WCAT # 2010-240-AD

NOVA SCOTIA WORKERS' COMPENSATION APPEALS TRIBUNAL

Appellant:	**[X] (Worker)**
Participants entitled to respond to this appeal:	**[X] (Employer)** and **The Workers' Compensation Board of Nova Scotia (Board)**

APPEAL DECISION

Representative:	[X]
Form of Appeal:	Written submissions
WCB Claim Nos:	[X]
Date of Decision:	April 12, 2011
Decision:	The appeal of the March 30, 2010 Board Hearing Officer decision is allowed, according to the reasons of Appeal Commissioner Sandy MacIntosh.

CLAIM HISTORY AND APPEAL PROCEEDINGS:

The Worker had several workplace injuries. The most significant injury occurred on August 22, 1991, when the Worker fell more than 35 feet, sustaining multiple injuries. The Board provided the Worker with extensive vocational rehabilitation services; however, the Worker was unable to return to the workforce. In 2000, the Board awarded the Worker an extended earnings-replacement benefit which he received until recently, when he turned 65.

The Board found that the 1991 injury resulted in a 25% permanent medical impairment due to his developing a psychiatric impairment (25% is the top rating for a 'moderate' impairment of the total person). It found that he has a 10.5% rating for his left hip injury. It also found that he had chronic pain in relation to his right shoulder (a 3% pain-related impairment).

On April 6, 2005, a Case Manager reviewed the Worker's psychiatric impairment rating and found that it remained properly assessed at 25%.

In 2008, the Worker's treating psychiatrist, Dr. Sheard, wrote to the Board requesting a review of the Worker's permanent medical impairment rating. In particular, he questioned whether the Worker's severe paranoia had been properly taken into account.

On April 24, 2009, a Hearing Officer directed the Board to commission an independent medical examination by Dr. Gosse, to determine whether the Worker's compensable psychiatric condition had deteriorated.

Dr. Gosse assessed the Worker on September 14, 2009.

On October 15, 2009, a Case Manager found that the Worker was not entitled to a reassessment. She accepted Dr. Gosse's opinion that the Worker's condition had not significantly deteriorated.

On March 30, 2010, a Hearing Officer confirmed the Case Manager's decision. The Hearing Officer adopted Dr. Gosse's opinion.

This decision addresses the Worker's appeal of the Hearing Officer's decision.

The Worker's representative argues that the Worker functioned well before his injury. She argues that the file evidence supports anxiety and withdrawing behavior flowing from the

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This decision contains personal information and may be published. For this reason, I have not referred to the participants by name.

workplace injury. She argues that Dr. Sheard noted symptoms consistent with paranoid ideas from the beginning of his treatment of the Worker in 2001. She argues that a delusional disorder was first diagnosed in 2004. She argues that the opinion of Dr. Sheard should be accepted over that of Dr. Gosse and that Dr. Sheard has explained why portions of Dr. Gosse's opinion do not accord with the evidence. She argues that the Worker developed a delusional disorder and obsessive-compulsive disorder due to the injury which are separate and independent from the post-traumatic stress disorder. She argues that the Worker's permanent medical impairment rating should be increased by 60%.

ISSUES AND OUTCOME:

Has there been a change in the Worker's permanent medical impairment rating not taken into account during the previous rating?

Yes. The Worker's psychiatric impairment should now be assessed as a major impairment of the total person.

ANALYSIS:

Under s. 71 of the *Workers' Compensation Act,* the Board may review and adjust a permanent medical impairment rating where there has been a change that was not taken into account at the most recent assessment.

The PMI Guidelines describe Moderate (Category II) impairment as being able to look after personal needs, but at times losing confidence and becoming dependent on family members for all non-family activities. Those with a moderate impairment are described as having a moderate anxiety state, agitation, and strong passive tendencies.

The Major (Category III) impairment is described as a severe anxiety state with definite deterioration in family adjustment, breakdown in social integration, and longer periods of depression. Those with a major impairment tend to withdraw from family and have diminished stress tolerance. They may become homebound at frequent intervals.

The Severe (Category IV) impairment is described as a chronic severe limitation of adaptation and function in the home and outside. Those with a severe impairment are withdrawn, unable to concentrate, and need continuous emotional support in the family. They are incapable of self-care and neglect personal hygiene. They are extremely irritable, and have uncontrollable bursts of temper. They are usually home or room-bound.

Under s. 187 of the *Workers' Compensation Act,* the Worker must be given the benefit of the doubt. This means that evenly disputed possibilities are decided in the Worker's

favour. In other words, a tie goes to the Worker.

The Worker's permanent medical impairment was last assessed in 2005, based largely on reviews of progress reports from Dr. Sheard. Therefore, I must review that decision and the information on which it was based to determine whether there has been a change.

2005 review

The April 6, 2005 Case Manager decision accepted a diagnosis from Dr. Sheard that the Worker has both post-traumatic stress disorder and a delusional disorder. The Case Manager reviewed a December 6, 2004 progress report from Dr. Sheard. She noted that Dr. Sheard reported that the Worker was coherent and orientated for time, place and person. However, he was in possession of self-defence weapons. He was intensity burdened by flashbacks to his workplace injury. He had paranoid beliefs including that his wife may try to poison him, and was on constant guard. Dr. Sheard indicated that the Worker's GAF (global assessment of functioning) was 50-55.

The Case Manager reviewed a March 11, 2005, report from Dr. Smith, a Board physician. Dr. Smith reviewed Dr. Sheard's progress reports. He noted that Dr. Sheard has indicated that the Worker's GAF was 50-55. On this basis of this he recommended continuing the 25% permanent medical impairment rating.

Key evidence since April 2005

On July 17, 2008, Dr. Sheard wrote to the Board requesting a review of the Worker's permanent impairment rating. He wrote that the Worker continues to have severe paranoia with phobic avoidance, hyper vigilance, exaggerated startle response. He has constant reflection back to the original accident with intermittent flashbacks, broken sleep, and nightmares. He wrote that most recently the Worker's mental state was woeful, downcast, inattentive, easily distracted, exhibiting poor eye contact, with little spontaneity of speech and facial expressions. He wrote that the Worker had significant suspicion and mistrust of others.

On September 17, 2008, Dr. Marche, a Board physician, reviewed the Worker's claim file. She wrote that Dr. Sheard's 2008 report did not contain any new information that had not been considered at the last review. She noted that the Worker previously had been diagnosed with post-traumatic stress disorder with paranoid delusions and obsessive compulsive disorder.

On March 24, 2009, Dr. Sheard wrote a letter in support of the Worker challenging his permanent medical impairment rating. He wrote that, in the past three months, the Worker had become more socially withdrawn, and more paranoid. The Worker was beginning to

draw improper conclusion from facial expressions. This was causing the Worker to restrict his movement outside his house and was giving him a marked lack of confidence.

On September 14, 2009, Dr. Gosse, psychiatrist, assessed the Worker as directed by the Hearing Officer. Dr. Gosse wrote that the Worker presents with some residual symptoms of post-traumatic stress. However, the Worker reported being less fearful than he used to be, but still is occasionally cranky and has a short fuse at times. The Worker felt that his post-traumatic stress was less bothersome than it had been in the past.

Dr. Gosse wrote that the Worker describes significant obsessive-compulsive symptoms. He had hoarding and checking behaviours. He constantly uses timers on his lights as he wants people to believe he is home when he is out. He believes that his wife is trying to kill him. He does not trust his wife and their relationship has deteriorated to the point where they no longer have a sexual relationship. He usually falls asleep quickly, but tends to stay in bed until noon the next day.

The Worker reported that he had some improvement since 2004, as he was basically housebound then. Now he goes out for coffee, has a few friends, and is increasing his socializing. He feels financially stressed as his extended earnings-replacement benefit is ending.

The Worker was engaging and talkative during the assessment. He had no overt psychotic symptoms except for paranoid ideation. The Worker carried a concealed axe and club which he stated were for protection.

Dr. Gosse wrote that it was unclear whether the paranoid ideation and obsessive-compulsive symptoms were related to the accident. They appeared to develop after the accident. He felt that those symptoms had been relatively stable in the past few years. He felt that the post-traumatic stress disorder was gradually improving. He expressed the view that the Worker's GAF was approximately 55 to 60. Overall, he did not think that the Worker's condition had significantly deteriorated.

On November 2, 2009, Dr. Sheard wrote Dr. Gosse asking him to reconsider his opinion regarding the cause of the delusional disorder (paranoia). He noted that there was no evidence of a pre-existing disorder. He attributed it to the time that the Worker was wheelchair bound following the injury. He wrote that it slowly developed into a full blown disorder. He expressed the view that the Board had failed to compensate the Worker for this condition.

On December 11, 2009, Dr. Sheard wrote the Worker's representative. He repeated his view that the delusional disorder had never been compensated and that it was linked to the workplace injury. He expressed the view that Dr. Gosse had downplayed the disorder.

On October 18, 2010, Dr. Sheard wrote a report for the Worker's representative. He indicated that the Worker's compulsive behaviour and paranoia were part of his delusional disorder. He wrote that the post-traumatic stress disorder had improved, but that the Worker remained quite morbidly obsessed with protecting himself. He repeated his view that the delusional disorder had its origins from the Worker being confined to a wheelchair following the injury.

He expressed the view that the Worker should be rated at least 60% for his delusional disorder on top of his award for post-traumatic stress disorder. He felt that it should be categorized as a severe impairment of the total person under the PMI Guidelines. He noted that the Worker rarely leaves his home, and has been unable to maintain and develop even a small network of friends. He wrote that the Worker has been unable to function in an outside environment, has neglected personal hygiene, has been unable to concentrate, and has needed continuous emotional support.

Sufficient evidence to warrant a reassessment

The evidence from Dr. Gosse has put into issue whether the Worker's delusional disorder (the paranoia and obsessive compulsive symptoms) is causally connected to the compensable injury.

On an 'as likely as not basis' I accept the opinion of Dr. Sheard regarding the causal connection. There is no evidence of pre-existing delusional disorder. Dr. Sheard provides a reasoned explanation for its causal connection to the workplace injury (its origins with the time that the Worker was required to remain in a wheelchair) and its gradual worsening. I note that the Board physicians appear to accept a causal relationship as well.

The evidence supports that the Worker's post-traumatic symptoms have become less severe. Both Dr. Gosse and Dr. Sheard agree on this point. However, there is conflicting evidence as to whether there have been significant changes in the Worker's total condition. Dr. Gosse is of the view that there has been no significant change (remains in the moderate category), while Dr. Sheard expresses the view that the Worker should be rated in the severe category.

Overall, I find that the evidence supports that the Worker should be rated under the Major category. Dr. Gosse has noted significant deterioration in the Worker's marital relationship to the point where there is no longer a sexual relationship. While Dr. Gosse has documented that the Worker has started going out for coffee and making some friends, Dr. Sheard has noted that the Worker is incapable of maintaining these relationships.

The Worker's psychological profile appears now to best fit in the major category in that the Worker has had a definite deterioration in family adjustment, and a breakdown in social

integration. He is withdrawn from his family and has diminished stress tolerance. He is housebound at frequent intervals.

I do not accept Dr. Sheard's opinion that the Delusional disorder should be assessed separately from the post-traumatic stress disorder. That is not the proper application of the PMI Guidelines (unless there is a non-compensable psychological condition, in which case such a breakdown may be necessary to apply the apportionment policy).

I also do not accept Dr. Sheard's opinion that the Worker should be categorized in the severe category. The Worker is far too capable of self-care to be considered for that category.

The Board will reassess the Worker's psychiatric impairment to provide him with an appropriate rating within the major category (30% to 50%).

CONCLUSION:

The appeal is allowed.

The Worker is entitled to an increased permanent medical impairment rating within the major category.

DATED AT HALIFAX, NOVA SCOTIA, THIS 12th DAY OF APRIL, 2011.

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Sandy MacIntosh
Appeal Commissioner