. In his letter of April 5, 2000, Dr. Willer advised that he offers a continuing education program in brain injury rehabilitation. He found it surprising that Dr. Margulies would offer an opinion on the etiology of the worker's current symptoms without having examined the worker. Dr. Willer suggested that the psychiatrist's comments on brain injury would be accurate in referring to severe brain injury. Dr. Willer however went on to note the following:

> …in the case of mild brain injury, there is a tendency at the time of the injury, for clinicians and patients to focus on other injuries if there are any and to ignore the symptoms associated with the brain injury. In addition, the research on mild brain injury indicates that immediately following the injury patients experience denial. As a result, symptoms are only recognized, for the most part, after a period of time when the confusion and the headaches etc. simply will not go away. However, I will agree with Dr. Margulies that the symptoms do not appear years later. They are most likely to be recognized within six months and are most likely to be evident in reduced performance at work.
>
> ….
>
> Again, I am unwilling to comment specifically on [the worker's] situation since I have not interviewed him or reviewed all of the records. However, I can tell you that in some instances there can be fairly severe symptoms with relatively little altered state of

> consciousness. A direct correlation should not be equated with a perfect one to one relationship between loss of consciousness and symptoms.
>
> ….
>
> …I find it surprising that Dr. Margulies would comment on the subjective nature of neuropsychological evaluations when, in fact, psychological testing represents the most objective approach available for evaluation after brain injury.

[49] Ms. Chambers argued that, given the absence of all other possible causes of the worker's psychotraumatic disability, it was more likely than not that his condition was caused by a brain injury. Subsequent medical examinations have confirmed the worker did suffer organic brain injury and the treating physicians had concluded that the psychotraumatic disability was caused by the head injury sustained at the time of the 1985 compensable accident. In the event that the Panel determined the medical evidence was not so compelling she submitted that at very least the evidence for and against entitlement was approximately equal in weight and the benefit of the doubt must be resolved in favour of the worker.

(b) Mr. Bruce

[50] Mr. Bruce submitted that in order for the worker to establish a proper claim he must: prove that he suffers from a psychotraumatic disability; prove that the disability was caused by a head injury; prove that the head injury which caused the psychotraumatic disability occurred during an accident at work; and, prove that this disability manifested itself within five years of that workplace accident.

[51] In Mr. Bruce's view, none of the above had been met. He argued there had been varying diagnoses of the worker's condition and they had been nowhere near decisive in establishing that he has a psychotraumatic disability. There was only some speculation that the condition might have been caused by a head injury and that the head injury might have occurred as a result of a work injury.

[52] Mr. Bruce submitted that the post-hearing information confirmed the worker never complained of or showed any symptoms of a head injury following the May 1985 accident. He relied on the report by Dr. Margulies that the head injury theory was not plausible and was totally inconsistent with the recognized clinical course of head injury.

[53] With respect to Ms. Chambers' submissions, Mr. Bruce pointed out that her reliance on contemporaneous documentation to demonstrate that a head injury occurred, proved only that the worker had hurt his neck. Mr. Bruce also noted that Dr. Willer confirmed that brain injury symptoms do not occur years later as the worker claimed they did in his case.

(vii) The Panel's findings

[54] This is a difficult case, made more so by differential diagnoses, a complex medical situation, the passage of time and the accompanying erosion of memory. The last is especially pertinent as poor memory is one of the worker's complaints and yet his is the only direct testimony available of the May 2, 1985, accident. In the final result, the Panel must make its decision on the best available evidence and its sense of what is most probable.

[55] We turn first to the accident itself. Notwithstanding Ms. Chambers' capable submissions on this point, we are not persuaded there is any contemporaneous documentation to attest to the fact that the worker suffered a head injury. All the medical reports alluded to by the worker's representative refer only to a neck injury. Had the worker hit his head or lost consciousness or had a bump over his right eye, one would expect to see reference to that in the medical documentation. There is none. It is difficult for the Panel to understand how the worker could mention to emergency staff and/or his family physician that he had "flown through the air and hit his head on the asphalt" without either of them making a note of this or taking skull x-rays. We know the worker mentioned his neck and back because cervical and lumbar spine x-rays were taken. We also note that the worker himself did not mention hitting his head in his progress reports, although he did detail several other areas of concern. Had he hit his head at the time of the accident, one would expect to see some reference specifically to that in at least one piece of the contemporaneous documentation; yet none exists.

[56] We acknowledge that, at the hearing, the worker directly testified to hitting his head and losing consciousness for a few moments. We also acknowledge his is the only direct testimony on this point. Assessing credibility is a delicate exercise. Often, there is genuine disagreement as to facts or their interpretation. An individual may, quite naturally and honestly, wish to provide his or her perspective in the best possible light. This is by way of acknowledging that there are situations where strikingly different versions of events can be presented without loss of credibility to anyone offering a perspective. However in the case before us, certain versions must be preferred as more likely and/or more plausible than others. It follows that the Panel must carefully explain why it prefers the evidence that it does.

[57] The assessment of the credibility of interested witnesses has been discussed as follows in the following decision of the British Columbia Court of Appeal, *Faryna v. Chorney* (1951), 4 W.W.R. (N.S.) 171, (which was quoted with approval by the Ontario Court of Appeal in *Phillips v. Ford Motor Co.*, [1971] 2 O.R. 637):

> The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.

[58] In the matter before us we must either find that the worker did or did not suffer a head injury. While we do not in any way believe the worker was less than truthful with us as far as his recollection goes, we are not sanguine that this recollection is accurate for the reasons enumerated above. It might not be uncommon for the worker to focus on his back rather than his head, but if he had originally reported the accident to the doctors the way he did at the hearing, it seems to us there would have been mention of him striking his head.

[59] The Panel does note the occasional mention of headaches – in the worker's progress report of May 22nd he states he sometimes has headaches, although this is not noted in his next report of June 12th. The worker's report of July 11th speaks about dizzy spells but this was after an episode where he was clearly worried about his chest pains and tingling in his left arm – concern that it

might be a heart attack (cf., Dr. McDonald's report of July 3rd, 1985). As the worker did have a whiplash type injury to his neck, the Panel does not find it unusual that he would have headaches for a time following. We would observe that by the time of his pension assessment in April of 1986, there is specific mention that the worker "has no complaints of headaches." From a lay perspective it appears to the Panel that the headaches resolved with the neck injury.

[60] We also note that the worker was at Downsview Rehabilitation Centre for a four week period in the fall of 1985. While there was some comments about his being over-protective, there is no reporting of confused or disoriented behaviour or difficulty in following the routines in which he was participating. By the time of the worker's continuity report of March 1986, he is focused primarily on his back and ankle pains with no mention of headaches or dizziness.

[61] From this overview of the documentation for the year following the May 1985 accident, it is not demonstrated that the worker sustained a head injury or showed any ongoing signs of a head injury.

[62] Ms. Chambers has argued that there was a significant fall-off in the worker's performance following his compensable injury and such deterioration could reasonably be attributed to his head injury. With respect, the Panel would point out that the worker's 1985 performance appraisals – arguably his only weaker ones – reflected on a worker who had been off work for most of the year and who had been, as attested to in his contemporaneous documentation, preoccupied with his ongoing physical back, neck and ankle problems. It is not, in our view, surprising that his performance fell off for that year. By 1987 the worker was back to all "very good" and "good" scores, with a couple of excellent scores reflecting on his relationships with fellow officers and supervisors. As Dr. Margulies pointed out, were someone to suffer from a head injury it would manifest itself in difficulties in relationships with peers and moodiness. However, it is the worker's relationship with others that is described as excellent. We cannot therefore accept Ms. Chambers arguments as to what inferences we should draw from the worker's performance appraisals.

[63] Since we have not found that the worker suffered a head injury at the time of his compensable injury, we cannot relate the emergence of a bipolar disorder in 1990 to his compensable injury. Further, while some of the treating psychiatrists suggested there would be a causal connection between the worker's psychiatric problems and his work injury, the Panel is at a loss to see how the worker's paranoid and delusional episodes could causally be connected to a closed head injury. Both Drs. Margulies and Willer agreed that symptoms from a head injury would emerge immediately (within a few weeks) and would certainly not deteriorate over time. This does not describe the worker's situation. However, the worker's condition – periods of rational behaviour with manic episodes – does reflect the course of bipolar disorder. Not one of the supportive treating psychiatrists has explained how bipolar disorder or schizoid delusional behaviour could reasonably be related to a head injury. We also note that the supportive medical reports are predicated on the assumption that the worker suffered a head injury at the time of his work injury and we have found this, as a matter of fact, not to be the case.

[64] The Panel accepts that memory loss, some cognitive deficits and difficulties in relationships are symptoms of a head injury. However, the worker's condition is far worse than this and is helped by the medication one takes for bipolar disorder.

[65] The Panel can understand that the worker and his wife would like there to be a reason for this debilitating illness – a cause and effect as it were. However, the evidence in this case does not, on the balance of probabilities, lead us to conclude that the worker suffered a head injury in May of 1985, which in turn led to the development of his bipolar disorder in the early 1990's. The Panel also appreciates that the worker and his wife believe the worker's personality changes closely followed his compensable injury but the contemporaneous documentation suggests this was not the case. If we look to the worker's records from the Clarke Institute in 1993, the worker was telling the physicians that his mood change came in "1991 when he came out of the police force" or that he had "fluctuating symptoms of paranoia in the past three years." When he was asked to describe himself, the worker stated – in an August 1993 interview – that he was "usually a happy and outgoing person but not recently." If the worker had been having significant problems since 1985, one would reasonably have expected that to have been what he related to the psychiatrist. The Panel would point out that the Clarke Institute commented on the history of alcohol abuse on the maternal side and that this might have masked a family history of psychopathology. If this were the case, it could provide a genetic etiology to the worker's bipolar disorder.

[66] More importantly, the early psychiatric reports do not mention the 1985 motor vehicle accident at all. It is not until 1994 that this surfaces as a possible connection and there then emerges a more distinct pattern of the worker experiencing problems since 1985. What this suggests to the Panel is that when the worker and his wife quite sincerely came to believe there was a connection, it then necessarily coloured their perspective on events. Nonetheless, the file documentation does not substantiate the worker experienced any psychiatric problems prior to 1990.

[67] In the final analysis, while the Panel has no difficulty finding the worker suffers from a debilitating psychiatric condition, we cannot find that he suffered a head injury during the May 2, 1985, incident or that he developed a psychotraumatic disability as a result. In our view, the weight of evidence is not approximately equal and therefore, the benefit of the doubt does not apply.

THE DECISION

[68] The appeal is denied.

DATED: April 9, 2001.

SIGNED: M.F. Keil, B.M. Young, P. Klym.