WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1033/11

BEFORE:	J. Noble : Vice-Chair B.M. Young : Member Representative of Employers K. Hoskin : Member Representative of Workers
HEARING:	May 12, 2011, at Hamilton Oral Post-hearing activity completed on January 17, 2013
DATE OF DECISION:	May 17, 2013
NEUTRAL CITATION:	2013 ONWSIAT 1077
DECISION UNDER APPEAL:	WSIB Appeals Resolution Officer (ARO) decision dated March 26, 2010

APPEARANCES:

For the worker:	Mr. J. Cooke, Office of the Worker Adviser
For the employer:	Not participating
Interpreter:	None

REASONS

(i) Issues

[1] The issues to be decided in this appeal are whether the worker should have entitlement for Loss of Earnings (LOE) benefits subsequent to April 1, 2006; and whether the worker should have entitlement for Psychotraumatic disability.

(ii) Background

[2] The worker sustained a back injury on December 23, 2005, after lifting some boxes that weighed 15 to 20 pounds. The worker was employed as an assistant manager in a drug store.

[3] The Board allowed the worker's claim and he was granted entitlement for LOE benefits from January 3, 2006 to January 5, 2006, and from January 14, 2006 to March 1, 2006.

[4] The Board determined that the worker was fit for modified work. The worker returned to modified work on a graduated return on February 15, 2006 for a 3 hour shift but stopped work. The worker returned to work again on March 1, 2006, and worked approximately every other day for 3 hours per shift until approximately March 31, 2006.

[5] The worker stopped working on approximately March 31, 2006. The worker was authorized off work in a report dated April 5, 2006 from the family physician, due to the worker's psychological symptoms that included being highly anxious, overwhelmed and depressed, and suspicious of the doctor's intentions. The Board Adjudicator determined that the worker should be paid partial LOE benefits from March 1, 2006 to April 1, 2006 based on the graduated return to work plan that had been established.

[6] In a letter dated April 26, 2006 the Adjudicator stated that benefits beyond April 1, 2006 were denied as the worker was under medical care for a condition not related to the work accident of December 23, 2005, and the worker was unable to participate in an assessment at the Board's Regional Evaluation Centre due to a non work related condition.

[7] The Board also denied entitlement for Psychotraumatic disability in a decision letter dated September 12, 2008. The Board stated that the worker's psychological diagnosis did not appear to be related to the low back injury that occurred in the course of employment.

[8] On October 18, 2006 the worker sought medical attention at a hospital emergency room complaining of a 4 day history of right facial numbness/tingling, right eyelid twitching and drooling when drinking. The diagnosis was Bells' Palsy. The worker's past medical history included depression.

[9] In October 2007 the worker was diagnosed with "Bipolar Affective Disorder Type 1 – currently cycling between Depression with Psychotic Features and Hypomania."

[10] The ARO decision under appeal dated March 28, 2010 denied the worker's appeal for entitlement for Psychotraumatic disability and for Loss of Earnings (LOE) benefits beyond April 1, 2006. The ARO decision concluded that the worker was not entitled to ongoing Loss of Earnings benefits after April 1, 2006 since the worker's main disabling condition was a psychological condition, and since there was insufficient evidence indicating that the worker's lumbar strain/sprain which was sustained on December 23, 2005 resulted in a residual organic impairment.

[11] The ARO decision under appeal also denied entitlement for a Psychotraumatic disability, on the grounds that the requirements in Board policy were not met. The ARO decision stated that the ARO was not satisfied that the worker's psychological conditions were a direct or an indirect result of the physical injury he sustained on December 23, 2005, given the minor nature of the workplace incident, the resulting minor injury and the conservative treatment. The ARO decision stated:

> The healthcare providers who either assessed or treated the worker after April 1, 2006 describe several stressors which included working in a hostile work environment. Even if these were proven to be true, these stressors do not meet any [of] the conditions outlined under WSIB [policy] concerning the granting of entitlement to benefits for a Psychotraumatic disability.

[12] The worker appeals this decision to the Tribunal.

(iii) Medical evidence

[13] In an Independent Medical Examination (IME) report for Great West Life insurance company dated October 1, 2007, Dr. L. Taylor, psychiatrist, stated that he had been asked by the insurance company to clarify the worker's diagnosis and make treatment recommendations. Dr. Taylor assessed the worker and stated that the worker had a Bipolar Affective Disorder Type I – Currently cycling between depression with psychotic features and hypomania; Obsessive Compulsive Disorder – Moderate to Severe; and Social Phobia – Severe. Dr. Taylor stated that the worker endorsed significant symptoms of Social Phobia from childhood; that the worker endorsed longstanding symptoms of Obsessive Compulsive Disorder; and other symptoms. Dr. Taylor stated that there was extensive family psychiatric history on the paternal side. Dr. Taylor was also asked about workplace issues and stated:

> Although there were workplace issues, it is my opinion that [the worker's] medical leave of absence is due to very significant psychological illness.

[14] The worker was seen for psychotherapy by a family physician psychotherapist, Dr. Susan Hulley, since April 4, 2006. In her report dated May 14, 2008, Dr. Hulley stated that the worker did not have any previous psychiatric treatment; however he had a longstanding history of symptoms of Social Phobia and Obsessive Compulsive Disorder. In her report dated May 14, 2008, Dr. Hulley stated that workplace stress precipitated the worker's Bipolar Disorder and Post traumatic Stress Disorder.

(iv) Testimony

[15] The worker testifies that he worked with the employer in its retail operations for 12 years, and he became a store manager. The worker states that in 2004 the store that he managed was closed, and he was offered a job by the employer as an assistant manager in another store. The worker states that he took this job and started around December of 2004. The worker states that he accumulated 16 weeks of vacation time that he did not take, because as a manager he did not take much time off. The worker states that he loved his job and he had an excellent work ethic. The worker states that prior to December 2005 he had no back problems.

[16] The worker states that in December of 2005 he worked almost every day for about 3 weeks, because the store was very busy during the Christmas season. He states that on December 23, 2005 he was lifting boxes and some weighed 20 pounds. The worker states that

he lifted, and he got a sharp pain in his lower back. The worker states that he sought medical attention, possibly from a walk in clinic, and then from the family doctor Dr. Rosati.

[17] The worker testifies that he continued working from December 23, 2005 to January 3, 2006, with a couple of days off for the statutory holidays. He states that he had back pain during this time.

[18] The worker states that one day, after December 23, 2005 and prior to January 3, 2006, he was pulling a manual pump truck which was loaded with product, and was heavy, and he hurt his back again and he had major back pain. The worker states that the store manager advised him that this did not need to be reported, because it was all covered under the worker's initial accident report. The worker states that the employer made no accident report about this incident.

[19] The worker states that he went off work on January 3, 2006 because he could hardly move or walk due to the lower back, with pain radiating down the legs. The worker states that he saw Dr. Rosati who prescribed medication, and referred him to the chiropractor Dr. Carson.

[20] The worker states that then he returned to work on February 15, 2006, and he worked one scheduled 3 hour shift, and this caused a lot of back pain. The worker states that he was doing the cashiers' trays and floats, and was bending down to access the safe which was at floor level and this caused back pain. The worker states that although the trays themselves were light, the bending caused pain.

[21] The worker states that he was continuing to see the chiropractor Dr. Carson several days per week, and Dr. Carson said the worker had restrictions regarding lifting, prolonged standing and walking. The worker states that these restrictions were provided to the employer.

[22] The worker testifies that he believes that he continued to work from February 15, 2006, every other day for 3 hours per day, through to the end of March 2006.

[23] The worker states that after he had his back injury on December 23, 2005, his relationship with his store manager deteriorated.

[24] The worker testifies that before his December 2005 back injury there was an incident with cash missing, and the loss prevention personnel attended. The worker states that the store manager got in trouble over his processes and he told the worker he would get him.

[25] The worker states that after his back was injured, the store manager mocked him and told him his work was not acceptable. The worker states that while he was off work the store manager called him twice a week to ask when he was coming back, and advised the worker that he had to work on his days off. The worker states that he felt pressure. The worker states that the store manager also offered him a package to leave his employment, and the worker said no.

[26] The worker states that his last day of work was March 31, 2006. The worker states that he went into work that day for his 3 hour shift, and then he was unexpectedly called into the office. The worker states that he went in, and there were 3 people in the office already, and he was told that they were all going to have a meeting. The worker states that the store manager was there, as well as the Board Adjudicator, and another person from the Board who identified herself as a nurse. The worker testifies that the Adjudicator stated that she spoke to Dr. Rosati about the worker, because the worker was not increasing his hours beyond 3 hours per day, and she stated that by now the worker should be capable of working 8 hours per day. The worker states that he said he was still in pain, however the Adjudicator advised that she had spoken to

Dr. Rosati and he agreed the worker could work 8 hours a day. The worker states that he told them that his doctor said he should work 3 hours, and he told them that they could not assess him because they were not doctors. The worker states that the other person then stated that she was a nurse, and the Adjudicator said that she had the right to make suggestions about health care. The worker states that the manager then got out a schedule and started to change the schedule and placed the worker on everyday for 8 hours. The worker states that then the Adjudicator told the worker that the Board was no longer allowing payment for the chiropractor visits.

[27] The worker states that then, at the March 31, 2006 meeting, he broke down crying because all 3 people in the room were attacking him. The worker states that the store manager and the nurse started talking about the worker's medication and were saying that he should not be taking that. The worker states he was not ready to work more than 3 hours per day every other day, because he could not tolerate the pain. The worker states that he could not breathe, and he felt the Adjudicator was taking the side of the store manager and was not listening to him. The worker states that the store manager was trying to get rid of him.

[28] The worker states that after March 31, 2006 he was so stressed out he got sick, and he could not return to work. The worker states that his wife and brother took him to the doctor, and he had so many problems, and everything was going back and forth in his head, especially about what the store manager did to him.

[29] The worker states that the Adjudicator called his home and put pressure on his wife, when he could not return to work.

[30] The worker states that he started seeing the psychiatrist Dr. Hulley in April 2006, and was referred by Dr. Rosati. He states that he had psychiatric problems then, but he was not hospitalized.

[31] The worker states that in 2006 and 2007, he continued to see Dr. Cameron for his back 4 to 5 times a week. He states that he only remembers going to physiotherapy once. The worker states that he saw Dr. Carson from 2009 to 2011, 2 to 3 times a week. The worker states that he still has pain in the lower back.

[32] The worker states that Dr. Hulley moved away and now Dr. Shaw is his psychiatrist. He states that at first he saw a psychiatrist once a week, and after about 2 years it changed to every 3 weeks. The worker states that the psychiatrist prescribed Lithium and Clonazepam and something else.

[33] The worker states that he saw the psychiatrist Dr. Taylor once, for the insurance company Great West Life. He states that he still receives Long Term Disability (LTD) benefits from Great West Life and he receives the Canada Pension Plan (CPP) disability pension.

[34] The worker states that prior to December 23, 2005 he never saw a counselor or a psychiatrist. He states that emotionally he feels a little better now.

[35] The worker states that his store manager did not like him, and thought he was after his job but he was not. The worker states that the store manager wanted to get rid of him, and once he hurt his back he actively tried to get rid of him. The worker states that often he would be up all night because of what the store manager said and did to him regarding the back injury, and in the end he could not handle it anymore.

(v) Post-hearing activity

(a) Further medical documentation

[36] The Panel determined that prior to issuing any decisions regarding this appeal, we would prefer to obtain the medical documentation related to the worker's CPP disability application, and the documents from the worker's Great West Life Long Term Disability (LTD) file. The Tribunal Counsel Office (TCO) obtained the documentation in question, and it was provided to the worker's representative, who was given an opportunity to make submissions. The additional medical information is now included in the case materials for this appeal.

(b) Medical assessor

[37] The Panel observed that the Tribunal Medical Liaison Office (MLO) recommended to this Panel that a Medical Assessor be asked to review the case materials and provide further information regarding the worker's condition. The Panel determined that it was advisable to follow the MLO recommendation in the circumstances of this appeal. The Panel released Interim *Decision No. 1033/11I*, dated February 27, 2012, which posed questions for a Medical Assessor and which provided factual findings upon which the Medical Assessor was to rely.

[38] Interim *Decision No. 1033/11I*, dated February 27, 2012, made the following findings of fact:

> (c) Findings of fact
>
> The Panel finds that the worker sustained a back injury on December 23, 2005 after lifting some boxes. The Panel finds that the worker was off work as a result of the back injury for a time in January of 2006, and in February of 2006. The Panel finds that the worker likely attempted a return to modified work for a 3 hour shift on February 15, 2006, but stopped work that day, and returned to work on March 1, 2006 working every other day for 3 hours, but stopped work on March 8, 2006. The Panel accepts that the worker may also have felt some back pain when he bent down to access a safe in the workplace on February 15, 2006.
>
> The Panel finds that the weight of the medical evidence indicates that the worker had certain longstanding psychological conditions that pre-existed the December 23, 2005 back injury including Social Phobia and Obsessive Compulsive Disorder.
>
> The Panel accepts, based on the worker's testimony and the accounts on file, that the worker felt pressure in relation to his ability to perform work following the December 23, 2005 back injury. The Panel also accepts, based on the worker's testimony and the accounts on file, that it was the worker's perception that the store manager was placing pressure on the worker following the December 2005 back injury.

[39] Interim *Decision No. 1033/11I* requested that the following questions be posed to the Medical Assessor:

> (d) Questions for the Medical Assessor
>
> The Panel requests that the following questions be posed to the Medical Assessor.
>
> 1. On the basis of your review of this case, please provide your diagnosis/es, both preferred and differential diagnoses, for any psychiatric condition following the worker's back injury in December 2005, and give the reasons for each.
> 2. Is there medical evidence to suggest the presence of a pre-existing psychiatric condition? If so, did the course of the worker's condition differ from that expected over time?

3. Would an examination at this time help to clarify the diagnosis of the worker's condition?

4. Please comment on any relationship between the worker's psychiatric condition and any sequelae of the back injury, as described by the Panel in their findings of fact. If it is your view that the worker's diagnosis includes Bipolar Affective Disorder, please comment on the likelihood that this condition could be caused by events such as the sequelae to the worker's back injury. Please explain.

5. Please comment on any other factors which may have contributed to the onset of the worker's psychological/psychiatric condition. Are there any factors that may have contributed to the ongoing condition?

6. What is the prognosis in this case?

7. Can you provide any other information which you feel would be helpful to the Panel and parties in this appeal?

[40] Interim *Decision No. 1033/11I* stated that once the Tribunal had received the Medical Assessor's report, the Medical Assessor's report should be provided to the worker's representative and submissions should be invited from the representative on the new information. Interim *Decision No. 1033/11I* stated that following the receipt of the Medical Assessor's report and the representative's final submissions, the Panel would issue a final decision concerning this appeal.

[41] In a Memorandum from the Tribunal Counsel Office (TCO) dated March 16, 2012, the Panel was advised that Dr. Margulies was the chosen Medical Assessor, and that Dr. Margulies would like to examine the worker if the Panel approved. In a Memorandum to TCO dated March 27, 2012, the Panel indicated that it approved of an examination of the worker by the Medical Assessor.

(vi) Medical assessor's report

[42] As the Panel has stated, Tribunal Counsel Office (TCO) advised in March 2012 that the chosen Medical Assessor was Dr. Margulies. According to Dr. Margulies Curriculum Vitae, which is included in the file materials, Dr. Margulies is a certified specialist in psychiatry; from 1992 to 2000 he was the chairman, Section on Psychotherapy, Canadian Psychiatric Association; from 2000 to 2006 he was a member of the Executive Committee, Canadian Society of Medical Evaluators; from 2002 to 2004 he was the first Vice President and Chair of the Committee on bylaws, ethics and foundation, Canadian Society of Medical Evaluators; and from 2004 to 2005 he was the President, Canadian Society of Medical Evaluators. Dr. Margulies Curriculum Vitae also indicates that he has provided presentations and training on the subject of providing an Independent Medical Examination.

[43] In his Medical Assessor's report to the Tribunal dated June 19, 2012, Dr. Margulies stated:

> As requested, and in my capacity as an assessor (psychiatric) for the Workplace Safety and Insurance Appeals Tribunal, I undertook a psychiatric assessment of the above-captioned on May 29, 2012, meeting with [the worker] for a period of three hours. His wife was also interviewed during this time and was able to provide much useful additional information. Prior to preparation of this report, I was provided with extensive documentation, specifics of which are appended. This material has been reviewed, will be referred to in the body of this report where and as relevant, and is being returned with this report. [The worker] was fully aware of the nature and purpose of this psychiatric

assessment, and that it was undertaken in the context of an appeal of a WSIB decision with respect to possible psychiatric .sequelae of a work- related injury; he had already signed an appropriate authorization permitting disclosure of health information by the undersigned to the WSIAT for purposes of this report. [The worker] was unknown to this examiner prior to the date of evaluation and at no time has there been any personal or social, or prior professional relationship between this assessor and [the worker] or any member of his family.

On December 23, 2005, while employed as an assistant manager in a large chain drug store, [the worker] reportedly sustained a work-related injury to his lower back. By his account, his health, both physical as well as mental before this accident, had been "excellent", and he specifically denied any prior instances of back pain or ever attending for medical or chiropractic treatment for back pain. In this regard [the worker] may have been less than accurate, insofar as documented[1] he had sustained what amounted to a minor, work-related low back injury in February of 1989 and while he apparently lost no time from work, was placed on modified duties for an unknown period of time. He was said by one examiner,[2] to have "had two previous back injuries."

In terms of the low back injury under consideration and the object of WSIB claim, [the worker] attended upon his personal physician, Dr. D. Rosati, who apparently treated him with various analgesic, anti-inflammatory and muscle relaxing medications. He also came under the care of Dr. K. Carson, a chiropractor upon whom, he indicated, he has continued in attendance into the present. Following injury, he returned to modified and graduated work in early January of 2006 but within a matter of days he reportedly experienced an exacerbation of low back pain purportedly further to "re-injury." He again ceased work and was in receipt of WSIB benefits until April 1, 2006.

Over the periods when [the worker] was deemed vocationally disabled, he indicated that he was repeatedly harassed, humiliated and mocked by his manager who purportedly pressured him to return to work. At one point, according to [the worker], he was informed that a resignation package was available, an offer which he understood to indicate his manager's desire to "get rid of [him]," [The worker] spoke of his profound reaction of feeling "worthless" and "helpless" in his fear of the loss of his job which meant so much to him, and of his future.

While in attendance upon Dr. Rosati, it was noted[3] on a number of occasions in March of 2006, that [the worker] was "becoming more anxious and irritable. … not sleep[ing] well … worrying about his job… becoming restless" and appearing to have a depressed mood." At a meeting with his employer and WSIB representatives on March 31, 2006, [the worker] described "breaking down" in purported reaction to what he perceived to be efforts to get him to return to work when he believed he was incapable, by reason of back pain, of do so. Crying and upset, feeling very low and having no energy, he attended upon Dr. Rosati who supported his ongoing disability and found him to be "highly anxious and depressed . . . unable to focus . . . [and] suspicious of our [i.e. Dr. Rosati's] intentions," in a manner never made clear. Deemed by Dr. Rosati to have developed "major depression and anxiety in relation to work stresses and his injury," he was referred to Dr. S.J. Hulley, a GP psychotherapist whom [the worker] misidentified as a psychiatrist. While [the worker] described his emotional state at the time, i.e. early April, 2006, as one in which he felt "very very down" and was crying a great deal, it is to be noted that at the time of initial attendance, Dr. Hulley[4] found [the worker] fearing that his manager "might put something into his drink or put something into his pocket." Also noted by Dr. Hulley at that time were palpitations, racing thoughts, sleep disruption, ruminations over his employment circumstances, withdrawal, and eating disturbance with

[1] WSIB Claim #[...].
[2] Dr. L. Taylor, October 1, 2007.
[3] Dr. D. Rosati, April 5, 2006.
[4] Dr. S.J. Hulley, clinical note, April 4, 2006.

weight gain. Noteworthily, these symptoms were said to be similar to what one of [the worker's] brothers had experienced in terms of "depression — paranoia" for which he had been hospitalized and treated with medication.

Because [the worker] was a poor historian at the time of this evaluation (for reasons which will be elaborated upon below) and because little additional information was to be found in the relevant records of Dr. Hulley, it was not possible directly to obtain a comprehensive account of the development of these various symptoms. It is to be noted, however, and apparently confirmatory of the similarity of symptoms experienced by a brother, in a Worker's Rep Statement, dated August 27, 2007, that [the worker's] wife had reported that "maybe in January, 2006, his brother took [the worker] to the emergency of St. Joseph's Hospital in [a local city] as he [i.e. [the worker]] was experiencing stress symptoms [much the same] as another brother. He was seen by a doctor and probably given medication and then released." Because [the worker] reported, and there are references in the provided documentation that two of his male siblings had experienced severe and likely psychotic symptoms, these notations of Dr. Hulley would suggest the presence of significant and possibly psychotic symptoms sometime in early January of 2006, two to three months prior to his attendance upon Dr. Hulley. It would be, therefore, extremely important that the record of his emergency attendance at St. Joseph's Hospital in January, 2006, if, indeed, it did occur, be obtained in order to provide further clarification of his emotional state at that time.

According to [the worker], treatment by Dr. Hulley consisted of talking "mostly about what [his manager] did" and the prescription of venlafaxine (Effexor antidepressant) which led, so he believed, to him becoming "hyper" in a manner which he did "not remember" but which he believed was characterized by an essentially unstable mood with ups and downs, varying between hyperactivity and withdrawal. This account was generally confirmed by his wife and reference to the relevant records of Dr. Hulley[5] notes treatment with increasing dosages of venlafaxine, observations of [the worker's] suspiciousness and his conviction of being observed by his manager, mood instability, difficulties with attention and concentration, and much worry and concern about workplace issues, irritability and anger. Noteworthily, in a clinical note dated June 23, 2006, [the worker] was said to have tangential and pressured speech, grandiose thinking, psychomotor agitation with moderate irritability, and a mildly elated affect, all of which were deemed to indicate a "hypomanic" episode.

Diagnosed with an "affective psychosis" (presumably a form of bipolar disorder), he was treated with clonazepam (benzodiazepine anixiolytic/sedative), risperidone (atypical antipsychotic) and the gradual discontinuation of venlafaxine. At some point in the summer of 2006, treatment with lithium (Duralith; mood stabilizer) was initiated with what can best be described as variable, inconsistent and modest and unsustained improvement in mood stability. In the course of time, treatment with additional medications, risperidone, quetiapine (Seroquel) and olanzapine (Zyprexa), has apparently been attempted but has generally proved no more effective than earlier efforts. Since July of 2008, following Dr. Hulley's move to another city, [the worker] has been under the care of Dr. A.E. Shaw, a GP psychotherapist whom he also misidentified as a psychiatrist and upon whom he has continued into attendance into the presence.

From what can best be determined, the sole report of Dr. Shaw (December 2, 2008) providing little relevant information and in the absence of contemporaneous documentation, treatment has apparently continued more or less in the same vein as noted above, but with no appreciable long term or sustained improvement. Currently, [the worker] and his wife identified what amounted to periods lasting for weeks, which were likened to a "light bulb" turning on and off, the former being characterized by what amounted to excessive and pressured speech, increased energy, excitability, diminished

[5] Dr. S.J. Hulley, clinical notes, April 11, 25, May 2, 15, 18, June 5, 16, 23, 27, July 7, 14, 21, 28, August 1, 18, 22, 25, September 1, 5, 8, 12, 2006.

need for sleep, and a degree of elation, and the latter by periods of withdrawal, apparent sadness and personal neglect with no energy. When "hyper," he has impulsively purchased many items of questionable utility to him and his family and has made increased sexual demands upon his wife, often to the point of argument. He has continued to believe intermittently that he is being observed and followed by his manager and by various others, currently by representatives of WSIB in order to determine his level of activity. Additionally, he acknowledged that his telephones are being tapped and such electronic surveillance may also extend throughout his entire home as well.

Current medication was reported to include lithium, 1200 mg daily, a drug which he has been taking for the past six years with purported adequate blood levels, olanzapine, along with clonazepam, omeprazole (Losec; gastric acid inhibitor), acetaminophen/codeine compound (Tylenol #3; opioid analgesic) and cyclobenzaprine (Flexeril; muscle relaxant). He has not worked for the past more than six years and currently was in receipt of LTD benefits through his place of work and Canada Pension Plan disability benefits. His level of activity would appear to vary according to his affective (mood) state and level of energy, when up he is actively involved in child transportation and when low he rarely leaves his home.

As part of a comprehensive psychiatric evaluation and in order to obtain some understanding of biopsychosocial factors that may be related to his current emotional difficulties, a review of [the worker's] past and psychosocial history was undertaken. It was learned that he was born in Eritrea, but raised since infancy in Addis Ababa, Ethiopia, the second child and second male in a sibline of six boys and four girls, of whom three, one brother and two sisters, have remained in Ethiopia, the rest living in the [city name] area. Of his siblings, two younger brothers were said to have suffered from psychiatric illness, one having been hospitalized on a number of occasions and treated with medication and ECT and another, to have apparently been successfully treated for what would appear to have been a psychotic illness.

[The worker] revealed little, in terms of his important feelings, attitudes and relationships throughout his significant developmental years, simply noting that his mother was a "very sweet lady" and his father "a very very hardworking tailor". She died in Canada in 2003 at the age of 56 of hepatitis while his father died six months later, shortly before his 70th birthday, of stomach cancer, having remained in Ethiopia while his wife had immigrated to Canada in 1993. [The worker] disclaimed any understanding or knowledge of what amounted to *de facto* parental separation.

An average student, [the worker] completed high school, went on to study English for an additional year and when he was roughly 20 years old, with a cousin, escaped from the civil war then raging in Ethiopia. He described a trek of 11 days of near starvation and great privation before finding refuge in Somalia where he remained in a refugee camp for roughly two years before his immigration to this country, sponsored by a brother who had preceded him. Settling in the [city name] area, where he has remained into the present, [the worker] was apparently instrumental in sponsoring the immigration of his various siblings and mother. He upgraded his English skills, worked part time in a factory for roughly two years and for six years, until 1993, worked in a discount retail chain where, before it closed, he had been promoted to the position of store manager. He was able to obtain employment with a large drug store chain, initially as a clerk but eventually advancing to a store manager from which position, because of store closure, he was transferred, as an assistant manager at the same rate of pay, to another store where he had been employed for nine months when he sustained the subject work-related back injury.

In 2000, after two years of courtship and limited prior dating experience, [the worker] married an Ethiopian woman 14 years his junior presently employed as a registered practical nurse in a chronic hospital/nursing home. He described a fundamentally good marriage which at times has been stressed by his difficult behaviours and which has produced three daughters, twins presently eight years of age and the eldest 11 years old.

In self description, [the worker] portrayed himself as a highly conscientious, very organized, neat and tidy individual who was devoted to his work. He described a pattern of checking and re-checking whether lights were turned off and doors and windows properly locked, never being certain and continuing to doubt whether things were proper. Another examiner[6] apparently noted more extensive checking and re-checking, repeated counting, and difficulty in throwing out items of little apparent value. He is also said to be prone to anxious worry about many things, significant or otherwise.

Mental status assessment revealed a neatly dressed, neatly groomed, 49 year old black man who looked younger than his years. There was a noticeable and almost constant tremor to his hands that was present only at rest. He was of average to tall stature and muscularly built; he showed no signs of personal neglect.

From the outset, [the worker] was extremely talkative to the point of pressured speech rapid, difficult to interrupt, loud and, if permitted, non-stop and over talking this examiner. He was overinclusive with much detail in his speech which, nonetheless, was generally goal directed in his conviction that the subject accident was ultimately responsible for his acknowledged disturbed mood. He was highly excitable, at times bordering upon irritable, with shifts and changes taking place at a rapid rate. By history, his behaviour has shown an increased sexual drive and impulsive purchasing.

His affect: was generally elated, but not to the point of euphoria. He was quick to smile and laugh with little provocation, but was prone to rapid shifts to excitability and irritability. His mood was subjectively reported to be, at times, low which was not consistent with objective observation of a generally elated affect. He tended to gesticulate a great deal but otherwise showed no other behavioural irregularities, distortions or abnormalities.

His thinking tended to be somewhat tangential but was generally, goal directed, lacking the marked circumstantiality and loosening of associations of a significant thought disorder. Delusions of a persecutory nature were present, [the worker] reporting his beliefs that he was being followed by representatives of the WSIB and that his telephone was, and home may have been bugged. There were no signs of organic brain dysfunction with a generally clear sensorium, and intact and average to likely above average intelligence. Memory tended to be defective at times, particularly in terms of a lack of awareness of much of his past psychiatric disturbance but showed no organic (structural or brain damaged) qualities.

[The worker] had some insight into the pathological nature of his fundamental mood disturbance, recognizing its instability, but, notwithstanding, showed poor judgment in much of his behaviour, the pathological significance of which often escaping him.

By history, his mood was reported to fluctuate with periods of being "up", as noted during this examination, to periods of feeling "down" with a generally saddened mood, withdrawal to the point of isolating himself from his family for days on end, much personal neglect and a general sense of uncaring apathy. There were no reported sustained periods of so-called normalcy or a generally stable mood.

Prior to the work-related accident in question, it would appear that [the worker] had many longstanding obsessive and compulsive characterological traits including perfectionism, extreme conscientiousness, devotion to work, an inability to throw out useless objects, and was prone to excessive organization and order. This would be consistent with and support the diagnosis of an obsessive-compulsive personality disorder. Symptoms of repeated counting and checking, also present, are suggestive of an obsessive-compulsive disorder which is to be distinguished from the former "by the presence of true obsessions or compulsions which cause marked distress or significantly interfere with the person's

[6] Dr. L. Taylor, October 1, 2007

.

normal functioning.[7] It is not entirely clear whether these criteria have been fully met and while [the worker] is said to have shown a pattern of hoarding, on the basis of this examination such behaviour would appear to have reflected more the trait of the obsessive/compulsive personality disordered individual's inability to discard worn out or worthless material or objects rather than actual hoarding. Whatever may be, whether obsessive compulsive personality disorder, obsessive compulsive disorder, or both, as a result, [the worker] had an increased vulnerability to develop depressive illness.

On the basis of this examination, the information provided by [the worker's] wife, and review of documentation, certain conclusions can be reached. However, it is important to note that, by reason of the serious psychiatric illness which [the worker] is experiencing, his judgment is poor and his recollections are coloured by his affective state and, more significantly, by what are clearly delusional misbeliefs. Consequently, one cannot uncritically accept [the worker's] accounts and must look to alternate sources of information for clarification and/or elaboration as needed.

While [the worker] vaguely described a gradual onset of increasing emotional distress and "depression" following injury and his manager's purported increasing harassment, the first contemporaneously documented mention of any such distress was noted by Dr. Rosati[8] in reference to attendances on March 11, 15, 22, 29, 2006 to the effect that [the worker] was experiencing what would appear to have been increasing emotional distress and "signs of reactive stress and depressed mood" in the context of what is said to be increasing harassment. In the absence of any information of [the worker's] emotional state prior to that time, i.e. in January and February, 2006, and assuming that there was none, in view of historic characterological makeup and the time frame of chronological evolution there may very well be a strong etiological relationship between [the worker's] perception of harassment and threat of losing his job and what would appear to have been his emotional decompensation. A person to whom his work, about which he was very conscientious, was very important, which formed an important part of his self esteem and provided his financial support, whose obsessive and compulsive personality traits left him more vulnerable to the development of depressive illness, and whose strong family history of serious psychiatric illness left him at greater risk to develop mental illness, [the worker] may very well have felt sufficiently threatened by reason of his perceptions of criticisms, put downs, harassment and threats of termination, to have emotionally decompensated and, according to his predisposition, develop a depressive illness.

All of this of course, is contingent upon the accuracy of the accounts provided by [the worker] and documented by Dr. Rosati. However, his apparent attendance for emergency care in early January of 2006, as indicated,[9] when he was purportedly experiencing "stress symptoms" not unlike one of his brothers who was known to have severe psychiatric illness ("paranoia-depression"[10]), would strongly suggest the much earlier presence of psychiatric symptomatology, at that time no more than two weeks after the subject work-related accident. Assuming the accuracy of this report — and it is essential that it be confirmed — and in the absence of other and reliable information of the apparent development of [the worker's] psychiatric difficulties, it is difficult to see how any emotional or psychological sequelae from the subject accident could have arisen within such a short (i.e. two week) period of time. Assuming that [the worker] was showing signs of emotional decompensation by January 6, 2006 when he attended for emergency care, it is far more likely than not that this developed independent of and unrelated to the accident under consideration. [The worker] has a strong family history of psychiatric illness in two of his siblings and was predisposed as a result to the

[7] Diagnostic and Statistical Manual of Mental Disorders, IV Edition, Text Revision, American Psychiatric Association, 2000.
[8] Dr. D. Rosati, April 5, 2006.
[9] Worker's Rep Statement, August 27, 2007.
[10] Dr. S.J. Hulley, clinical note, April 4, 2006.

development of similar psychiatric illness which, it is well recognized, may develop de novo, i.e. without the obvious presence of external stressor(s). In other words, by January 6, 2006, [the worker] was already decompensating and his perception of subsequent difficulties vis-a-vis his workplace may have been, in part at least, a function of misperceptions is a result of his developing psychiatric illness.

No information has been provided with respect to [the worker's] emotional state prior to January 6, 2006 but, if possible, it should be obtained in order to determine if any signs of an evolving mental illness were present in early 2006 or before. On the basis of provided information and assuming that [the worker] did attend for emergency care at St. Joseph's Health Centre on January 6, 2006, as described, he was already psychiatrically ill and any relationship to a back injury sustained two weeks earlier is highly unlikely.

Making reference to contemporary documentation (of Dr. Rosati and Dr. Hulley) it would appear that in March and April of 2006 [the worker] was presenting with many depressive symptoms, anxiety and agitation. He was also noted by Dr. Rosati, as early as sometime in March of 2006, to be suspicious of the doctor's intentions, and later, by Dr. Hulley on April 14. 2006 to be suspicious and feared that his manager "might put something into his drink or put something into his pocket." These suspicions likely were of delusional proportions as it really is highly unlikely that his manager may have done what [the worker] feared.

At the time of evaluation by Dr. Hulley on April 4, 2006, and likely in March, 2006 when seen by Dr. Rosati, that [the worker] was experiencing a major depressive episode with mood incongruent psychotic features. Treatment with venlafaxine (Effexor; antidepressant) had been initiated by Dr. Rosati in late March and was continued in increasing dosages, according to response or lack thereof by Dr. Hulley, and by mid-June of 2006 [the worker] was noted to be increasingly agitated and highly irritable, and to show what amounted to a fundamentally unstable mood which on June 23, 2006, was accompanied by pressured speech, tangential thinking, grandiosity, elation, and much irritability and psychomotor agitation. This account is entirely consistent with the diagnosis of a hypomanic episode which, having occurred while undergoing antidepressant therapy, and in the absence of any history of prior hypomanic or similar episodes, would be deemed a substance-induced mood disorder. The development of manic, hypomanic or psychotic symptoms during antidepressant treatment, particularly in the early phases, is a not unusual complication of treatment, and does not necessarily indicate the presence of a bipolar disorder or count towards the diagnosis of a bipolar disorder. It may or it may not, but only time, response to treatment, and outcome can determine the eventual diagnosis.

Despite utilization of mood stabilizing and antipsychotic agents, there is no compelling evidence that [the worker] has achieved any appreciable improvement while in attendance upon Dr. Hulley or Dr. Shaw. While the course of [the worker's] illness and therapies undertaken are not fully known, by his account and that of his wife, a more reliable historian, he has, for the past unknown period of time been experiencing episodes of roughly four weeks' duration, of what has amounted to manic or hypomanic episodes alternating with depressive episodes, with little or no normal mood periods in between. This is a form of rapid cycling can be difficult to treat and which clearly has not responded to what therapies he has undergone in the four years during which he has been under the care of Dr. Shaw.

Because [the worker] did not respond to initial treatment for what likely had been a drug-induced manic or hypomanic episode, and because he has continued to experience both depressive and hypomanic and manic episodes, the diagnosis is bipolar I disorder. Because there is no evidence that, since onset, he has experienced significant periods of euthymia (normal mood) and because he currently, and for a while, has been experiencing rapid changes in mood, from elation to depression, the specifiers, respectively, of without full inter-episode recovery and rapid cycling apply.

> The etiology of bipolar disorder in [the worker's] instance is primarily genetic/biochemical with the possibility that stressors associated with the accident and primarily his manager may have been a factor in, at most, permitting his inherent vulnerability, which more likely than not would have eventually become apparent, to emerge. His subsequent course of what is now rapid cycling can be attributed to a number of factors including the inherent or the fundamental nature of his bipolar disorder, the failure to immediately cease utilization of venlafaxine when manic or hypomanic symptoms first became apparent, and the failure to initiate far more aggressive treatment than what he has received. The prognosis may be poor but is to be deferred until all appropriate therapeutic interventions have been undertaken.
>
> I trust that this report sufficiently addresses the pertinent issues as outlined in the letter of direction to me dated May 7, 2012….

[44] Subsequent to receiving the Medical Assessor, Dr. Margulies's report to the Tribunal dated June 19, 2012, and as a result of comments contained in the Medical Assessor's report, the Panel determined that it would prefer to obtain further information to confirm whether or not the worker attended at hospital for psychological/psychiatric symptoms in January of 2006. The Panel requested that TCO obtain information in this regard.

[45] In a Memorandum to the Panel and the worker's representative dated October 25, 2012, TCO confirmed that the hospital in question had been contacted, and had advised that the worker was not seen at that facility in January of 2006, and there was no Emergency Room visit for the worker that pertained to mental health.

(vii) Submissions

[46] The worker's representative submits that the worker had an emotional reaction to the back injury and to treatment from the employer in the return to work process, and the worker should have entitlement for Psychotraumatic disability, a NEL assessment. The worker's representative submits that the worker also has an ongoing organic back disability. The worker's representative submits that the worker is entitled to ongoing LOE benefits based on an ongoing organic and an ongoing Psychotraumatic disability. The worker's representative submits that the thin-skull argument applies with respect to the development of the worker's Psychotraumatic disability.

(viii) Law and policy

[47] The accident occurred December 23, 2005, and therefore the *Workplace Safety and Insurance Act* (WSIA) applies to the appeal. Sections 13 and 43 of the WSIA are applicable and provide as follows:

> **13(1)** A worker who sustains a personal injury by accident arising out of and in the course of his or her employment is entitled to benefits under the insurance plan.
>
> **(2)** If the accident arises out of the worker's employment, it is presumed to have occurred in the course of the employment unless the contrary is shown. If it occurs in the course of the worker's employment, it is presumed to have arisen out of the employment unless the contrary is shown.
>
> **(3)** Except as provided in sections 18 to 20, the worker is not entitled to benefits under the insurance plan if the accident occurs while the worker is employed outside of Ontario.
>
> **(4)** Except as provided in subsection (5), a worker is not entitled to benefits under the insurance plan for mental stress.

(5) A worker is entitled to benefits for mental stress that is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment. However, the worker is not entitled to benefits for mental stress caused by his or her employer's decisions or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment.

43(1) A worker who has a loss of earnings as a result of the injury is entitled to payments under this section beginning when the loss of earnings begins. The payments continue until the earliest of,

(a) the day on which the worker's loss of earnings ceases;

(b) the day on which the worker reaches 65 years of age, if the worker was less than 63 years of age on the date of the injury;

(c) two years after the date of the injury, if the worker was 63 years of age or older on the date of the injury;

(d) the day on which the worker is no longer impaired as a result of the injury.

(2) Subject to subsections (3) and (4), the amount of the payments is 85 per cent of the difference between,

(a) the worker's net average earnings before the injury; and

(b) the net average earnings that he or she earns or is able to earn in suitable employment or business after the injury.

However, the minimum amount of the payments for full loss of earnings is the lesser of $15,312.51 or the worker's net average earnings before the injury.

(3) The amount of the payment is 85 percent of his or her pre-injury net average earnings less any earnings the worker earns after the injury if the worker is co-operating in health care measures and,

(a) his or her early and safe return to work; or

(b) all aspects of a labour market re-entry assessment or plan.

(4) The Board shall deem the worker's earnings after the injury to be the earnings that the worker is able to earn from the employment or business that is suitable for the worker under section 42 and,

(a) if the worker is provided with a labour market re-entry plan, the earnings shall be deemed as of the date the worker completes the plan; or

(b) if the Board determines that the worker does not require a labour market re-entry plan, the earnings shall be deemed as of the date this determination is made.

(5) The calculation of the amount of the payments is subject to the following rules:

1 The amount of the net average earnings before the injury must be adjusted by the alternate indexing factor for each January 1 since the date of the injury.

2. The amount described by clause (2)(b) must reflect any disability payments paid to the worker under the Canada Pension Plan or the Quebec Pension Plan in respect of the injury.

3. If the amount described by clause (2)(b) is not zero and does not consist solely of disability payments in respect of the injury paid to the worker under the Canada Pension Plan or the Quebec Pension Plan, the amount of the payment must be adjusted,

> i. by multiplying, for each January 1 since the date of the injury, the amount of the payment by the sum of one plus the general indexing factor expressed as a fraction, and
>
> ii. by dividing, for each January 1 since the date of the injury, the amount of the payment by the sum of one plus the alternate indexing factor expressed as a fraction.
>
> **(6)** Every year on January 1, the Board shall adjust the amount of the payments otherwise payable to a worker using,
>
> (a) the alternate indexing factor, if the amount described by clause (2)(b) is zero or consists solely of disability payments in respect of the injury paid to the worker under the Canada Pension Plan or the Quebec Pension Plan; or
>
> (b) the general indexing factor in any other case.
>
> **(7)** The Board may reduce or suspend payments to the worker during any period when the worker is not co-operating,
>
> (a) in health care measures;
>
> (b) in his or her early and safe return to work; or
>
> (c) in all aspects of a labour market re-entry assessment or plan provided to the worker.

[48] Pursuant to section 126 of WSIA, the Board advised that the following Policy Packages are applicable to this appeal: #9 (Revision #8) – Psychotraumatic Disability ; #33 – LOE Benefits – decisions as of July 1, 2007; #38 – Recurrence; #61 – NEL Entitlement; #73 – Worker Co-operation Obligations; #86 – Early & Safe Return to Work with Accident Employer – DOA as of January 1, 1998; and #300 – Decision Making/Benefit of Doubt/Merits and Justice.

(ix) The Panel's conclusions

(a) Psychotraumatic disability

[49] On the issue of, and whether the worker should have entitlement for Psychotraumatic disability, the Panel finds for the worker.

[50] The Panel finds that the weight of the evidence, including the medical evidence, indicates that the sequelae to the compensable December 23, 2005 accident were a significant contributing factor in the development of the worker's Psychotraumatic disability in 2006. The Panel finds that the worker's psychiatric condition is likely an indirect result of the physical injury, and is related to extended disablement and/or to non-medical socioeconomic factors, the majority of which can be directly and clearly related to the work related injury. The Panel finds, accordingly, that there is entitlement for Psychotraumatic disability in this claim.

[51] The Panel notes at the outset that pursuant to section 13 of WSIA, a worker who sustains a personal injury by accident arising out of and in the course of his employment has entitlement under the Act. The Panel also notes that included in the Policy Packages that the Board advised were applicable to this appeal Board *Operational Policy Manual* (OPM) Document No. 15-04-02 – Psychotraumatic Disability – which policy provides in part as follows:

> **Policy**
>
> A worker is entitled to benefits when disability/impairment results from a work-related personal injury by accident. Disability/impairment includes both physical and emotional disability/impairment.

Guidelines

General rule

If it is evident that a diagnosis of a psychotraumatic disability/impairment is attributable to a work-related injury or a condition resulting from a work-related injury, entitlement is granted providing the psychotraumatic disability/impairment became manifest within 5 years of the injury, or within 5 years of the last surgical procedure.

Psychotraumatic disability/impairment is considered to be a temporary condition. Only in exceptional circumstances is this type of disability/impairment accepted as a permanent condition.

Psychotraumatic disability/impairment resulting from organic brain damage is assessed as a permanent disability/impairment.

Psychotraumatic disability entitlement

Entitlement for psychotraumatic disability may be established when the following circumstances exist or develop

- Organic brain syndrome secondary to
  - traumatic head injury
  - toxic chemicals including gases
  - hypoxic conditions, or
  - conditions related to decompression sickness.
- As an indirect result of a physical injury
  - emotional reaction to the accident or injury
  - severe physical disability/impairment, or
  - reaction to the treatment process.
- The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socioeconomic factors, the majority of which can be directly and clearly related to the work-related injury....

[52] We see that pursuant to OPM Document No. 15-04-02 – Psychotraumatic Disability – there will be entitlement for a Psychotraumatic disability if it is established that the condition is an indirect result of a physical injury, or is related to extended disablement and to non-medical socioeconomic factors, the majority of which can be directly and clearly related to the work related injury.

[53] Turning to the facts of this appeal, the worker's representative Mr. Cooke submits that the worker should have entitlement for Psychotraumatic disability since the worker had an emotional or psychological reaction to the back injury and to its sequelae, including the resulting return to work process. The Panel finds that we agree that the evidence indicates that the worker should have entitlement for Psychotraumatic disability, in the circumstances of this case. We make this finding for the following reasons.

[54] First, we note that the Panel sought the opinion of an independent Tribunal appointed Medical Assessor in this case. As we have stated in this decision, the Tribunal appointed Dr. Margulies, psychiatrist, as the Medical Assessor, and Dr. Margulies provided a report dated June 19, 2012 which is referenced above. The Panel places significant weight on the opinion of the Tribunal appointed Medical Assessor Dr. Margulies for the following reasons:

1. The Panel finds that as a certified specialist in psychiatry; and as the chairman of the Section on Psychotherapy, Canadian Psychiatric Association from 1992 to 2000; and as a member of the Executive Committee, Canadian Society of Medical

Evaluators from 2000 to 2006; and as the first Vice President and Chair of the Committee on bylaws, ethics and foundation, Canadian Society of Medical Evaluators from 2002 to 2004; and as the President, Canadian Society of Medical Evaluators from 2004 to 2005; and since he also has provided presentations and training on the subject of providing an Independent Medical Examination, Dr. Margulies is qualified to provide an opinion on diagnosis and etiology in this case involving mental and emotional illness.

2. The Panel finds that as an independent Tribunal appointed Medical Assessor, Dr. Margulies' opinion is objective and independent;

3. The Panel observes that Dr. Margulies reviewed all of the relevant medical documentation on file, and interviewed and assessed the worker in person, prior to providing his opinion;

4. The Panel finds that Dr. Margulies opinion was set out in a clear, logical and convincing manner.

[55] Turning to the contents of the Medical Assessor's report, we observe that after reviewing the relevant documentation on file, and after interviewing and assessing the worker in-person, Dr. Margulies concluded that the worker's experiences as related to the back injury and the subsequent attempted return to graduated work likely played a causal role in the emergence of the worker's psychiatric illness later in 2006. Dr. Margulies stated that the etiology of the worker's bipolar disorder was primarily genetic or biochemical, but that the stressors associated with the workplace accident and the worker's subsequent relationship with his manager in the context of his gradual return to work may also have had an etiological relationship with the worker's psychological decompensation. We note in this regard that Dr. Margulies stated:

> While [the worker] vaguely described a gradual onset of increasing emotional distress and "depression" following injury and his manager's purported increasing harassment, the first contemporaneously documented mention of any such distress was noted by Dr. Rosati[11] in reference to attendances on March 11, 15, 22, 29, 2006 to the effect that [the worker] was experiencing what would appear to have been increasing emotional distress and "signs of reactive stress and depressed mood" in the context of what is said to be increasing harassment. In the absence of any information of [the worker's] emotional state prior to that time, i.e. in January and February, 2006, and assuming that there was none, in view of historic characterological makeup and the time frame of chronological evolution there may very well be a strong etiological relationship between [the worker's] perception of harassment and threat of losing his job and what would appear to have been his emotional decompensation. A person to whom his work, about which he was very conscientious, was very important, which formed an important part of his self esteem and provided his financial support, whose obsessive and compulsive personality traits left him more vulnerable to the development of depressive illness, and whose strong family history of serious psychiatric illness left him at greater risk to develop mental illness, [the worker] may very well have felt sufficiently threatened by reason of his perceptions of criticisms, put downs, harassment and threats of termination, to have emotionally decompensated and, according to his predisposition, develop a depressive illness.

[11] Dr. D. Rosati, April 5, 2006.

[56] As the Panel understands Dr. Margulies opinion, he is of the view that there was likely a strong etiological relationship between the worker's perception of the threat of losing his job and the criticisms related to his inability to return to work on full time regular duties following the back injury, and the worker's emotional decompensation. As the Panel noted in Interim *Decision No. 1033/11I*, the Panel accepts that the worker felt pressure in relation to his ability to perform work following the December 23, 2005 back injury; and the Panel accepts that it was the worker's perception that the store manager was placing pressure on the worker following the December 23, 2005 back injury. The Panel also notes that the worker's testimony indicates that the employer offered the worker a termination package, and we accept that this occurred given that there is no evidence to the contrary. We conclude that the worker reasonably felt that his job security was in question as a result of these events. The Panel concludes from Dr. Margulies' report that the sequelae to the compensable December 23, 2005 accident were a significant contributing factor in the development of the worker's Psychotraumatic disability in 2006.

[57] Dr. Margulies also stated:

> The etiology of bipolar disorder in [the worker's] instance is primarily genetic/biochemical with the possibility that stressors associated with the accident and primarily his manager may have been a factor in, at most, permitting his inherent vulnerability, which more likely than not would have eventually become apparent, to emerge.

[58] We see that Dr. Margulies is of the opinion that the workplace stressors, which the Panel finds are sequelae to the back injury, permitted the worker's inherent vulnerability to emerge and the worker developed a mental illness. We find that this evidence establishes that the worker likely had a predisposition to a mental illness, but that the worker's predisposition was in the nature of a largely asymptomatic pre-existing condition or predisposition. According to the 'thin skull' doctrine of causality, the worker would have entitlement for Psychotraumatic disability notwithstanding the genetic predisposition, or the largely asymptomatic pre-existing condition, since that doctrine requires that the 'victim' be taken as they are found. In this case the evidence indicates that the worker was a thin skull 'victim' with a possible genetic predisposition to develop emotional, psychological or mental illness. We find that the evidence does not indicate that the worker was a 'crumbling skull' victim, since the evidence indicates that the worker was functioning in the workplace on a full time basis prior to the December 23, 2005 back injury. We also find that even though Dr. Margulies was of the view that the worker likely would have developed a mental illness in the future, due to his inherent vulnerability or predisposition, the principles of causality provide that if the work-related causal factors either caused or advance the development of the illness, then entitlement for the illness is in order. In this case there is no evidence to indicate that the worker's psychological issues were disabling prior to the December 23, 2005 back injury, since the evidence indicates that the worker was functioning in full time regular duties as an assistant store manager; and since the evidence indicates that the worker did not previously require psychiatric care or psychological counseling. The sequelae to the workplace accident caused the worker's psychiatric problems to emerge in 2006, we find, and there is therefore entitlement for the Psychotraumatic disability.

[59] We find that since the workplace events that were the sequelae to the back injury made a significant contribution to the development of the worker's Psychotraumatic disability, there is entitlement for the Psychotraumatic disability in accordance with the legislation and policy. In particular we note that Board policy OPM Document No. 15-04-02 – Psychotraumatic Disability – provides that there will be entitlement for a Psychotraumatic disability if it is established that

the condition is an indirect result of a physical injury, or is related to extended disablement and to non-medical socioeconomic factors, the majority of which can be directly and clearly related to the work related injury. In this case we conclude that the worker's Psychotraumatic disability is an indirect result of the physical back injury, and is also related to non-medical socioeconomic factors, the majority of which can be directly and clearly related to the work related injury, since the worker required modified work as a result of the back injury, and came under criticisms and stress as a result of this inability to work increased hours, all of which precipitated the emotional decompensation.

[60] The Panel is aware that Dr. Margulies stipulated that in the event that the worker was seen and treated for mental illness in hospital in early January of 2006, as the worker's wife had thought she recollected, then this would suggest that the psychiatric difficulties would not be the result of the sequelae to the work related accident since it would be difficult to see how any emotional or psychological sequelae from the subject accident could have arisen within such a short (2 week) period of time. As we have noted above in this decision, the Panel took steps to ascertain whether the worker had indeed been seen in hospital in early January 2006, and we were advised that there was no record of any such visit for psychiatric treatment in January of 2006. We conclude that the worker was not likely treated for mental illness in January of 2006, and we conclude that the medical evidence that indicates that the worker's symptoms emerged in March of 2006 is reliable. We note that according to the evidence, the worker broke down emotionally at the return-to-work meeting that occurred on March 31, 2006. The Panel is persuaded that the weight of the evidence indicates that the workplace events that were the sequelae of the December 23, 2005 back injury made a significant contribution to the development of the Psychotraumatic disability.

[61] The Panel accepts the opinion of the Medical Assessor Dr. Margulies. The Panel concludes that the sequelae to the work place back injury, including the stresses and criticisms associated with the worker's return to graduated work, made a significant contribution to the development of the Psychotraumatic disability.

[62] Second, the Panel finds that there is other support in the medical evidence for our conclusions that the sequelae to the work place back injury, including the stresses and criticisms associated with the worker's return to graduated work, made a significant contribution to the development of the Psychotraumatic disability.

[63] We note in this regard that in her report dated December 2, 2008, Dr. Anne Shaw, family physician psychotherapist, stated that she had seen the worker since July 28, 2008, to monitor his mood and adjust psychiatric medications. Dr. Shaw stated that the worker's return to work experience following the December 2005 back injury led to the worker's severe anxiety and mental health problems.

[64] We also note in this regard that in a report dated October 10, 2008, Dr. Rosati, family physician, stated that the worker's experience of threats and pressure related to his return to work following the back injury contributed to the worker's personal stress and led to his emotional decompensation and illness.

[65] Finally, we note in this regard that in her report dated May 14, 2008, Dr. Susan Hulley, GP psychotherapist, stated that workplace stress precipitated the worker's mental illness. Dr. Hulley stated:

> Relationship between psychopathology and work-associated factors:
>
> Workplace stress precipitated this patient's Bipolar Disorder and post-traumatic Stress Disorder…. When he was on leave he received daily phone calls from the boss pressuring him to return to work. When the patient tried to explain his condition, the boss hung up the phone. When the patient returned to work his boss failed to accommodate tot the patient's needs for light duties. There were daily meetings with negative feedback. He was yelled at when he made a mistake. The boss's demeanor was angry and aggressive. The boss stopped greeting the patient. The patient was accused of being unmotivated and disrespectful. He was then offered a severance package. This patient had been a diligent employee for many years and was highly motivated to support his wife and 3 young children.

[66] The Panel places significant weight on the opinions of Dr. Shaw, Dr. Rosati, and Dr. Hulley, since as physicians they are qualified to provide an opinion on medical causality; since they each saw and treated the worker over the span of several months or years; and since their opinion is essentially supported by the opinion of the Tribunal Medical Assessor.

[67] Third, the Panel finds that the evidence before us indicates that the worker was apparently functioning well psychologically prior to the December 23, 2005 accident. We find that the evidence, including the documents on file and the testimony of the worker, indicates that the worker was functioning in his performance of full time regular store manager duties prior to the December 23, 2005 back injury; and that the worker had indeed been promoted to store manager by the employer in the previous years. The Panel concludes that the evidence indicates that the stressors involved in the return to work process, and the other sequelae of the December 23, 2005 back injury, present as the most likely precipitants of the worker's Psychotraumatic disability.

[68] Since the evidence indicates that the worker's Psychotraumatic disability has been ongoing and symptomatic to some degree since 2006, the Panel directs the Board to provide the worker with a Non-Economic Loss (NEL) assessment with respect to the Psychotraumatic disability.

[69] In summary, the Panel finds that the worker has entitlement for Psychotraumatic disability in this claim. The Board is directed to provide the worker with a Non-Economic Loss (NEL) assessment with respect to the Psychotraumatic disability.

[70] Based on all of the foregoing, this aspect of the appeal is allowed.

(b) LOE subsequent to April 1, 2006

[71] On the issue of whether the worker should have entitlement for LOE benefits for the period of time subsequent to April 1, 2006, the Panel finds that this issue should be remitted to the Board to be determined once the severity of the worker's Psychotraumatic disability has been determined by the Board.

[72] The Panel notes in this regard that in this decision the Panel has granted entitlement for Psychotraumatic disability. The Panel finds that it does not have sufficient information or evidence concerning the severity of the worker's Psychotraumatic disability, since the worker has not been assessed for NEL purposes by the Board. The Panel also finds that we do not have sufficient evidence concerning the degree of the worker's Psychotraumatic disability throughout the time period since April 1, 2006. The Panel further notes that we did not receive extensive submissions from the worker's representative regarding the issue of the worker's entitlement for

LOE. We also note that there was some suggestion on file that the worker was diagnosed with Bells' Palsy in October of 2006; however there is scant evidence on file to indicate whether this diagnosis was confirmed, or what effect it had with respect to the worker's ability to function.

[73] Given that the Board has been directed to provide the worker with a Non-Economic Loss (NEL) assessment with respect to the Psychotraumatic disability, the issue of the worker's entitlement for LOE benefits subsequent to April 1, 2006 is remitted to the Board, to be determined once the worker's NEL for Psychotraumatic disability has been assessed and rated.

[74] Based on all of the foregoing, this appeal issue is remitted to the Board, for determination once the worker's NEL for Psychotraumatic disability has been assessed and rated.

DISPOSITION

[75] The appeal is allowed in part.

[76] The worker has entitlement for a Psychotraumatic disability under this claim.

[77] The issue of the worker's entitlement for LOE benefits for the time period subsequent to April 1, 2006 is remitted to the Board for determination once the worker's NEL for Psychotraumatic disability has been assessed and rated.

DATED: May 17, 2013

SIGNED: J. Noble, B.M. Young, K. Hoskin