LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Tribunal File Number: 18-009821/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8, in relation to statutory accident benefits.

Between:

D.M.

Applicant

and

Toronto Transit Commission

Respondent

DECISION

PANEL: **Jesse A. Boyce, Adjudicator**

APPEARANCES:

For the Applicant: Michelle Kudlats
Michael Wolkowicz

For the Respondent: Chad Townsend
Alexandra Vaiay

HEARD: **In person on: July 22-26, 2019**

OVERVIEW

[1] On November 6, 2014, the applicant, D.M., was struck by a streetcar while crossing the street as a pedestrian. D.M. sustained physical injuries because of the accident but claims psychological, emotional and behavioural impairments which have resulted in concentration issues, irritability, anxiety, stress, depression, sleep issues, headaches and suicidal ideations since. He argues that he is now catastrophically impaired ("CAT") and sought benefits from the respondent, the Toronto Transit Commission ("TTC"), under the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] (the "*Schedule*").

[2] After several multi-disciplinary examinations ("IEs"), TTC determined that D.M.'s impairments were not CAT and denied treatment beyond the limits in the *Schedule*. On the basis of his own IE's, D.M. argued the opposite.

[3] D.M. submitted an application to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal") for dispute resolution. A case conference was held but the parties were unable to come to a resolution and proceeded to an in-person hearing on the following issues. The main issue in this hearing is whether D.M.'s impairments impede his daily function, qualifying him for a catastrophic designation and increasing his treatment limits.

ISSUES IN DISPUTE

[4] The parties were able to resolve some issues in advance of the in-person hearing. The following is the sole issue to be decided, as per the Case Conference Order dated February 6, 2019:

i. Did the applicant sustain a catastrophic impairment as defined under the *Schedule*?

RESULT

[5] I find D.M. sustained a catastrophic impairment as a result of the accident.

ANALYSIS

Catastrophic Impairment

[6] I find, on a balance of probabilities, that D.M. has sustained at least one Marked impairment due to a mental or behavioural disorder he sustained as a result of the accident. Accordingly, I find that he has sustained a catastrophic impairment

[1] O. Reg. 34/10.

as defined by the *Schedule* and is therefore entitled to the extended policy limits.

[7] In order to be determined CAT[2] under the *Schedule*, D.M. must prove, on a balance of probabilities, that the impairments he suffered as a result of the accident have resulted in at least one Class 4 (Marked) impairment in any of the four domains outlined in Chapter 14 of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*[3] (the "*Guides*") due to a mental or behavioural disorder. In the alternative, D.M. may also prove that he is CAT under Chapter 4 of the *Guides*, if he can demonstrate that he has a combination of physical and psychological impairment ratings from medical professionals that exceed the 55% Whole Person Impairment ("WPI") threshold provided for in the *Schedule*. D.M. is only required to prove his case under one of Chapter 4 or 14 and not both, and, if successful, he is deemed to be CAT and is entitled to the extended tier of benefits that accompanies the designation. I consider Chapter 14 first.

Chapter 14

[8] The test for CAT impairment is a legal test, not a medical test.[4] The five classes of impairment are identified on a continuum in Chapter 14 of the *Guides,* in ascending order of severity from Class 1 to Class 5, with language identifying the level of functioning at each class. For the purposes of this proceeding, the relevant classes—and the resulting disagreement between the parties—concern whether D.M.'s impairments fall within the Class 3 (Moderate Impairment) or Class 4 (Marked Impairment) designations. The difference between the classes is subtle, but critical: in Class 3, impairment levels are compatible with *some, but not all*, useful functioning. Meanwhile, Class 4 impairment levels *significantly impede* useful functioning. To determine which class D.M.'s impairments fall within, assessors assign a level of impairment to four areas or aspects of functioning, called domains: activities of daily living (ADL), social functioning (SF), concentration, persistence and pain (CPP) and adaptation (AD).[5] If D.M. is determined to have four Class 3 (Moderate) impairments, he does not receive a CAT designation. Under the *Schedule*, if it is determined that D.M. has one or more Class 4 (Marked) impairments in any

[2] Defined in s. 3(2)(f) of the *Schedule* as a marked (Class 4), or extreme (Class 5) psychological impairment that affects useful function in any one of the four functional domains. "Impairment" is defined in s. 3 of the *Schedule* as "a loss or abnormality of a psychological or anatomical structure or function."
[3] *Guides to the Evaluation of Permanent Impairment,* 4th Edition, 1993, at Ch. 4 and 14 [Criterion 6, 7, 8].
[4] *Liu v. 1226071 Ontario Inc. (Canadian Zhorong Trading Ltd.)*, 2009 ONCA 571, at para 30.
[5] *Guides*, at s. 14.3, pg. 294. The full domain name for "Adaptation" is actually: "Deterioration or decompensation in work or work like settings."

domain, he receives a CAT designation[6], and his limits for medical and rehabilitative treatment expand significantly.

[9] While the pain and physical impairments experienced by D.M. as a result of the accident were a subject of the hearing, I do not find that pain and, to a larger extent, D.M.'s physical impairments, are a significant contribution to his CAT designation. The parties seem to agree. By all accounts, D.M. can complete most physical activities with some modifications, including grocery shopping and golf. The most debilitating pain-related aspect—addressed below—are his headaches. On the evidence, I am not prepared to make D.M.'s physical impairments and pain a substantive factor in his CAT designation.

[10] Indeed, most of the hearing was dedicated to D.M.'s emotional, psychological and behavioural impairments that have arisen because of the accident and how this dramatic change has resulted in a loss of useful function. I find D.M.'s lack of emotional and psychological regulation, which has resulted in irregular moods and behaviour, sleep issues and suicidal ideations, can be traced directly to the traumatic brain injury he suffered from the accident and the trauma and stress that ensued.

[11] When assessing a CAT determination, part of the analysis concerns the individual's post-accident function, and whether it is useful in comparison to their pre-accident function. As would be expected, the parties presented opposing narratives on D.M.'s life and function pre-accident. On one hand, D.M. presented his pre-accident life as one on the rise: a dynamic, personable executive chef on the cusp of stardom in the celebrity culinary scene – his ascent cut short by an accident that robbed him of his ability to smell and taste and left him with sleep issues, persistent headaches, a raw temper, thoughts of suicide and a broken, care-giver-like marital arrangement. On the other, TTC frames D.M.'s pre-accident life as erratic and not nearly as optimistic as presented, with a past plagued by alcohol and substance abuse, poor decision making, a criminal record, a violent temper and a spotty income history. I find the truth, like most things in law and life, lies somewhere in between. I have afforded D.M. the benefit of the doubt.

[12] To be frank, D.M. was a poor historian of his own life and a combative witness. His recall vacillated between extremes: at times, he was unable to recall simple details from recent years (for *e.g.,* how many drinks he consumed on average) and chalked inconsistencies up to "brain injury talk" (after telling an assessor he made $200,000, but not to tell the government) then, at other times, he

[6] *Pastore v. Aviva Canada Inc.,* 2012 ONCA 642, at para. 43.

remembered minor details with clarity (he only wrapped the bacon roses in a photograph but did not prepare them, only mowed the lawn once, never said that to an assessor, *etc*.). As the trier of fact, the struggle was in discerning between what truths were inconvenient and which were the result of a brain injury. Still, I continued to return to three significant factors which, in my view, consistently surfaced in the evidence and testimony and are, cumulatively, a compelling indication that D.M. sustained a CAT impairment impeding his useful function.

[13] First, I found the fact that D.M. was contracted to appear as a celebrity chef and host on a popular television food show (even if only for two episodes) to be evidence of considerable success and clout in an ultra-competitive industry. To be a chef at this level requires experience, skill, attention to detail, time management and focus. I find the medical evidence indicating that D.M. struggles with these essential tasks and can no longer perform as a chef for extended periods post-accident to be a significant departure from his pre-accident life. That D.M. was able to achieve this professional success despite the darkness that TTC claims was plaguing his life only bolsters D.M.'s case. Second, I could not ignore the fact that D.M. signed over power of attorney to his wife at 46 years of age. In my view, this speaks to a realization that he cannot overlook mounting evidence of his inability to handle his finances and decision-making. By all accounts, these seemingly minor decisions—arranging for transportation, a place to live, treatment, delivery of meal boxes, *etc*.—are handled by his wife because he is no longer capable. Third, I found D.M.'s four documented suicide attempts, continued outbursts and withdrawal from social events to be obvious cries for help and an indication that there are psychological and behavioural irregularities affecting his day to day life that are beyond his control. Finally, I find that these themes and D.M.'s departure from his pre-accident life coincides with the timing of his accident and the traumatic brain injury he sustained.

The medical evidence and experts

[14] I found D.M.'s neuropsychologist, Dr. Davidson, to be one of the more reliable and compelling experts I have seen at the Tribunal and afforded her testimony and report significant weight as a result. Dr. Davidson's report indicates that the neuro-imaging provides clear, objective evidence of injury to D.M.'s brain. I found her explanation that D.M.'s impairments are caused by a "combination of things" consistent with a traumatic brain injury and emotional and cognitive factors to be in line with the evidence, especially considering how she took D.M.'s vulnerability factors—his psycho-social issues, involvement with the law,

his rehabilitation stints, cannabis use, *etc*.—into account, noting that he is likely more susceptible because of these factors. Against this backdrop, she offered two diagnoses for D.M. For neuro, an unspecified cognitive disorder due to a traumatic brain injury under DSM-IV and a mild neurocognitive disorder due to a traumatic brain injury under DSM-V; for psych, a major depressive disorder, moderate somatic symptom disorder with pain and a pain disorder associated with psychological factors and medical condition. As part of her assessment, she conducted a battery of validity measures and tests, all of which D.M. passed, indicating no evidence of poor effort or engagement. Several doctors agreed with Dr. Davidson's diagnoses.

[15] Dr. Davidson's findings for Chapter 14 focused on the Adaptation sphere, the category where she found D.M. exhibited a Marked impairment which formed the basis for her CAT designation.[7] Her opinion in assigning the Class 4 rating under Criterion 8 was based on D.M.'s recurring need to escape noisy or uncontrolled situations, his inability to cope with the stressors such situations entail and his difficulties in interacting with others and processing information. Having heard testimony about D.M.'s public and private outbursts in the days prior, I found Dr. Davidson's finding for Adaptation to be reasonable and supported by the evidence. For example, the evidence consistently indicated that D.M. has to leave concerts, sporting events and dinner parties—activities he previously enjoyed—early due to competing noises, crowding and the reactions these situations cause, including his debilitating headaches. Testimony revealed an incident on a cruise ship, where D.M., delirious from a lack of sleep, had to be relocated to an interior cabin after barricading himself in his room and threatening suicide. On another occasion, while attempting a return to work, D.M. quit a three-day promotional cooking shoot due to stress. On another, D.M. had to abruptly leave his family's beach vacation and was later found to have wrapped a garden hose around a beam in preparation for suicide. Cumulatively, these events are a red flag for this domain and, in my view, represent a marked inability to cope with stress. Notably, most of these occurrences happen around family and friends where stakes are relatively low. In contrast, and to borrow the language from the *Guides*, I find this type of behaviour would significantly impede D.M.'s useful function in work or work-like settings where the stakes are far greater.

[16] On cross-examination, I found Dr. Davidson to be authoritative and non-combative; she identified common ground (Dr. Lawson agreed with much of her

[7] I note Dr. Davidson rated D.M.'s emotional/behavioural impairment for Chapter 4, Table 3 under Chapter 14 instead. She also assigned a 15% mental status impairment rating under Chapter 4, Table 2 to D.M., which was echoed by Dr. Lawson.

report and found no validity issues) and made reasonable concessions on divisive issues (agreeing with Dr. Lawson that the brain-related cognitive impairment was mild) but was firm in defending her opinions. She highlighted the importance of collateral information (pointing out TTC's assessors did none) and D.M.'s vulnerability factors (not addressed by TTC's assessors) while dismissing a lot of the more historic narratives framed by TTC, stating "we don't care about function from 10 years ago – function months before the accident is the primary concern." Indeed, I found that Dr. Davidson's testimony constituted a significant shift in the tone of the proceedings, where the focus swung to the medical evidence away from the competing narratives.

[17] Rather than call Dr. Lawson to rebut Dr. Davidson as listed, TTC opted to call Dr. Dowhaniuk as its neuropsychologist instead. In my view, this was problematic and, as the trier of fact, unhelpful, considering Dr. Dowhaniuk did not address CAT impairment in his report and therefore could not speak to it in testimony. This resulted in an expert witness who largely spoke to D.M.'s credibility and efforts on validity testing, which were allegedly poor. I note this contradicts the findings of the other three neuro experts who conducted validity testing and found no issues. Following the comprehensive and relevant testimony of Dr. Davidson, I afforded the evidence of Dr. Dowhaniuk little weight. Similarly, Dr. Debow was not called as a witness by TTC, despite his report commenting on CAT. In this report, which I assigned less weight to as well, he assessed D.M. as mild in all four domains, which, in my view, was incredibly inconsistent with the details of his own report and with the findings of the other assessors.

[18] I found the testimony and reports of the competing occupational therapists to be less helpful in my analysis. I found TTC's occupational therapist, Ms. Shaw, to be rigid in her opinion and her credibility was undermined during cross-examination. For instance, she conducted a home interview and functional test with D.M. wherein he was asked to move around his kitchen and home over two hours. From this test, she gleaned an ability to move fluidly around the kitchen without issue, which she believed was an indication of functional ability. Ms. Shaw stated that the home environment is "ideal" for testing. In my view, this testing is problematic, and I assign it little weight, because it did not address D.M.'s adaptation to outside stressors at all. *Of course* D.M. was able to move fluidly in his own kitchen—not only is he a chef, but he knows where everything is—it is his home. Ms. Shaw also indicated that D.M. was distracted during the interview stage, constantly looking at his phone and picking up the cat. From this, she determined that he is capable of multi-tasking and therefore functional. It did not seem to occur to her that D.M.'s multi-tasking could also be an inability

to focus, which can also be an indication that D.M. is struggling with concentration and persistence, troublesome for a chef. Further, Ms. Shaw failed to realize how truly bizarre and unreasonable the responses D.M. gave to her emergency-related questions were, which, in my view, called into question his judgment and ability to safely care for himself or others. Had she been provided with evidence of D.M.'s suicide attempts or his capacity assessment and power of attorney, I suspect her opinion may have changed.

[19] I found D.M.'s OT, Ms. Kara, was slightly more helpful. This assessment was conducted over two days—a more appropriate sample size given the issue in dispute—and featured tasks designed to test D.M.'s adaptation and function with stressors. One of the tasks involved D.M. "cooking" in a mocked-up kitchen (turning over a Lego "steak", threading bead "shish-kabobs", making play-doh "meatballs" as directed). While creative, I found D.M.'s reaction—he completed the tasks incorrectly and was angered by the fake restaurant noise being played—to not necessarily be an indication of his inability to function or adapt but rather an obvious frustration at the absurdity of asking an executive chef to cook with toys. I agree with TTC that this arrangement was likely intended to provoke a beneficial reaction rather than to test D.M.'s actual function. On the other tasks, D.M. had varying degrees of function: on day one, he allegedly acted inappropriately towards the assessor and the community outing was cancelled; on day two, he completed the scheduling task despite artificial noise; he then took a taxi to the mall and completed the task but apparently lacked attention to detail, answering questions incorrectly. I found the testing provided slightly more insight into D.M.'s day-to-day function and ability to handle curveballs and afforded it more weight as a result.

[20] While I need not make definitive findings for every domain, I also find it likely that D.M.'s impairment in the adaptation domain can affect his functioning in the social domain. At times, it seems D.M. can be pleasant and cooperative in controlled situations. At other times, his breakdowns can be irregular and unpredictable when he is forced to adapt to changing circumstances and stress. In social or group situations, this unpredictability would likely impede his ability to socialize and maintain positive relationships, a fact echoed by lay-witnesses who characterized his social issues as embarrassing and also by the strained relationships he has with his children. And yet, I do not find that D.M. is hostile or uncooperative to the point where the "overall degree of interference," as contemplated by the *Guides*, significantly impedes others. In any event, I note that none of the reports assigned a Class 4 Marked impairment rating in this domain, so in the absence of compelling evidence otherwise, I follow the experts' lead.

[21] For completion, I found the evidence provided was not supportive of a Class 4 Marked impairment in the ADL domain. For example, I find D.M. can complete most of his daily tasks by himself: he can shower, change his clothes, grocery shop with a list, play video games, *etc*. While it was not particularly damning, I found the surveillance to be evidence of appropriate function in his daily activities and, while the daily activities observed were not particularly onerous, I find he can perform routines with a quality of independence, if transportation and guidance is provided. This was supported by the reports, where none of the assessors assigned a Class 4 rating in this domain. In the CPP domain, there was evidence D.M. struggles. Assessors remarked how unfocused D.M. was in completing testing and how tangential his thoughts were during interview stages. D.M.'s reaction to the menial tasks prepared by the OT's and his inability to focus generally suggests, in my view, that he may have difficulties in this domain as well, however, none of the reports assigned a Class 4 rating.

[22] For these reasons and on a balance of probabilities, I find D.M. has a Class 4 Marked impairment in the Adaption domain and therefore suffered a catastrophic impairment as a result of the accident.

Chapter 4

[23] The Guides make it clear that a diagnosis of a specific psychological impairment is not required for CAT but that the focus is on function. The parties focused quite a bit on the WPI% ratings and Chapter 4, arguing over the California conversion scales, apportionment, double counting, impairment by analogy, *etc*. While I am alive to all of the parties' submissions, I found it quite clear that D.M. meets the criteria for CAT under Chapter 14 in the adaptation sphere and focused my analysis there.

[24] As noted, D.M. is only required to prove his case under one of Chapter 4 or 14 and not both in order to be determined CAT. Having determined that D.M. is Class 4 Marked under Criterion 8, he is designated as CAT. I am similarly not required to undertake a complete analysis, however, for completion, I note that the ratings provided by the respective assessment teams—Omega for D.M. and KRA for TTC—featured many similarities. Indeed, six of the impairment categories received identical ratings: under Chapter 3, lower extremity (1%), cervicothoracic (5%), thoracolumbar (5%), lumbosacral (5%), anosmia/olfaction (5%) and, notably, under Chapter 4: mental status impairment, where the parties both rated at 15% WPI.

[25] Where the parties disagreed was on the Chapter 14 ratings for mental and behavioural impairment, where there was a significant disparity when using the

GAF conversation scale and whether it was appropriate to rate by analogy.[8] The parties disagreed strongly on whether D.M.'s headaches and sleep issues could be rated, which further accounted for the total combined WPI discrepancy of 62% (Omega/D.M.) and 37% (KRA/TTC). I find much of this discrepancy can be attributed to Dr. Debow's WPI rating of 7%, which I found to be a substantial underestimation of D.M.'s impairments in the grand scheme of the evidence.

[26] Several other reports spoke to WPI, but I found the live testimony to be the most hopeful in parsing out what was defensible in the face of the evidence. While I found both neurologists to be authoritative and reasonable in defending their reports, I afforded more weight to the findings of D.M.'s neurologist, Dr. Robinson, over TTC's, Dr. Esmail, because I found his report to be more proportional to the body of evidence before the Tribunal. Dr. Robinson diagnosed D.M. with a moderate complicated brain injury with persistent post-concussive symptoms, which he identified as belonging to three categories: physical (headaches, sleep disturbances, loss of smell and taste); cognitive; and psychoemotional/mental-behavioural. He referenced D.M.'s consistent complaints of pervasive headaches (in all of Drs. Dance, Bates, Bhalerio and Youffi's clinical notes, as well as the majority of the reports) to justify his 4% WPI rating for headaches by analogy, which he described as conservative, given the impact it has on D.M.'s daily function. I agree that D.M.'s headaches impact his function over three years post-accident. Further, he found a second-tier mental status impairment (15-29% range) rating on the basis that D.M. requires direction and planning support and that he signed over power of attorney. I agree with this rating as well.

[27] This contrasted with Dr. Esmail, who indicated that he cannot rate headaches despite an extensive paragraph on D.M.'s struggle with headaches. He also did not comment on mental-behavioural impairments at all, as the rating for this category was based on Dr. Debow's report instead. Further, Dr. Esmail declined to rate D.M.'s sleep disorder, arguing that there are many types of sleep disorders while opining that D.M.'s could be the result of alcohol or marijuana use and that, in any event, it is better determined by a psych expert. Interestingly, he remarked that the *Guides* do not consider headaches a permanent impairment but stated that he disagreed with the *Guides* because consistent headaches are an impairment. He said that cases with ratings for headaches by analogy are very serious—he gave occipital neuralgia and epilepsy as examples—and that, in his opinion, D.M.'s headaches do not rise

[8] The GAF is formally known as the Global Assessment of Functioning Scale and is used as a conversion tool in catastrophic determination cases. Meanwhile, rating by analogy allows an assessor to assign a percentage for a specific impairment by using a Table from a different chapter of the *Guides*.

to the level warranting a rating because D.M. can still do many things. In the end, I found his diagnoses of loss of smell/taste, loss of sensation in the thigh and a closed-head injury to be too far out of line with the bulk of the evidence.

[28] For completion, I find it reasonable on the evidence that Omega rated D.M.'s headaches and sleep disorder and agree with the Chapter 14 rating it assigned for mental and behavioural impairment based on the GAF. Given the ranges and evidence presented, combined with the context provided by Dr. Becker, I find that D.M. meets the 55% WPI threshold for CAT impairment as well.

CONCLUSION

[29] For these reasons, I find D.M. sustained a catastrophic impairment as a result of the accident and is entitled to the expanded policy limits that accompany the designation.

Released: August 27, 2019

Jesse A. Boyce,
Adjudicator