**Injured worker case study**

## Introduction

Following my early retirement from WCAT I had an opportunity to do some curriculum work on disability prevention and management with Pacific Coast University for Workplace Health Sciences. While involved in that project I received a request to assist a severely injured worker with a technical policy issue related to his claim as part of an upcoming appeal. The circumstances of his 2010 accident was tragic and it was clear from speaking with him that he was both confused and frustrated with the administrative hoops and bureaucratic hurdles he was having to navigate.

His story was compelling. He was crushed in a sawmill accident while attempting to dislodge a log jam. Another worker inadvertently energized the conveyer carrying large 1,000 lb. logs impacting his right shoulder and forcing him backwards in a semi-twisted position through a narrow 19 inch metal frame folding him in half causing multiple injuries including significant injuries to his right shoulder, upper back, neck, and chest. The crush caused a punctured lung and a fractured sternum and caused him to stop breathing for over 5 minutes. The accident happened in 'slow motion' and he developed a serious PTSD condition as a result of experiencing what he believed was his imminent death. He also sustained a cognitive disorder from the anoxic injury to the brain that was associated with severe migraine headaches that occurred unpredictably 12-15 days per month.

His wife left her full time job following the accident and set up an online business so she would be able to assist him in his recovery and in dealing with his claim. In my discussion with him in 2014 it was clear that he was highly motivated for his own recovery, but was distressed that he was not getting the medical assistance and treatment to deal with the multiple injuries. He and his wife had no funds to secure independent representation, so I agreed to assist him on a pro bono basis in conjunction with my work at Pacific Coast University to help him untangle the complex of adjudicative issues and overlapping decisions and to provide me with an opportunity to directly engage in the disability management process.

A review of his 4,500 page file showed that in June 2010 a Board appointed neuropsychologist diagnosed a cognitive disorder from the anoxic brain injury and the Board arranged for psychological counselling for his PTSD condition. There was no focused medical treatment for his physical injuries. The Board's repeated attempts to reactivate him to return to work through community rehabilitation programs were unsuccessful, mainly because the physical demands of those programs worsened his physical symp-

toms and precipitated and intensified his migraine headaches. His family physician repeatedly withdrew him from those programs as a result of the worsening of his symptoms.

**Adjudication and reviews: Part I**

In July 2012 after multiple unsuccessful attempts by the Board to get him to return to work against his doctor's advice, the Board concluded his wage loss benefits on the basis that all of his physical injuries "had healed." The Board adjudicator concluded that the only permanent conditions were PTSD, a minor brain injury associated with headaches and several chronic pain conditions. The treating specialist appointed by the Board generally supported the Board's position and did not recommend any further treatment. The worker secured an independent medical exam from a specialist at his own expense that documented a number of ongoing injuries including a significant shoulder injury requiring further treatment, but this report was not considered by the Board.

The worker sought a review of the 2012 decision on the grounds that his injuries had not healed and the decision failed to consider a number of ongoing injuries including a significant cognitive disorder and an ongoing shoulder impairment that required further treatment. The February 2013 review decision **(RD#1)** was partially successful. The review officer agreed that the worker's injuries to his neck, right shoulder and upper back had not resolved by June 24, 2012. He also found that the PTSD and mild traumatic brain injury had not resolved or stabilized but found he did not have jurisdiction to address issues such as the cognitive disorder that were not specifically mentioned in the July 5, 2012, decision. The review officer advised the worker that it was open to him to request a decision from the Board on the cognitive disorder and other issues not addressed in the July 2012 decision. The worker wrote to the Board on March 25, 2013, requesting adjudication of all outstanding issues not previously addressed.

In March 2013 the Board case manager 'implemented' the favourable February 2013 review decision by concluding that any conditions that had not healed by June 2012 had resolved or become permanent prior to the February 15, 2013, review decision and no temporary disability benefits were payable beyond that date. The worker applied for a review of that decision. In the December 5, 2013, review decision **(RD#2)**, the review officer found that his physical injuries accepted on the claim had likely resolved as of November 9, 2012, and any residual problems related to chronic pain and post traumatic headaches.

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In April 2013 the Board case manager “retroactively” accepted the cognitive disorder, but concluded that it had resolved prior to June 2012 and there was no further benefit entitlement for that condition. The Board refused to conduct further follow-up neuropsychological testing as recommended by the neuropsychologist who initially diagnosed the cognitive disorder in 2010. The worker applied for a review of this decision.

On July 25, 2013, the Board case manager addressed a number of outstanding injuries the worker had raised in his March 2013 letter to the Board. The case manager denied acceptance of the sleep disorder and any neck injury and thoracic injury beyond the chronic pain condition previously accepted. The worker requested a review of the July 25 decision on grounds that the Board failed to consider all of the medical evidence and failed to authorize the proper treatment for some of those injuries. In the March 11, 2014, review decision **(RD# 3)** the review officer confirmed the Board’s decision to deny the sleep disorder and further health care benefits. The review officer noted a number of issues for which he did not have jurisdiction to consider and indicated the worker could go back to the Board for further decisions.

In July 2013 the worker discontinued treatment with the Board's appointed specialist in favour of an independent specialist with similar credentials who arranged for ongoing medical treatment including more effective Botex injections into his scalp every 3 months to help control the sometimes debilitating migraine headaches. He also secured treatment from a specialist physiotherapist who provided very helpful treatment for his upper back and neck conditions. He also was referred for an MRI of his right shoulder in September 2013 which revealed a significant lesion to the rotator cuff that had been previously missed by the Board's appointed specialist.

In the October 2013 review decision **(RD# 4)** a review officer confirmed the Board's April 2013 decision that the worker's compensable cognitive disorder had resolved.

The Board's case manager referred the issue of the relationship of the right shoulder lesion to the Board's orthopaedic consultant for an opinion regarding the relationship between the shoulder lesion and the 2010 accident. The Board's orthopaedic consultant concluded that the documented right shoulder lesion was more likely "to be anatomical variants of normal anatomy" and unrelated to the accident or the shoulder injury previously accepted under the claim. In the February 14, 2014, decision the case manager denied the worker's rotator cuff lesion documented on the MRI and the worker sought a review of that decision.

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The worker's treating specialist disagreed with the decision to deny the ongoing shoulder problems under the claim and referred the issue of the right shoulder lesion to an independent orthopaedic surgeon who carried out extensive diagnostic tests and recommended consideration of surgery for the lesion. Given the delay in identifying the lesion the surgeon believed that the worker would achieve a 40% improvement in the shoulder function from the proposed surgery. In the review decision of September 18, 2014, **(RD# 5)** the review officer confirmed the Board's decision that the right shoulder lesions documented on the MRI were not compensable under the claim.

As previously noted I became involved in the worker's case in the summer of 2014. It was clear at that point that the worker was totally confused and frustrated by the piecemeal adjudication and the convoluted decision making in his case. It was also apparent that the impact of the claims and appeal process had been non-therapeutic and had caused he and his family considerable emotional and financial distress. He had lost confidence in the Boards ability to fairly adjudicate his claim and was distrustful of the Board's medical consultants who consistently overruled the opinions of his treating physicians.

We were able to secure the assistance of a leading neuropsychologist who agreed to carry out the previously recommended neuropsychological testing that had been refused by the Board. That testing demonstrated that the worker continued to suffer from the cognitive disorder first diagnosed in 2010 and that the likelihood of future improvement was remote. We were also able to secure a medical-legal opinion from the workers treating specialist who expressed the opinion that the right shoulder lesion documented on the MRI was directly related to the 2010 accident.

In the August 27, 2015 WCAT decision (WCAT-2015-02691) the panel accepted the independent neuropsychologist's opinion and found that the worker's ongoing cognitive disorder was acceptable under the claim. The WCAT panel preferred the opinion of the worker's independent specialist over the opinion of the Board doctors since the independent specialist's opinion was based on direct clinical evaluation and the specialist provided detailed reasons to support the opinion.

In June 2015 the WCAT panel had directed the Board to issue a determination under section 246(3) of the Act on when each accepted condition under the claim became permanent (or resolved) and whether the worker was entitled to be assessed for a permanent partial disability award for each of the accepted conditions. In response, the Board case manager issued an August 7, 2015 determination stating that all of the worker's

compensable conditions other than PTSD, pain disorder and chronic pain were considered to have resolved and there would be no further referral to disability awards.

In the WCAT decision dated December 2, 2015 (WCAT-2015-03653) the WCAT panel considered the worker's appeals from the review decisions dated February 15, 2013 (RD#1), December 5, 2013 (RD#2) and March 11, 2014 (RD#3) and allowed the worker's appeals in part. The panel concluded that the worker's right brachial plexus injury had not resolved and should be assessed for permanent disability entitlement. The panel also concluded that the worker's post traumatic headaches and PTSD were no longer temporary had become permanent as of May 2012 and June 2012 respectively. The panel found that the workers neck injury had stabilized and become permanent by May 2012.

**Implementation challenges and conflicting medical evidence**

In the course of his employment as a sawmill worker the worker had developed a significant permanent cedar allergy condition that was recognized by the Board. As a result the Board determined that he would not be able to return to the forestry sector given the risks of a worsening of that condition from further exposure. The Board agreed to sponsor a retraining program and accepted the worker's proposal for support to complete the final two years of a university program in business administration.

The worker was highly motivated to complete this program but had considerable difficulty with the course load given his cognitive disorder and migraine headache challenges. The worker's physicians advocated a reduced course load which the Board initially resisted, but eventually agreed to. With tutoring support from his wife who had a Provincial Instructor Diploma and ongoing support from the university disability support services and accommodation by course instructors he was able to complete the degree in 2016. In recognition of his achievements he received the Remarkable Achievement Award which is awarded to a student “who has dealt with significant obstacles in both reaching university and completing their program of choice while being an inspiration to others and the university community.”

On the basis of the two WCAT decisions the workers claim was referred to the Board's Disability Awards Department for assessment of his permanent disability. On May 3, 2016, the Board case manager concluded that the worker was capable of full time employment as a human resources specialist and not entitled to a loss of earnings assessment. The worker requested a review of that decision.

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In support of the worker's permanent disability entitlement we requested an independent medical examination and medical legal opinion by a former Board medical advisor and former medical consultant to the WCAT. In the 218 page report dated June 1, 2016, the independent medical specialist summarized the relevant medical evidence on file, documented the workers medical limitations and concluded that the worker was not reasonably capable of performing any work activity on a full time basis.

The worker was examined by a Board disability awards medical advisor in June 2016. On the basis of that evaluation the disability awards officer issued the July 19, 2016 decision granting the worker a permanent disability award of 35.5% that included 15% for the PTSD, chronic pain and cognitive disorder. The worker also requested a review of the July 19 decision.

On August 24, 2016 the Board case manager denied acceptance of the thoracic outlet syndrome supported by his treating specialist and authorization for the right shoulder surgery recommended by his treating specialist and by the neurosurgeon who recommended that surgery. The Board's orthopaedic consultant reiterated his earlier opinion that the MRI documented right shoulder lesions were "…incidential findings that are present to a greater or lesser extent in a person of [the worker's] age." The case manager relied on that opinion even though it had been rejected by the December 2015 WCAT panel. The worker requested a review of that decision.

In support of the review of these decisions we sought additional medical evidence from the independent neuropsychologist and the independent medical specialist regarding the nature and extent of the worker's permanent impairment and his employability. The independent neuropsychologist opined that the worker's permanent psychological impairment should be assessed in the range of 45-50% in accordance with the impairment ratings in the Board's permanent psychological disability evaluation schedule. The independent medical specialist questioned the validity of the method used to assess the worker's permanent physical impairment and agreed with the neuropsychologist's opinion that the psychological impairment was in the range of 45-50%.

In October 2016 the Board discontinued the workers psychological treatment and terminated his vocational rehabilitation benefits, even though he had not found any gainful employment after an extensive job search. This termination of benefits forced the worker to file for bankruptcy protection.

**Adjudication and reviews: part II**

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In the decision dated December 12, 2016, (**RD#6**) the review officer acknowledged the discrepancies in the Board's method used to assess the worker's permanent physical impairment with respect to the worker's right shoulder, headaches and chronic pain and referred these back to the Board for further investigation. The review officer also questioned the neuropsychologist's conclusions regarding the worker's employment limitations and referred the worker's claim back to the Board for further investigation and assessment of employability.

To say that this decision came as a major blow to the worker would be a gross understatement. He had been counting on a positive decision from the Review Division on the basis of the compelling medical evidence from the neuropsychologist and independent medical examiner or alternatively at least a negative decision that he could appeal directly to WCAT for a final resolution of the issues. The decision to delay the matter and force him through another round of intrusive investigations at the Board had a significant psychological impact on him. This impact was intensified coming just before Christmas when he was undergoing a financial crisis.

It did not help that the review officer who issued the December 12 decision was the same review officer who had upheld the Board's decision to deny acceptance of the right shoulder lesion.

In the January 25, 2017, review decision (**RD# 7**) the same review officer who had issued the September 18, 2014, decision upholding the Board's decision to deny acceptance of the right shoulder lesion confirmed the Boards August 2016 decision to deny the authorization for the right shoulder surgery. The review officer agreed with the analysis of the Board's orthopaedic consultant and agreed with a Board medical advisor's opinion that the estimated 40% improvement from right shoulder surgery that had been supported by the independent orthopaedic surgeon, by the worker's treating specialist and by the independent medical specialist was "an unreliable speculation."

Needless to say, this further exacerbated the worker's psychological condition.

**The impact of delayed adjudication and undercover surveillance**

In March 2017 the Board's vocational rehabilitation consultant requested information on a wide range of issues regarding the worker's activities and the nature of his involvement with his wife's online business. The worker attended his wife's business meet-up sessions and assisted with minor activities to stay active whenever he felt he was able.

He received no payment for these activities. We detailed these activities in a 5 page letter to the consultant and offered to provide any further information the consultant require. None was requested.

At that stage in the claim the worker's psychological condition had deteriorated to such an extent that I concluded further professional evaluation was required. The neuropsychologist who had carried out the previous neuropsychological assessment agreed to evaluate the worker on a pro bono basis since the worker had no funds available.

In his May 9, 2017, the independent neuropsychologist carried out further neuropsychological testing although formal cognitive testing was described as "fairly limited". The neuropsychologist reported that the worker's emotional and behavioural functioning had "significantly deteriorated" since 2014 which he attributed in part to the inability to resolve his claim and to find employment and the resulting financial stresses.

The neuropsychologist indicated that the ongoing claims investigations and adjudication was having a major impact on his psychological state. He expressed concern that the worker was "rapidly moving into a crisis mode" and was at risk of further significant psychological deterioration if these matters were not resolved in a timely matter. He strongly recommended that the worker receive further psychological intervention. He concluded that it was highly unlikely that the worker would be able to obtain and retain competitive employment.

The neuropsychologist cautioned against a immediate repeat neuropsychological testing by the Board given to professional protocol regarding the validity and reliability issues related to administering the same tests in close proximity. However, he agreed to provide the Board psychologist with his raw test data for the Board's review.

The independent neuropsychologist's May 9 report was immediately shared with the Board with a request that the Board support a referral for further psychological treatment on an expedited basis. The Board did not respond to this request.

Given the fact that the Board had not taken any steps to further evaluate the worker's permanent disability entitlement, I arranged for the independent medical specialist, who was fully qualified to carry out permanent disability evaluations, to do a formal impairment assessment to help expedite the process. In his July 26, 2017 permanent impairment assessment he provided a detailed report and concluded that given the physical

challenges combined with the severe headaches, chronic pain disorder and the cognitive disorder that it was unlikely that the worker could work in even the most sedentary occupations for any significant period of time.

In late July the rehabilitation consultant contacted me for an update on the worker's work status which was provided with an offer to provide any further details on request. No further information was requested.

In early August the rehabilitation consultant contacted me and advised the Board had carried out several months of undercover surveillance and wanted to meet with the worker to examine him under oath regarding their findings.

I explained that I would need to get professional advice regarding the advisability of the worker participating in such an exercise given the neuropsychologist's finding in May that I had shared with the Board. The consultant was insistent that this interview be carried out before the end of August and offered to have a Board psychologist present during the examination under oath.

The news of this surveillance came as a major shock to the worker and the possible deterioration outlined in the May 9 neuropsychologist's report took place as predicted. It was clear to me that the worker was fully immersed in "crisis mode" and I contacted the neuropsychologist who provided advice in a letter dated August 21, 2017. He indicated that the worker would find attending a session with a Board field investigator to view surveillance tapes "extremely emotionally traumatic" and the fact that he was not currently receiving psychological treatment would likely intensify the disruption and lead to possible decompensation and/or self-destructive behaviours. He strongly advised that further psychotherapy sessions be authorized before any such meeting occur and the worker "obtain psychological clearance" before attending any such meeting or not attend the meeting. He offered to discuss this matter with a Board psychologist. The Board did not pursue that offer.

I provided this letter to the Board and again requested the Board authorize further psychological treatment before considering any such treatment. I requested that the Board provide a decision in writing if they were not prepared to authorize further treatment. The Board did not authorize further treatment and declined to provide a decision in writing that would allow us to seek recourse.

I contacted the worker's former treating psychologist who was involved in research and no longer accepting patients. When she learned the circumstances she agreed to make

an exception and initiated psychotherapy sessions with the worker starting in early October. At that point the Board was not responding to my repeated requests to authorized treatment. The worker had just completed bankruptcy and had no funds. I arranged for a private loan to cover the cost of treatment on an interim basis.

The Board also did not take any steps to complete the worker's permanent disability until we contacted the Provincial Ombudsperson. On January 8, 2018, the rehabilitation consultant provided a memo to file reviewing the results of the video surveillance and concluded:

> Although I've viewed the surveillance information critically, I did not assess any of the information I saw or heard to be in direct contradiction with the limitations or restrictions accepted on [the worker's] claim. In other words, my review of the evidence did not compel me to request any re-adjudication given his activities appear to be in keeping with the limitations already accepted under the claim.

A Board psychologist reviewed the raw neuropsychological test data provided by the worker's neuropsychologist and advised the Board disability awards officer that the neuropsychologist's conclusions in his May 2017 report could not be relied upon because they were not drawn from valid data. She recommended that the worker's psychological impairment rating should be set at 15% as previously established by the Board.

In the February 2, 2018 decision the Board disability awards officer concluded that the worker was entitled to an additional 2% increase of his previous award of 35.5% disability. In a further letter dated February 9, 2018 a Board officer concluded that there would be no change to the boards conclusion that the worker was capable of full-time employment as a human resources professional and, as a result, no loss of earnings assessment would take place. Also the board would not pay for further treatment for the worker's permanent psychological injuries.

The worker requested reviews of both the February 2 and 9 decisions to the Review Division. In the September 26, 2018 review decision (**RD# 8**) the review officer increased the worker's psychological impairment from 15% to 25% but found that the worker was not entitled to the chronic pain awards for the neck, back and right shoulder.

In the September 27, 2018, review decision (**RD#9**) by the same review officer the issue of loss of earnings was referred back to the Board. The review officer confirmed the

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Board's decision not to provide further psychological treatment. The worker appealed these decisions to the WCAT

At the December 12, 2018, WCAT oral hearing the worker's wife testified how she curtailed her work activities so she could assist the worker in his recovery and deal with the impact of his injuries. She described how she tutored him through his schooling with the rehabilitation program. The worker detailed the support he received with his school studies though the disability support services at the university.

In the January 22, 2019 WCAT decision (WCAT-A1802966) the panel restored the worker's chronic pain awards for the neck and upper back, but not the shoulder. With respect to psychological impairment, the panel preferred the analysis of the independent neuropsychologist and his interpretation of the test data to the opinion of the Board psychologist who did not have the benefit of direct clinical evaluation of the worker. The panel found that the worker was entitled to a 45% award for psychological impairment. The panel also found that ongoing psychological treatment was required to alleviate the effects of the psychological conditions accepted under the claim.

Following the WCAT decision the Board reviewed the worker's employability and concluded on the basis of the WCAT findings that the worker would not likely be capable of obtaining and durably maintaining suitable and available employment given the extent of his compensable limitations and permanent disability. As a result, the worker has now been granted a 100% loss of earnings award.

It took nearly 7 years from the July 2012 decision that would have resulted on a 17.5% - 20% permanent disability award to gain full and fair recognition of the complex of permanent physical and psychological impairments resulting in the 2010 sawmill crush injury. The toll on the worker and his family resulting from the convoluted appeal process was immeasurable. Without the support of his family, the expert medical and psychological evidence from the independent specialists and the worker's own persistence in the face of repeated bureaucratic denials, he and his family would have faced a bleak future of poverty in addition to the unrelenting pain and disablement that has resulted from the 2010 accident. While the worker eventually overcame the "toxic dose" of bureaucratic opposition to his rightful entitlement under the Act, he will never be repaid for the toll it took on him and his family.