Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A09-001224

BETWEEN:

M.R.

Applicant

and

GORE MUTUAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Richard Feldman

Heard: September 27, 28, 29 and October 4, 2010, in Hamilton, Ontario.

Appearances: Michael L. Lamont for the Applicant
Arthur R. Camporese for the Insurer

Issues:

The Applicant, M.R.,[1] was injured in a motor vehicle accident on December 1, 2006 (the "accident"). He applied for statutory accident benefits from Gore Mutual Insurance Company ("Gore"), payable under the *Schedule*.[2] Issues arose between the parties concerning the Applicant's entitlement to certain statutory accident benefits. The parties were unable to resolve their disputes through mediation and the Applicant applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

[1]The Applicant requested that his identity be withheld in this decision as this case deals with sensitive issues of the Applicant's mental health. The Insurer did not oppose this request. I found the request to be reasonable and note that an earlier decision (a decision on a motion for interim benefits by Arbitrator Alves issued December 30, 2009) was also released in an anonymized format.

[2]*The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

There a number of issues in dispute in this proceeding (as identified in the pre-hearing letter of Arbitrator Alves, dated November 24, 2009). The parties requested, however, that at this time this hearing be **restricted to the following issues** and that the hearing of all other issues (primarily, the claims for a special award and for the expenses of this proceeding) be postponed until after the determination of these issues:

1. Did the Applicant sustain a catastrophic impairment as a result of the accident within the meaning of clause 2(1.2)(g) of the *Schedule*?

2. Pursuant to section 16 of the *Schedule*, is the Applicant entitled to attendant care benefits in the amount of $2,460.69 per month from April 10, 2008 onwards?

3. Pursuant to section 46(2) of the *Schedule*, is the Applicant entitled to interest for the overdue payment of attendant care benefits?

Result:

1. The Applicant did sustain a catastrophic impairment as a result of the accident within the meaning of clause 2(1.2)(g) of the *Schedule*.

2. The Applicant is entitled to attendant care benefits in the amount of $2,460.69 per month from April 10, 2008 onwards.

3. The Applicant is entitled to interest for the overdue payment of attendant care benefits pursuant to section 46(2) of the *Schedule*.

The Hearing

Thanks to the co-operation of counsel for both parties, the number of documents submitted and the length of the hearing were both reduced substantially from what was originally anticipated. I accepted two joint books of documents into evidence and heard testimony from the following witnesses: Robert Kowalik (a former supervisor of the Applicant), the Applicant himself, Maria Ross (occupational therapist), Dr. Brian Levitt (psychologist), Atul Kaul (occupational therapist) and Dr. Sergey ("Serge") Shapiro (psychologist). Jill Theeuwen also appeared briefly as she was summonsed by the Insurer solely for the purpose of obtaining hospital records from Etobicoke General Hospital.

EVIDENCE AND ANALYSIS:

Background

On December 1, 2006, the Applicant was driving his van through an intersection. His two dogs were also in the van. According to the Applicant, another vehicle proceeded through a stop sign (without stopping) and slammed into the side of the Applicant's van, pushing the van across the road and into the ditch on the opposite side of the road. Both air bags deployed in the Applicant's vehicle and the vehicle itself was a "write off". It is unclear whether the Applicant lost consciousness but he did have a cut at the back of his head.[3]

His main concern at the time of the accident was caring for his dogs that were also shaken up in the accident. He did not want to leave his dogs unattended so he refused to go to the hospital in the ambulance that attended the accident scene. The Applicant got someone to drive him and his dogs home and then he went to the hospital the next day.

[3]which suggests that either he struck his head on something during the accident or something loose within the vehicle (such as unsecured tools that he reported having in the vehicle) struck him in the back of the head.

According to the notes of the Applicant's family physician, it first appeared that the Applicant had only suffered whiplash-type injuries from this accident and lumbar strain (i.e., soft-tissue injuries) as the Applicant's initial complaints were mainly about headaches, neck pain and back pain. This initial diagnosis is reflected in the first disability certificate prepared by the family physician.

Within a few months of the accident, the Applicant began to complain of pain radiating down into his left hip and thigh and problems with his memory. Because it was suspected that the Applicant may have suffered a brain injury, neurological and neuropsychological testing was done.

Also, within a few months of the accident (i.e., by April 2007), psychological problems were becoming apparent so the Applicant was referred to Kaplan and Kaplan (psychologists) for assessment and, subsequently, for treatment.

At the time of the accident, the Applicant was 43 years old. Prior the accident, the Applicant had been working as a truck driver for a number of years. Since the accident, the Applicant has not returned to any sort of work. As of the date of the hearing, the Insurer was continuing to pay income replacement benefits to the Applicant.

The Applicant continues to complain of chronic pain in his head, neck, back, left hip and left leg but his main impairments, and the ones that are the focus of this hearing, are the Applicant's mental and behavioural impairments. The Insurer has also paid for substantial medical and rehabilitation benefits, including extensive psychological treatment and assistance from occupational therapists and rehabilitation support workers, until funding for such medical and rehabilitation benefits was terminated. Eventually, the Applicant applied for and received an interim order (issued December 30, 2009) requiring the Insurer to pay for further psychological treatment pending this hearing (in which, amongst other things, I must determine if the Applicant has suffered a "catastrophic impairment" within the meaning of the *Schedule*).

Catastrophic Impairment

The Law – The Relevant Threshold

Under the *Schedule*, impairment is defined as a "loss or abnormality of a psychological, physiological or anatomical structure or function".

For an accident that occurs after September 30, 2003 (as in this case), under clause 2(1.2)(g) of the *Schedule*, a catastrophic impairment includes an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993,[4] results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

In assessing the severity of mental and behavioural impairments under the *Guides*, four aspects of functional abilities are considered: (1) activities of daily living; (2) social functioning; (3) concentration, persistence and pace; and (4) deterioration or decompensation in work or worklike settings (sometimes referred to as "adaptation"). Also, independence, appropriateness, and effectiveness of activities must be considered.

The Table at page 301 of the *Guides* provides a guide for "rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment." The following are recommended by the *Guides* as anchors for the categories of the scale (see pp. 300-301):

[4]hereinafter referred to as the "*Guides*".

"None"	▪ means no impairment is noted in the function
"Mild"	▪ implies that any discerned impairment is compatible with most useful functioning
"Moderate"	▪ means that the identified impairments are compatible with some but not all useful functioning
"Marked"	▪ is a level of impairment that significantly impedes useful functioning
"Extreme"	▪ means that the impairment or limitation is not compatible with useful function (i.e., impairment levels preclude useful functioning) ▪ this implies complete dependency on another person for care ▪ in the sphere of social functioning it implies no meaningful contact, such as in a catatonic state ▪ in the sphere of concentration, persistence and pace, it means that the person cannot perform any productive task at all ▪ in the sphere of adaptation, it means that the person cannot tolerate any changes at all to their environment or routine and that the person may completely break down when there are even minor changes

The appeal level of this Commission has ruled in *Pastore*[5] that a rating of marked or extreme impairment in any one or more of these four areas of function is sufficient to qualify as a catastrophic impairment.

Summary of Relevant "CAT" Assessments

There are two assessments of catastrophic impairment in this case (although there are numerous other medical records and assessments that touch upon the same issues).

[5]*Aviva Canada Inc. and Pastore* (FSCO Appeal P09-00008, December 22, 2009).

The first "CAT" assessment was arranged by the Insurer.[6] It was conducted by Riverfront Medical Services in or about December 2008. The team consisted of Dr. Curt West (neuropsychologist), Dr. Greg Jaroszynski (orthopaedic surgeon), Dr. Serge Shapiro (psychiatrist) and Dr. Rehan Dost (neurologist, who also prepared the summary). Relying primarily upon the opinion of Dr. Shapiro, this team concluded that the Applicant's mental and behavioural impairments were affecting his functioning in the four spheres but only to a *mild* degree (class 2) and, therefore, the Applicant did not sustain a catastrophic impairment as a result of the accident within the meaning of clause 2(1.2)(g) of the *Schedule*.

A rebuttal was prepared by Kaplan and Kaplan in April 2009. The team consisted of Dr. Susan Goodwin (neurologist), Dr. Scott Garner (physiatrist), Dr. Gary Chaimowitz (psychiatrist), Dr. Brian Levitt (psychologist) and Ms. Asma Malik (occupational therapist). They all agreed that the Applicant did sustain a catastrophic impairment as a result of the accident within the meaning of clause 2(1.2)(g) of the *Schedule* because they found marked (class 4) impairments in at least three of the four spheres of function.

The Applicant's Psychological Condition

The medical evidence in this case is remarkably consistent both across assessors and over time. I find it to be significant that similar observations concerning the Applicant's conduct have been made by treating practitioners, assessors retained by the Applicant and assessors retained by the Insurer.

As early as February 2007 (i.e., within two months of the accident), Dr. R. Brett Dunlop noted that the Applicant appeared very animated, easily distracted, agitated, anxious and exhibited pressure of speech. The fact that this was an insurer's *orthopaedic* examination makes such comments unusual. Dr. Dunlop also noted that the Applicant was reporting problems with short-

[6] the Insurer having received a form OCF-19 (Application for Determination of Catastrophic Impairment) in or about September 2008.

term memory. Although it was outside of his area of expertise, Dr. Dunlop was clearly indicating concern over the Applicant's emotional and cognitive status.

The records of Dr. Glen Pierce, the Applicant's family physician, are replete with references to the Applicant's mental and behavioural issues, including his own observations throughout 2007, 2008, 2009 and 2010. Dr. Pierce frequently notes that the Applicant is anxious, restless, constantly pacing around the office, rambling in his speech, easily confused, rarely making eye contact and complaining of feeling depressed and overwhelmed. As a result of these concerns, the Applicant was referred to Kaplan and Kaplan, psychologists, for an assessment (and possibly treatment).

On May 30, 2007, Deanna Garraway met the Applicant at his home to conduct an occupational therapy assessment in order to evaluate the Applicant's functional impairments. In her report of June 7, 2007, she described his cognitive-emotional functioning as follows:

> During the occupational therapy assessment, [the Applicant] was observed to be easily distracted, tangential, frequently lost track of conversations and often repeated himself. [The Applicant] required frequent re-direction and was at times inappropriate with topics of conversation… <u>It is strongly recommended that [the Applicant] undergo neuropsychological testing</u>. (emphasis in original)
>
> [The Applicant] reported driving and passenger anxiety since the accident.… He reported he avoids driving during busy times and that he plans ahead to run errands on appointment days, or asks someone to drive him to commitments. He reported now he has "road rage" in his vehicle.
>
> Emotionally, [the Applicant] reported difficulty coping since the motor vehicle accident. He reported irritability, anger, decreased motivation and that he becomes easily frustrated. [The Applicant] reported he feels "safe and comfortable" at home since the accident and that he is not leaving his home very much… [The Applicant] repeated several times during the assessment that he has experienced relationship problems since the accident, particularly with respect to sexual relationships.
>
> [The Applicant] reported difficulty managing his daily activities and responsibilities since the motor vehicle accident such as his home, mail, appointments and self-care. As previously reported, he was observed to have piles of mail overflowing inside his home, mailbox and his car.

Ms. Garraway noted that the Applicant was unshaven and unkempt on the day of his assessment. His home was cluttered and unclean. Throughout the home there was garbage and soiled food, as well as piles of mail and dirt. The Applicant indicated that the house had been relatively clean prior to the accident. The Applicant reported feeling overwhelmed, that he was often so depressed that it was hard to get out of bed and that he did not know where to begin.

Hoarding[7] quickly became one of the most serious problems for the Applicant. He reportedly did not remove any garbage from his home for at least one year. He will not throw anything away. He has let his dogs defecate in the basement, and there it remains. He has not used the furnace for years, choosing instead to heat the room in which he lives with an electric space heater. When that room becomes so full of garbage that it is impossible to continue using it, the Applicant simply moves to the next empty room in the house. When that room also becomes completely uninhabitable, he moves on to the next room. The house now has an infestation of mice and, due to moisture and lack of heat, a mould problem as well. The problem of debris is no longer restricted to the house itself as the Applicant has begun to store things outside the house. He has also neglected his pool and the grass and weeds in his yard to the point that the municipality has had to intervene.

As for his personal hygiene, the Applicant admits that he rarely bathes (perhaps once a week or if he has an important appointment) and that he has been told that, at times, his lack of hygiene has resulted in an offensive odour. He says that it does not bother him as he has lost his sense of smell. He rarely does laundry. He will wear the same clothes for extended periods of time. When his clothes get so dirty that they can no longer be worn, he leaves them in a pile and buys some new clothes.

[7]While there may be a clinical definition of this term, when I refer to "hoarding", I mean the collecting by a person of an unusually large number of items in and around that person's living accommodations and an unwillingness to dispose of those items, even where the presence of those items poses a health risk to that person or others or otherwise interferes with usual activities of daily living or social functioning.

On July 12, 2007, Kaplan and Kaplan issued its report based upon the neuropsychological assessment of the Applicant. Dr. Levitt, interviewed the Applicant on May 1, 2007. Additional information was obtained by Dr. Christopher Dywan, psychologist and he and Ronald Kaplan prepared the report and treatment plan of July 12, 2007. They found the Applicant to be easily distracted, agitated and tangential. The Applicant reported significant emotional distress, severe suicidal ideation, significant interpersonal difficulties and problems with activities of daily living. They were unable to complete neuropsychological testing because the Applicant arrived late and left early. They felt that the results they did obtain likely reflected less than the Applicant's optimal abilities[8] but that these results (although somewhat exaggerated and incomplete) probably were indicative of how the Applicant would handle complex tasks in the real world. They diagnosed the Applicant's impairments/conditions as follows:

- Concussion
- Chronic pain
- Headache
- Severe depressive episode, without psychotic symptoms
- Adjustment disorder, with symptoms of generalized anxiety
- Post-traumatic stress disorder
- Irritability and anger
- Automobile anxiety (driver/passenger)
- Problems related to employment and unemployment
- Non-organic insomnia, partially resolved but with evidence of recent relapse
- Limitation of activity due to disability (functional limitations)

This is reflected in a Disability Certificate prepared by Ronald Kaplan on December 28, 2007.

In August 2007, an independent occupational therapy assessment of the Applicant was conducted at the request of the Insurer at the Applicant's home. It was conducted by Tina Cagampan. She found the Applicant to be impaired with respect to meal preparation, laundry, pet care and cleaning. She also found him to be unfocused, tangential, easily distracted, unable to screen inappropriate comments, labile (oscillating between anger and friendliness), depressed and paranoid. She had several safety concerns. First, it appeared that the Applicant had

[8]They did not attribute sub-maximal effort to malingering. Rather, they felt that it was more likely indicative of his difficulties in focusing and completing any task (i.e., his distractibility).

forgotten pots on a lit stove (as evidenced from the burnt condition of the pots). Second, there were large piles of cigarette butts piled around the house (and not necessarily in an appropriate, or any, receptacle). Third, there were piles of dog feces in the basement. Fourth, there was little food in the refrigerator and the food that was there was spoiled. She agreed that the home would require an extensive cleaning and, due to the Applicant's deteriorating mental and behavioural condition, his lack of initiation and motivation and his poor memory, ongoing assistance would also be required.

In January 2008, the Insurer had the Applicant attend a physiatry assessment with Dr. Emilie Newell. When Dr. Newell asked the Applicant what he meant when he referred to himself as "paranoid", the Applicant explained that (for protection) he carries small knives on his person at all times (including during this assessment), has a baseball bat in his car and keeps another beside his bed. The Applicant reported pulling a knife out during an argument at a bar on New Year's Eve just a few weeks prior to this assessment.

In February 2008, the Insurer had the Applicant attend a psychological assessment with Dr. Lawrence P. Tuff. Like the assessors who preceded him, Dr. Tuff observed pressured speech, tangentiality, difficulty maintaining a train of thought and poor eye contact. Dr. Tuff wrote:

> I note that the interview process was very much driven by [the Applicant] who exhibited marked difficulty following a train of thought. He was generally unable to respond fully to interview questions before digressing or otherwise switching topics of conversation altogether. He was [sic] equally difficult to refocus. He did not appear in any way evasive, however. In fact, he appeared was very candid, forthright and sincere in his reporting and genuinely concerned about his current life circumstances.

Dr. Tuff found that, as a result of the December 1, 2006 accident, the Applicant suffered from:

1. Major Depressive Disorder, Single Episode, Severe Without Psychotic Features; and
2. Pain Disorder arising from both Psychological Factors and a General Medical Condition

Also in February 2008, Dr. Dywan from Kaplan and Kaplan reported to Dr. Pierce that the prognosis for the Applicant was worse than originally expected. After sixteen 1.5-hour sessions with the Applicant, it was evident to Dr. Dywan that the Applicant's impairments and functional limitations were more severe than originally imagined. Dr. Dywan cited numerous examples of how the Applicant's mental and behavioural impairments were adversely affecting his function in virtually all areas.

In March 2008, the Insurer had the Applicant examined by Dr. A. Zielinsky (psychiatrist). Dr. Zielinsky found it very difficult to keep the Applicant focused on the tests being administered. As a result, he was unable to obtain reliable data. Based on this and the lack of "objective" evidence of the situation prior to the accident (i.e., evidence that did not come from the Applicant himself), Dr. Zielinksy concluded that there was no *objective* evidence of a psychiatric impairment caused by the accident.

Due to the deteriorating mental and behavioural condition of the Applicant, it was felt by the Applicant's treating practitioners that he might require attendant care. Therefore, in April 2008, Deanna Garraway conducted an attendant care assessment. While Ms. Garraway noted some physical limitations, she found that the Applicant's bigger problems were mental. His inability to self-cue, his lack of motivation, his difficulty with pacing and persistence all resulted in serious impairment of function, as evidence by, amongst other things, the deplorable state of his living accommodations.

In June 2008, the Insurer had the Applicant undergo a neuropsychological assessment by Dr. David Kurzman. Dr. Kurzman observed the Applicant to be highly agitated, frustrated and angry. The Applicant raised his voice at times, banged his fists on the table and paced around the room. He swore frequently and used inappropriate speech. He exhibited a high level of disinhibition. He went on angry tangents. Dr. Kurzman found it difficult to re-focus the Applicant. Dr. Kurzman was able to obtain what he felt was reliable test data. Like most of the other psychological experts who assessed the Applicant, Dr. Kurzman diagnosed:

1. chronic pain (with psychological factors and a general medical condition); and
2. depression (severe depressive episode with psychotic symptoms and post-traumatic stress disorder).

Dr. Kurzman also suspected some injury to the Applicant's right frontal lobe and recommended an MRI.

Around this time, the Insurer stopped funding some of the assistance (occupational therapy and rehabilitation services) that had previously been provided to the Applicant. Deanna Galbraith and Dr. Dywan both noted that the Appicant's mental and behavioural impairments got worse as a result of this lack of support. Several crisis interventions were necessary during the summer of 2008. The Applicant began exhibiting increased rage and paranoia and this created concern amongst the Applicant's treating health professionals (particularly female health practitioners who had to visit the Applicant at his home) as to their safety when working with the Applicant as well as concern for the Applicant's own safety.

In September 2008, the Applicant was referred to Dr. R. Van Reekum at the Acquired Brain Injury Clinic of Chedoke Hospital. Dr. Van Reekum saw many of the same behaviours that had been observed by numerous other assessors, including: tangential thoughts, disinhibition (for example, making inappropriate sexual or racist comments), anxiety and signs of depression. Dr. Van Reekum recommended prescribing Effexor or another antidepressant and concluded that the Applicant's cognitive and behavioural impairments were going to require, in all likelihood, long-term support and rehabilitation/intervention. As it turns out, according to a subsequent report from Dr. F. Muniz-Rodriguez (also of the Acquired Brain Injury Clinic at Chedoke Hospital), the Applicant mistrusts the use of such medication and has not been compliant in taking his antidepressant medication.

Also, in or about October 2008, the Insurer agreed to pay to have a professional crew do a thorough cleaning of the Applicant's house. Unfortunately, the crew only got the job half-finished when they stopped due to concerns about the potentially dangerous mould problem

discovered in the basement. Not surprisingly, the Applicant found this process to be extremely stressful. He was upset when the cleaning crew began to dispose of his property and he was even more upset when they stopped halfway through the job due to their concerns about toxic mould. The presence of mould also resulted in some treating practitioners (and one of the Insurer's "CAT" assessors) refusing to go to the Applicant's home, which further complicated matters.[9]

In December 2008, Riverfront Medical Services conducted the first catastrophic impairment assessment of the Applicant. Then, in April 2009, Kaplan and Kaplan prepared a rebuttal report. In June 2009, Dr. Dost and Dr. Shapiro (both of Riverfront Medical Services) responded to the rebuttal report by indicating that that their opinions remained unchanged. In the next section of this decision, I shall analyse these "CAT" assessments in detail.

Severity of Impairment Caused by Psychological Problems

Methodology Required under AMA Guides (4th ed.)

For an assessment to be considered valid, it must be done in accordance with the methodology required by the *Guides*. Amongst other requirements, the assessor must:

1. Gather and review as much information as possible;
2. Follow the *Guides* evaluation protocols;
3. Utilize the tables relating to the evaluation protocols; and
4. Prepare a report that conforms in form and content to the requirements of the *Guides*.

The *Guides* also remind us that it is also important not to confuse the seriousness of a diagnosis with the level of impairment. The *Guides* are designed to estimate impairment of function. A person can be diagnosed with a serious condition but have little or no impairment of function.

[9]The mould was not actually tested until February 2010. According to the report of Lori Sinclair (occupational therapist) dated March 12, 2010, the mould levels in the basement were found to be 30 to 80 times higher than what is considered to be safe.

This can be because the condition is in remission, the symptoms are being controlled by medication or other forms of treatment, the condition affects a function that is not crucial to this individual's daily activities and so forth.

As I indicated earlier, the medical evidence in this case is remarkably consistent both across assessors and over time. Although there have been some minor disagreements over the exact diagnoses, the experts in this case generally agree on the nature of mental and behavioural impairments suffered by the Applicant as a result of the accident. In any event, as long as there is sufficient evidence for me to conclude that the Applicant's mental and behavioural impairments were caused or exacerbated by the accident, even if there were more substantial disagreement as to the diagnoses, it would matter very little. What is important in an assessment of catastrophic impairment due to mental or behavioural impairments is the extent to which an applicant's mental and behavioural problems (that have directly resulted or been exacerbated by an accident) impair that person's functioning in the four spheres of activities considered in the *Guides*.

Causation

The Insurer questions whether the Applicant has proven that his mental and behavioural disorders are the result of the 2006 accident. The Insurer points out that there is little or no independent evidence as to the condition of the Applicant's home prior to the 2006 accident. The Insurer also points out that the Applicant was involved in two prior motor vehicle accidents (in November 2004 and May 2005) and asks that I consider whether his current difficulties might be related to those accidents rather than the one in 2006.

In November 2004, the Applicant was involved in a "rollover" accident while driving a truck. The evidence reveals that he suffered a fractured rib in that accident, was given some pain killers and was told to stay off work for two to four weeks. I find that there is no evidence of any serious or lasting physical or mental impairments as a result of the 2004 accident.

In May 2005, the Applicant was crossing a street as a pedestrian when he was struck by a car. He suffered a bruise and abrasion above his left eyebrow, an open wound on his left thigh and swollen left calf and foot. According to the hospital records, he did not lose consciousness, there was no nausea, vomiting or dizziness and he had no pain other than in his left ankle. Nevertheless, x-rays and a CT scan were done and then he was discharged. I find that there is no evidence of any serious or lasting physical or mental impairments as a result of the 2005 accident.

The Applicant saw his family doctor shortly after the 2005 accident and in January 2006. During the visit of January 2006, there were no complaints noted by Dr. Pierce of any accident-related problems and no notes by Dr. Pierce of any aberrant behaviour on the part of the Applicant. The next time the Applicant visited his family physician was following the December 2006 accident.

There is no evidence that, prior to the accident, the Applicant suffered from any mental or behavioural impairments.[10]

Robert Kowalik, the Applicant's manager for about four years immediately preceding the accident, described the Applicant as punctual, reliable, talkative and sociable. Mr. Kowalik admitted, however, that he only knew the Applicant at the workplace, not socially, and that he had never visited the Applicant's home.

The Applicant testified that, before the 2006 accident, he was a normal, active bachelor. He would cook, clean, work up to ten hours per day, walk or (weather-permitting) in-line skate with his dogs. He was "into" cycling and sailing. He visited his parents and sister at least weekly and would see his friends regularly. While his house may not have been spotless, it was clean and orderly. He described himself as being a "neat freak" prior to the accident.

[10]A friend of the Applicant was apparently interviewed and, in a neuropsychological assessment from Kaplan and Kaplan (July 12, 2007), he is quoted as saying that the Applicant "has always been a somewhat eccentric individual who generally kept mostly to himself". This statement constitutes hearsay evidence and cannot necessarily be relied upon for its truth. In any event, it is open to interpretation and needs to be considered within the context of all of the other information attributed to this individual which, in its totality, suggests that there *was* a big change in the behaviour of the Applicant immediately following the December 2006 accident. This individual was not called to testify at this proceeding. For all of these reasons, I assign little significance to this statement.

Since the accident of December 2006, the Applicant has suffered from numerous mental and behaviour impairments, which began to be noticed by the Applicant, his family physician and others in early 2007.

The Applicant testified that since the accident he has been depressed and that he rarely leaves his house. He feels uncomfortable around other people. He is easily confused and often feels overwhelmed even by tasks that, before the accident, he used to consider routine (such as picking up the mail, taking out the trash, cleaning, cooking or doing laundry). He has difficulty initiating and completing tasks. He cannot bear to throw anything away and has become a "hoarder". As a result, the Applicant rarely sees former friends or family and his house has become so cluttered and unclean that it has become unsafe to inhabit.

While most of the evidence concerning the Applicant's mental, physical and emotional condition and his lifestyle prior to the accident came from the Applicant himself, I found his testimony on these topics to be credible and supported by the testimony of his former supervisor and the available medical records.

Almost all of the mental health experts who assessed the Applicant following the 2006 accident agree that his mental and behavioural impairments likely resulted from the 2006 accident. The Applicant need only prove causation on a balance of probabilities. Based upon the evidence presented, and in the absence of any credible evidence to the contrary, I find that the Applicant has proven on a balance of probabilities that the mental and behavioural impairments under consideration were caused by the accident of December 1, 2006.

Analysis - Clause 2(1.2)(g) of the Schedule – Classifying the Applicant's Level of Impairment Due to Mental and Behvioural Disorders

The Insurer relies upon the "CAT" assessment of Riverfront Medical Services ("Riverfront"). I give little weight to that assessment.

Dr. Shapiro was the only assessor on the Riverfront team to comment on clause 2(1.2)(g) of the *Schedule*. In performing this assessment, Dr. Shapiro did not follow the procedures mandated in the *Guides*. He did not obtain all necessary and relevant medical documentation so that he had a complete and accurate understanding of the history of this case. He did not separately analyze each sphere of function and give examples of where the Applicant has demonstrated ability or disability in each area. He did not have the benefit of the report of an occupational therapist.

To be considered a valid assessment under the *Guides*, the assessors at Riverfront were required to gather and review as much information as possible about the Applicant (i.e., clinical notes and records, test results, assessments or reports from other mental health professionals who have treated or assessed the Applicant). Dr. Shapiro admitted that he was provided with almost no medical documents concerning the Applicant. According to the Appendix to the Riverfront Summary Report, other than some correspondence and insurance forms, the assessors at Riverfront were only provided with the following documentation:

1. The Application for Determination of Catastrophic Impairment and an addendum thereto;
2. Treatment Plan #4 from Kaplan and Kaplan;
3. Treatment Plan #5 from D. Garraway;
4. A Chiropractic In-person Examination Report from Dr. D. Liu; and
5. Application for Approval of a chronic pain assessment (form OCF-22).

The assessors at Riverfront were <u>not</u> provided with clinical notes and records of the Applicant's family physician, treating psychologists, physiotherapists, occupational therapists, rehabilitation support workers or other treating practitioners. They were <u>not</u> provided with important and relevant documents such as:

- an OHIP summary
- hospital records
- the neuropsychological assessment from Dr. Dywan (Kaplan and Kaplan)
- the insurer's occupational therapy assessment by Tina Cagampan
- the occupational therapy progress reports from Ross Rehabilitation & Vocational Services (Deanna Garraway and others)
- the various disability certificates
- the insurer's physiatry assessment by Dr. Emilie Newell
- the insurer's psychological assessment by Dr. Tuff
- the insurer's psychiatric assessment of Dr. Zielinsky
- the attendant care assessment of Deanna Garraway
- the insurer's neuropsychological assessment of Dr. Kurzman
- the psychological progress reports from Dr. Dywan (Kapland and Kaplan)
- the consultation report for Dr. Van Reekum

As an illustration of the amount of documentation that was available, the list of documents considered by Kaplan and Kaplan in their assessment goes on for eight full pages (and they clearly read those documents because they also provide a 65-page summary of the information obtained from that long list of documents)! Many of the relevant reports that were withheld from Riverfront resulted from assessments that were conducted on behalf of the Insurer and, therefore, were clearly in the Insurer's possession at the relevant time. All the Riverfront assessors include a statement in their respective reports that makes it clear that their opinions are based (at least in part) on the documentation provided by the referring party (the Insurer) and that additional information may produce different conclusions.

Dr. West specifically comments in his report on how limited was the documentation provided to him. At page 2 of his report, Dr. West writes:

> **…the documentation available for review with respect to [the Applicant] was extremely limited, and did not include any medical reports, ambulance call report, hospital report, or previous psychological or neuropsychological reports.** (emphasis in original)

At page 7 of his report, Dr. West notes that it appears that the Applicant may have undergone at least two prior neuropsychological examinations (by Kaplan and Kaplan in 2007 and by Dr. Kurzman in 2008) but,

> as noted above, the records provided did not include either of these assessments, and as such I am unable to comment upon or render an opinion in this regard.

Dr. West noted that, during his interview with the Applicant, the Applicant presented as unshaven, abrupt, abrasive and rude, that he stood throughout the process, that he appeared to be pain-focused and that he made multiple comments that were racially and religiously insensitive and offensive. Dr. West restricted his opinion solely to the question of whether the Applicant's impairments qualified as catastrophic under either clause 2(1.2)(e)(ii) or clause 2(1.2)(f) of the *Schedule*. With respect to catastrophic determination under clause 2(1.2)(g) of the *Schedule*, (which is the issue I must decide in this proceeding), Dr. West concluded as follows (at page 12 of his report):

> Certainly, [the Applicant] appears to demonstrate difficulties and/or impairments that may be relevant to other factors (e.g., psychiatric) and this will be addressed appropriately under Criterion 1 Clause (g) as part of this catastrophic determination. I therefore respectfully defer opinion in this regard to Dr. Serge Shapiro, Psychiatrist and the executive summary by Dr. Dost, Neurologist.

Dr. Dost, in his neurological report, focuses on the effects of what he considers to be, at most, a mild traumatic brain injury. Dr. Dost does not comment on the extent of functional difficulties experienced by the Applicant as a result of accident-related mental and behavioural impairments

(i.e., the analysis required under clause 2(1.2)(g) of the *Schedule*) as he leaves that to Dr. Shapiro.

Dr. Shapiro met the Applicant on November 11, 2008 for approximately one hour. According to Dr. Shapiro's report, the Applicant showed up that day "cleanly shaven and neatly groomed". Dr. Shapiro only had available to him the same documents that were available to Dr. West (and which Dr. West found to be inadequate). According to the testimony of Dr. Shapiro, he noted during this interview that the Applicant was suspicious, hyper-vigilant, frustrated, tense and combative, that he had a controlling and rigid style that might seem aggressive or intimidating, that he complained about pain and that he stood throughout the assessment. At the end of his report, Dr. Shapiro concludes as follows:

> Addressing specifically Criterion 1 Clause (g) from a psychiatric point of view … [the Applicant's] adjustment difficulties are affecting his functioning in four spheres (ADL, Socialization, Concentration, Persistence and Pace, and Adaptability) to a mild degree, ("reduced overall performance but do not preclude performance").

Dr. Shapiro provides no further analysis to explain this conclusion and does not examine each of the four spheres of function separately to give examples of functions that are, or are not, impaired and the extent of any such impairment (as required by the *Guides*).[11]

Since Dr. Shapiro had so little documentation available to him, he relied largely on his observations during the assessment and upon the Applicant's self-reports concerning his functional abilities. The Applicant apparently advised Dr. Shapiro that he continued to drive regularly, that he was independent in all aspects of his daily self-care, that he was in full control of his financial affairs, that he stayed in regular contact with his parents and that he spent time in their home during the holidays. He appeared alert, was able to answer questions and generally was able to remain focused throughout the assessment. Based upon this, Dr. Shapiro concluded

[11] At page 299 of the *Guides*, under the heading "Assessment of Severity", it states, "Describe in detail the severity of limitations imposed by the disorder in [each of] the following four respects, giving examples."

that the Applicant's functional impairments as a result of mental and behavioural impairments were mild.

After the "CAT" rebuttal assessment of Kaplan and Kaplan was prepared, a copy was provided to Riverfront for comment. There is no evidence before me that Riverfront ever requested or received any additional documentation concerning the Applicant. Dr. Dost and Dr. Shapiro each prepared a response in support of their original conclusions.

Dr. Dost disagrees with the conclusions of Kaplan and Kaplan concerning the extent of the Applicant's functional limitations due to mental and behavioural impairments. Dr. Dost, in his response dated June 4, 2009, focuses on the Applicant's ability to drive. Dr. Dost suggests that the ability to safely operate a motor vehicle, the "most demanding of the ADL":

> … implies a level of attention, processing speed, memory, forethought, judgement, visuospatial organization, eye hand coordination and perceptual integration which would preclude a rating of Marked under ADL and Concentration Persistence and Pace.

Dr. Dost states that a Marked (Class 4) rating implies that the impairment significantly impedes function, meaning all function. Thus, if a complex function (like driving) is spared, the implication is that the level of impairment cannot exceed Mild (Class 2), at least for: (1) activities of daily living; and (2) concentration, persistence and pace.

Dr. Dost also states that if any assessor or treating practitioner honestly believed that the Applicant's mental and behavioural impairments could affect his ability to safely operate a vehicle, this must be reported to the Registrar of Motor Vehicles. Subsequently, the Applicant's licence was, in fact, suspended pending the Ministry being provided with further information concerning the Applicant's psychological and cognitive condition and concerning his medications.

With respect to Social Functioning, Dr. Dost indicates that since the Applicant was able to establish some rapport with members of Riverfront's assessment team, the degree of impairment could not be Marked.

With respect to Adaptation, again Dr. Dost concludes that the ability to drive together with the ability to tolerate several medicolegal evaluations indicates a level of function which would preclude a Marked (Class 4) impairment. Dr. Dost does not explain in his report what he means when he says that the Applicant "tolerated" the evaluations and, of course, since he never bothered to seek further medical information, he would have no idea as to what effect (if any) the "CAT" assessments might have had on the Applicant once the assessments were completed.

Dr. Dost did not testify at this hearing. There is no indication that the other members of the assessment team at Riverfront concur in his opinion. I find Dr. Dost's reliance upon the Applicant's continued ability to drive in placing him in the "mild" category for three of the four areas of function to be an unreasonable method of assessing the degree of functional limitation experienced by the Applicant. According to Dr. Levitt, whose testimony I accept, driving is an "overlearned" activity — an experienced driver does not typically need to devote much conscious thought to this activity — and this is probably even more accurate for a professional driver like the Applicant. The idea that being able to drive would automatically mean that a person would be placed in the mild impairment category for three of four functional areas seems far too simplistic an approach and not one that is mandated by the *Guides*. According to the *Guides*, a person with *moderate* impairment levels can still have some useful functioning in all four areas of function. A person with *marked* impairment levels will find useful functioning significantly impeded (but not precluded). Therefore, even at the *marked* level of impairment, one can expect some useful function in multiple areas of functioning.

Dr. Shapiro, in his response of June 4, 2009, basically repeats his original observations and conclusions and states that he saw nothing in the Kaplan and Kaplan "CAT" assessment that would lead him to change his initial opinion. He then adds:

> The individual who would be markedly restricted in his functioning would be unable to live without assistance or supervision; unable to negotiate things with a store clerk or communicate with neighbours; unable of making common, simple transactions without assistance and would be in need of at least day hospital follow-up as a treatment. This is not the case with [the Applicant].

The opinion of Dr. Shapiro appears to be based, at least in part, upon a statement contained in the *Guides* (at pp. 300-301) to the effect that, "Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special support or assistance, such as that provided in a sheltered environment." Care should be taken, however, before placing too much reliance on this one sentence for the reasons that follow. First, this comment suggests that a person with multiple marked limitations will *likely* be precluded from performing complex tasks, not that they will *necessarily* be precluded from performing such tasks. Second, it suggests that such a person will require special support or assistance. Although it suggests that such support might be the type provided in a sheltered environment, it is not restricted to this type of assistance. The Applicant was receiving considerable support through his family physician, through ongoing psychotherapy, occupational therapy, rehabilitation support, housekeeping assistance, physical therapy and various types of medications (including antidepressants). Furthermore, this one line from the *Guides* cannot be taken in isolation. Only the extreme level of impairment suggests that useful functioning is *precluded*. At the marked level, some useful functioning is expected (i.e., useful function is significantly *impeded* but it is not precluded).

Dr. Shapiro is correct that a person with multiple functional areas that are impaired to a marked degree will have serious difficulties in performing a variety of tasks. Having spent very little time with the Applicant, however, and having reviewed almost none of the relevant medical records that he ought to have had, Dr. Shapiro did not have a complete or accurate picture of the Applicant's functional limitations. He relied too heavily upon the Applicant's self-report of being independent in most aspects of his life and, in this instance, the Applicant tended to understate the difficulties he was truly experiencing. Furthermore, *independence* in activities is just one of three criteria to consider under the *Guides*. It was also incumbent upon Dr. Shapiro to gather data on the *appropriateness* and *effectiveness* of the Applicant when engaged in a variety

of activities (see p. 294 of the *Guides*). There is no such analysis in either the original report from Dr. Shapiro or his follow-up report.

Since the analysis under clause 2(1.2)(g) of the *Schedule* is all about function, Dr. Shapiro agreed on cross-examination that it would have been useful to have had an occupational therapist as part of the assessment team. Kaplan and Kaplan had an occupational therapist as part of their assessment team. Riverfront was supposed to have an occupational therapist on their team as well but, unbeknownst to Dr. Shapiro, the occupational therapist refused to attend at the Applicant's home due to the potential health hazard posed by the presence of mould in the home.

Dr. Shapiro admitted on cross-examination that he was unaware:

- that the Applicant had not used his furnace to heat his home for years
- that he was hoarding
- that there was garbage throughout the house
- that it was infested by mice
- that there was decayed food left lying around and in the refrigerator
- that even the insurer's own occupational therapist (Atul Kaul) admitted that he had never seen a home in worse condition and that it was almost uninhabitable
- that there is evidence that the Applicant often forgets to turn off the stove
- that he is disinhibited and often makes inappropriate sexual comments
- that he has been asked to leave local establishments and/or has been barred from patronizing certain local establishments, and
- that his driver's licence had been suspended for failure to provide the Ministry of Transportation with medical reports concerning his psychological condition and prescribed medications.

Ultimately, Dr. Shapiro admitted on cross-examination that if he had had more complete information and documentation and if he had been aware of all of the difficulties the Applicant had been experiencing in his home and in the community and if these difficulties were causally

connected to the December 2006 accident, it would change his opinion concerning the severity of the Applicant's functional impairments as a result of mental or behavioural disorders.

Therefore, as previously stated, I find that, in performing this assessment, Dr. Shapiro did not follow the procedures mandated in the *Guides*. He did not obtain all necessary and relevant medical documentation so that he had a complete and accurate understanding of the history of this case. He did not separately analyze each sphere of function and give examples of where the Applicant has demonstrated ability or disability in each area. He did not have the benefit of the report of an occupational therapist. While it is not entirely the fault of Dr. Shapiro (since the Insurer failed to provide him with relevant documents that were clearly in its possession and since the Applicant in his interview tended to downplay his functional limitations), given all of the foregoing (including the admissions of Dr. Shapiro on cross-examination), I find that I cannot give the opinion of Dr. Shapiro (as expressed in his written reports) much weight. Since Dr. Shapiro was the only expert in the original report to deal with clause 2(1.2)(g) of the *Schedule*, this means that I am giving that report little weight in this case. I have also rejected the attempts by Dr. Dost to bolster Dr. Shapiro's original opinion (for reasons previously given).

Although I give little weight to the relevant portions of the Riverfront "CAT" assessment, that does not necessarily mean that I accept everything contained in the rebuttal report from Kaplan and Kaplan. I must consider each of the four areas of function and, based upon all of the evidence before me, decide for each area of function the degree to which the Applicant's functioning has been impaired as a result of his mental or behavioural disorders.

(1) Effect of the Applicant's Mental or Behavioural Impairments on Activities of Daily Living

Activities of daily living include such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, and social and recreational activities. Any limitations in these activities should (for the purposes of Chapter 14 of the *Guides*) be related to the mental disorder rather than to other factors. The quality of these activities is judged by their independence, appropriateness, effectiveness, and sustainability. It is necessary to define the

extent to which the individual is capable of initiating and participating in these activities independent of supervision or direction. What is assessed is not simply the number of activities that are restricted, but the overall degree of restriction or combination of restrictions.

Although, for the most part, the Applicant is *physically* capable of caring for himself and his home, as a result of *mental and behavioural impairments*, he is unable to do most of the activities of daily living in which he engaged prior to the accident.

He spends most of his time in bed, where he has become a chain-smoker. Photographs and testimony of a number of witnesses confirm that large mounds of cigarette butts can be found on and around the Applicant's mattress.

He does not cook or clean and the same pots and dishes have sat in his sink since around the time of the accident.

He has rarely taken out the garbage since the accident. He resists throwing anything away. He has let his dogs defecate in the basement. He has not used the furnace for years, choosing instead to heat the room in which he lives with an electric space heater. When that room becomes so full of garbage that it is impossible to continue using it, the Applicant simply moves to the next empty (or emptier) room in the house, until that room also becomes completely uninhabitable. The house now has an infestation of mice and, due to moisture and lack of heat, a mould problem as well. The Insurer attempted to assist the Applicant by hiring a professional crew to clean the house but they only got the job half-finished when they stopped due to concerns about the potentially dangerous mould problem. Since then, the hoarding and other problems have only gotten worse.

The problem of debris is no longer restricted to the house itself as the Applicant has begun to store things outside the house. He has also neglected his pool and the grass and weeds in his yard to the point that the municipality has had to intervene.

As for his personal hygiene, the Applicant admits that he rarely bathes (perhaps once a week or if he has an important appointment). He rarely washes his clothes. He has been told that, when he fails to wash himself or his clothes, he has an offensive odour. He says that it doesn't bother him as he has lost his sense of smell. When his clothes get so dirty that they can no longer be worn, he leaves them in a pile and buys some new clothes.

Until the Applicant's driver's licence was suspended for medical reasons, he continued to drive but he indicated that he tried to avoid driving during busy times. Also, since the accident, the Applicant began to experience "road rage".

He has reported experiencing problems with sexual function. He has repeatedly reported problems with sleep.

He has withdrawn and rarely engages in social or recreational activities. This may, in part, be related to physical limitations but largely this is attributable to his depression and also to his adjustment disorder.

Kaplan and Kaplan found the Applicant to be markedly impaired with regard to activities of daily living (i.e., that the level of impairment significantly impedes useful functioning). I agree. I find that the impairment to activities of daily living as a result of mental or behavioural impairments is **marked**.

(2) Effect of the Applicant's Mental or Behavioural Impairments on Social Functioning

Social functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. It includes the ability to get along with others, such as family members, friends, neighbours, grocery clerks, landlords, or bus drivers. Impaired social functioning may be demonstrated by avoidance of interpersonal relationships or social isolation.

Not surprisingly, given the state of his home, the Applicant almost never has anyone come to his house. He used to go out occasionally for meals and so forth but has found that to be difficult as well. Whereas people used to find his comments and stories humorous, now they find them to be offensive.

The Applicant has difficulty knowing what is appropriate and will often make comments that are racist, sexual or otherwise inappropriate for the situation. In conversation he is often tangential, he easily loses track of the conversation and often repeats himself. He perseverates on topics, is easily agitated and swears frequently. He has frequent mood swings. He also comes across as being argumentative and aggressive and has been asked to leave and/or has been barred from some local establishments.

The Applicant keeps weapons (such as knives) close to hand at all times and the interior of his house shows evidence that he has been throwing knives at the walls/doors. He has attempted to provide rational explanations for this behaviour (for example, that he is a collector of knives). It is true that the Applicant owned knives and baseball bats prior to the 2006 accident but, prior to the accident, he was not relying upon these weapons for self-defence, constantly practicing with them and displaying them (for example, during an argument) the way he does now. His paranoia and obsession with carrying or displaying weapons clearly makes people around him uncomfortable. Occupational therapists involved in this case, for example, have refused to attend his house unless accompanied by another professional (which is highly unusual and speaks to their level of discomfort with the Applicant's behaviour).

The Applicant does not care about calling friends and, most days, he isolates himself at home, too depressed to go out. He feels too guilty to have his parents see him in his current state and cannot bring himself to call them and talk with them.

Before the accident, the Applicant had a girlfriend for about three and one-half years. Since the accident, the Applicant attended his sister's wedding and has been on a couple of dates. He is not completely incapable of social interaction but when one considers the appropriateness and

effectiveness of his social functioning (i.e., his inability to engage in appropriate and effective social interaction), it is clear that his mental and behavioural impairments are significantly impeding useful function in this area.

Kaplan and Kaplan found the Applicant to be markedly impaired with regard to social functioning (i.e., that the level of impairment significantly impedes useful functioning). I agree. I find that the impairment to social functioning as a result of mental or behavioural impairments is **marked**.

(3) Effect of the Applicant's Mental or Behavioural Impairments on Concentration, Persistence and Pace

Concentration, persistence and pace refer to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings or everyday household tasks. According to the *Guides*, one should not place too great emphasis on results of psychiatric or psychological testing as a person may score well in a clinical setting but have real difficulties completing tasks in a real-world situation.

The Applicant has little motivation and has difficulty starting or finishing even routine tasks. He is easily distracted, as has been noted by numerous assessors and treating health professionals. During his "CAT" assessment with Dr. Levitt (at Kaplan and Kaplan), the Applicant was constantly drawn to objects in the room and, at one point in the interview, he actually got his arm stuck inside a vase.

Despite these difficulties, however, the Applicant has managed to pay most of his bills. He does keep most of his appointments. He attended at this hearing and was able to remain focused enough to complete a lengthy examination and cross-examination. Although many questions needed to be repeated or re-phrased, his answers were generally responsive to the questions being asked. As the Applicant grew more fatigued, he became more defensive and he occasionally required redirection but, in general, he demonstrated to me, at least in the setting of a formal hearing, the ability to concentrate and persist.

Asma Malik (the occupational therapist who was on the Kaplan and Kaplan assessment team) also found that the Applicant was capable of concentrating and persisting on some tasks, but that following such a period of concentration (like when he fixated on retrieving the keys he locked inside his truck), he would quickly deteriorate and be unable to focus thereafter. She also found that he had little ability to initiate actions and constantly required cuing and direction (which he often ignored). She found that his ability to concentrate and persist were highly dependent upon his mood (which constantly fluctuated) and the setting. It may also depend upon his level of pain and whether he has taken his medication (for pain, depression, etc.).

With regard to concentration, persistence and pace, Dr. Chaimowitz (psychiatrist) and Dr. Levitt (psychologist) of Kaplan and Kaplan both found the Applicant's impairments to be marked. Ms. Malik found the impairments in this functional area to be moderate to marked. In testifying at this hearing, the Applicant was able to demonstrate considerable concentration and persistence, so I do not find a marked classification to be appropriate. Nevertheless, at the hearing, there was a lot of cuing and direction given to the Applicant (from counsel and from me) and his real problems seem to arise in situations where there is no one there to assist him, to remind him what needs to be done and to keep him on task. The difficulty he encounters in this area also varies with his mood, his level of pain and whether he has taken his medication. His level of impairment therefore seems to fluctuate somewhere between moderate (impairment levels are compatible with some but not all useful functioning) and marked (impairment levels significantly impede useful functioning). I therefore agree with Ms. Malik and find that the Applicant's impairment in this area as a result of mental or behavioural impairments is **moderate to marked.**

(4) Effect of the Applicant's Mental or Behavioural Impairments on Adaptation

Deterioration or Decompensation in Work or Worklike Settings ("Adaptation") refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental

disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks.

The documentation presented is full of examples of situations in which the Applicant has had great difficulty coping with change or with stressful situations: when a relationship ended, during assessments, when he locked his keys in his truck, when his dog became ill, when one of his support workers changed jobs and he had to get used to someone new, when they came to clean his house, and so forth.

With respect to this area of function, all six assessors at Kaplan and Kaplan endorsed the following summary (contained at p. 18 of the Executive Summary):

> We note he is impulsive and will engage in dangerous and thoughtless acts such as sticking his arm in a glass vase.
>
> He makes inappropriate comments, especially to women, and cannot help himself from doing this. He will likely get fired on day one of a job. Many treating health professionals have been extremely uncomfortable with him due to his behaviour and comments. He would not be tolerated in a work-like setting. He becomes agitated by paranoid thoughts and these spiral out of control. He will not be able to engage in a socially appropriate fashion in a work setting. For example, he found it appropriate to put all his knives out on a table for an IE assessment, ranted at Jews, people of colour, and Muslims during our assessment, even though these had nothing to do with the topics covered. He drew a nude woman that he wanted to show our female staff.
>
> He is highly pain focused and it is likely any activity will exacerbate pain and cause psychological symptoms to worsen if he cannot isolate and rest for significant periods.
>
> He does not care about his appearance or hygiene and will not be able to regularly attend to work duties because he has no initiative. He cannot even bathe regularly. He could not keep up an acceptable appearance in the workplace.
>
> During his psychological assessment he could not complete a psychological test (PAI) on his own because his thinking is too tangential. He will not get through work tasks without constant structure and support.

> He takes OxyContin prn … If he takes his pain medications regularly it may affect his driving and will likely affect his mental state in a work setting…

With regard to adaptation, all assessors at Kaplan and Kaplan found the Applicant's impairments to be marked. I agree. I find that the Applicant's impairment in this area as a result of mental or behavioural impairments is **marked**.

Conclusion with respect to clause 2(1.2)(g) of the Schedule

I find that the Applicant has a **marked** level of impairment (Class 4) in three of four areas of function and a moderate to marked level of impairment in the fourth area. Therefore, I find that the Applicant has proven on a balance of probabilities that he sustained a catastrophic impairment within the meaning of clause 2(1.2)(g) of the *Schedule*.

Attendant Care

Pursuant to section 16 of the *Schedule*, an insurer shall pay an insured person who sustains an impairment as result of an accident an attendant care benefit for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant. The monthly amount payable shall be determined in accordance with Form 1.

A number of assessors have noted that, since the accident, the Applicant has lost his sense of smell. This has created a number of problems. As a result of his other mental and behavioural impairments (primarily pain, depression and anxiety), the Applicant began to neglect personal hygiene. This resulted in a number of people finding his body odour to be offensive. Since he had lost his sense of smell, he was unaware of this issue until it was pointed out by Dr. Dywan. Also, he was unable to smell food (or pots) burning on the stove or the BBQ when he forgot that he had food cooking. He also started chain-smoking after the accident (often while in bed), hoarding and using electric space heaters to heat parts of his home (instead of using the furnace). All of this behaviour creates a risk of fire and the Applicant would be unable to smell smoke if a

fire were to break out. In addition, he has suffered some loss of hearing which could also render him oblivious to potential dangers.

He has allowed his dogs to defecate in the home. He does not remove garbage. The debris has accumulated within and outside of his home to the extent that it has become a health and safety concern. There is a rodent infestation in his home. There are dangerous levels of mould.

Managing even the most mundane of tasks (such as collecting mail, paying bills, bathing, washing clothes or preparing meals) has become extremely difficult for the Applicant, mostly because of the mental and behavioural impairments that resulted from the accident of December 1, 2006. There is evidence that the Applicant has not been compliant in taking prescribed antidepressant and other medication. He exhibited increasingly paranoid behaviour and routinely carried and displayed weapons. Until his driver's licence was suspended, he was also increasingly experiencing episodes of "road rage".

After watching him continue to deteriorate throughout 2007 and into 2008, by the spring of 2008 the Applicant's treating health practitioners finally concluded that the Applicant required attendant care. On **April 10, 2008**, Deanna Garraway and Maria Ross prepared an Attendant Care Assessment Report and an Assessment of Attendant Care Needs – Form 1 (signed by Ms. Garraway). Ms. Ross testified that, in retrospect, they probably should have applied for attendant care benefits sooner.

While Ms. Garraway and Ms. Ross noted that the Applicant suffered from some physical impairment, in their opinion, his greater difficulties were caused by his mental and behavioural impairments. Like virtually all other assessors, they found that he had problems with initiation, motivation, pacing, persistence and so forth. They found him to be forgetful, unfocused and easily distracted. They were concerned about his safety within the home and his nutrition. Clearly, the Applicant was not coping well without attendant care, despite the fact that he was

getting other forms of assistance. They concluded that he required about 290 hours per month of attendant care, divided (roughly) as follows:

- 30 hours per month devoted to meal preparation
- 9 hours per month devoted to hygiene (including laundry)
- 5 hours per month to monitor medication intake and effect
- 4 hours per month devoted to co-ordination of attendant care
- 241 hours per month devoted to basic supervisory care that the Applicant required due to changes in his behaviour

This was equivalent to attendant care benefits of $2,460.69 per month.

In response to this Assessment of Attendant Care Needs (Form 1), the Insurer arranged for its own attendant care assessment by Mr. Atul Kaul (occupational therapist). The assessment was supposed to occur on May 19, 2008 but Mr. Kaul apparently felt unsafe conducting the assessment unless a chaperone was also present. When the chaperone did not appear after 45 minutes, Mr. Kaul left and the assessment was rescheduled for July 30, 2008. Mr. Kaul issued his report on **August 12, 2008**. Mr. Kaul concluded that the Applicant required no attendant care whatsoever.

Pursuant to section 39 of the *Schedule*, the insurer is required to begin paying attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 42 required by the insurer, shall calculate the amount of the benefit based on the original Form 1 submitted on behalf of the insured person. At the beginning of the hearing, I was advised by counsel that no attendant care benefits were ever paid by Gore to the Applicant.

It is not clear why the Insurer did not pay attendant care benefits after it received the Form 1 from Ms. Gallaway and pending receipt of the assessment by Mr. Kaul (i.e., between April 10, 2008 and August 12, 2008).[12] Upon receipt of the report and Form 1 from Mr. Kaul, that formed the basis of the refusal of the Insurer to pay attendant care benefits. In refusing to pay attendant care benefits, from December 1, 2008 onwards, the Insurer also relied upon subsection 18 of the *Schedule*, which provides that no attendant care benefits are payable more than 104 weeks after the accident unless the insured person sustains a catastrophic impairment as a result of the accident (and, based upon the December 2008 Riverfront "CAT" assessment, the Insurer concluded that the Applicant did not sustain a catastrophic impairment as a result of the December 2006 accident).

The problem with the Insurer relying upon the attendant care assessment of Mr. Kaul is that it is seriously and obviously flawed because he *explicitly* restricted his assessment solely to the Applicant's *physical* abilities and completely ignored mental and behavioural impairments.

Mr. Kaul testified that he was unaware that there were concerns of mental and behavioural disorders and that he would not have taken such a narrow approach if he had been advised that there were concerns of mental or behavioural impairments related to the accident.

There were many documents that the Insurer could have, but failed to, provide to Mr. Kaul that would have shed greater light on this issue, including the neuropsychological report of Dr. Kurzman. On cross-examination, after being shown a copy of Dr. Kurzman's report, Mr. Kaul testified that, if he had reviewed this report at the time he conducted his attendant care assessment, the results would definitely have been different. Mr. Kaul indicated that he only relied upon the documents he was provided and, as a result, he thought that he only needed to consider the Applicant's physical impairments. Mr. Kaul could not explain, however, why he ignored references to the Applicant's mental and behavioural problems contained in documents that were in his possession at that time, such as reports from Ross Rehabilitation and from Kaplan and Kaplan.

[12] as required by subsection 39(4) of the *Schedule*.

Towards the end of his cross-examination, Mr. Kaul conceded that the Applicant:

1. appears to have impairments that put him at risk and may necessitate supervision;
2. may require cuing with respect to hygiene; and
3. will likely require attendant care assistance in order to continue living independently.

I find that it was inappropriate for Mr. Kaul to restrict his attendant care assessment to physical impairments only. I therefore give no weight to his report and the Form 1 that he prepared. My decision in this regard is supported by Mr. Kaul's own admissions as to the errors and omissions contained in his original opinion.

I accept the opinion of Ms. Ross and Ms. Garraway. The Applicant does require attendant care and, in the circumstances of this case, the amount of attendant care proposed by them is eminently reasonable and well-supported by the preponderance of the evidence.

In closing arguments, counsel for the Insurer raised two possible defences.

First, the Insurer questions whether the Applicant has proven that his mental and behavioural impairments were *caused* by the accident of December 2006. I have found earlier in this decision that the Applicant has proven this, on a balance of probabilities.

Second, the Insurer takes the position that the Applicant has not proven that attendant care expenses were ever actually *incurred* by or on behalf of the insured person. On this issue, I need only refer to the decision of *Belair Insurance Company and McMichael*[13] in which it was held that it is sufficient in a case like this for the applicant to prove that the attendant care benefits being claimed were reasonable and necessary. To hold otherwise would mean that an arbitrator is without authority to require after the fact payment of benefits to which a claimant proves entitlement, unless the claimant found a way to obtain the services without the approval and the financial support of the insurer. According to the Director's Delegate in the *McMichael*

[13](P05-00006, March 14, 2006), upholding the decision in *McMichael and Belair Insurance Company* (FSCO A02-001081, March 2, 2005).

decision, that would be "an absurd result and would render the dispute resolution process meaningless." I am bound by this decision and, in any event, I agree with it.

For all of the foregoing reasons, I find that the Applicant is entitled to attendant care benefits in the amount of $2,460.69 per month from April 10, 2008 onwards.

Interest on Overdue Attendant Care Benefits

Pursuant to section 46(2) of the *Schedule*, if payment of a benefit under the *Schedule* is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly. Therefore, the Applicant is entitled to interest on the overdue payment of attendant care benefits.

At the beginning of the hearing, I was advised by counsel that no attendant care benefits were ever paid.

Very little evidence was adduced or submissions made concerning the calculation or quantum of interest owing on the overdue payment of attendant care benefits. If the parties cannot agree on the amount of interest that is owing to the Applicant and they require adjudication of this issue, this can be dealt with at the resumption of this proceeding. I am hopeful that this will not be necessary and that the parties will be able to agree on the calculation of interest owing on overdue attendant care benefits.

Conclusion:

Because the Applicant sustained class 4 impairment (marked impairment) due to mental or behavioural disorder as a result of this accident, the Applicant did sustain a catastrophic impairment within the meaning of clause 2(1.2)(g) of the *Schedule*.

He has also proven on a balance of probabilities that he requires and is entitled to the attendant care benefits he has claimed as well as interest on these overdue benefits.

	December 23, 2010
Richard Feldman Arbitrator	Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A09-001224

BETWEEN:

M.R.

Applicant

and

GORE MUTUAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is determined and ordered that:

1. The Applicant did sustain a catastrophic impairment as a result of the accident within the meaning of clause 2(1.2)(g) of the *Schedule*.

2. The Insurer shall pay to the Applicant attendant care benefits in the amount of $2,460.69 per month from April 10, 2008 to the present and ongoing.

3. Pursuant to section 46(2) of the *Schedule*, the Insurer shall pay interest to the Applicant for any overdue payment of attendant care benefits.

4. If the parties require a determination of other issues raised by the Applicant in his Application for Arbitration, within 30 days of the date of this order, the parties may request a teleconference with me to discuss the scheduling of the hearing of such remaining issues and any procedural issues related to that hearing.

December 23, 2010

Richard Feldman
Arbitrator

Date