As of February 16, 2015, this decision is no longer considered by WCAT to be noteworthy.

WCAT Decision Number: WCAT-2006-02777
WCAT Decision Date: July 05, 2006
Panel: Marguerite Mousseau, Vice Chair

Introduction

The worker appeals *Review Division Decision #R0051674*, dated November 9, 2005, in which the review officer varied a decision made by an officer of the Workers' Compensation Board (Board). The officer had decided that the worker was entitled to compensation for mental stress under section 5.1 of the *Workers Compensation Act* (Act). The employer requested a review of this decision and the review officer concluded that the worker was not entitled to compensation for mental stress. The worker appeals the review officer's decision.

The Workers' Compensation Appeal Tribunal (WCAT) has jurisdiction to consider this appeal under section 239(1) of the Act as an appeal from a final decision made by a review officer.

The worker is represented by a union representative who has provided a submission on his behalf. The employer is participating in the appeal and is represented by a management consultant who has provided a submission on behalf of the employer. The worker requested that his appeal proceed by "read and review" and I consider that this is an appropriate hearing mechanism for this appeal. The issue is primarily a question of the interpretation and application of the law and policies to facts that are largely undisputed and medical evidence.

Issue(s)

The issue on this appeal is whether the worker is entitled to compensation for mental stress under section 5.1 of the Act.

Background

The worker is a psychiatric nurse who has been employed by the employer since 1995 as an emergency mental health nurse.

In May 2004 the worker submitted an application for compensation for debilitating panic attacks which he attributed to an incident on November 21, 2002 when he discovered a patient who had hung himself from a curtain rod. The worker had been unable to revive him. He said that his job involved making suicide risk assessments and he was finding

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this very difficult to do. He was second-guessing every decision and unable to sleep due to worry/panic about whether he had made the right decision.

The worker also said that he was experiencing panic attacks before going into work. He had difficulty breathing, felt faint and had pain in his chest. At times, he felt very agitated without reason. He had attempted to deal with the problem through his physician and employee assistance program but he continued to have disabling panic attacks. At times, due to anxiety, he was unable to complete his thoughts or focus. This made it very difficult to perform his job.

A Board officer concluded that the worker's application for compensation did not meet the requirements of section 55 of the Act; it had been submitted more than a year after the date of injury and there were no special circumstances that had precluded the worker from filing the application within the statutory time frame.

The worker requested a review of this decision and the review officer upheld the Board decision, as did a WCAT panel on appeal. In the Review Division decision, which is dated January 6, 2005, the review officer noted that the evidence indicated the worker may have experienced other workplace incidents after November 2002 that might have caused post-traumatic stress disorder (PTSD) symptoms. The review officer stated that his decision was not intended to restrict the worker's ability to submit an application for compensation for any of those subsequent events.

The evidence referenced by the review officer included a letter from the worker dated June 22, 2004, a Post-Traumatic Stress Disorder Clinic consultation report dated June 28, 2004 signed by Dr. O'Neill, registered psychologist, and Dr. Passey, psychiatrist, as well as an email message from the worker's representative to Dr. Passey dated July 20, 2004 and Dr. Passey's reply dated July 29, 2004.

In the letter of June 22, 2004, the worker again described the suicide on November 21, 2002 and said that his PTSD symptoms started to surface in 2003 and became increasingly worse in the fall. He started to receive counseling and to take medication, which provided some initial relief. But, his job required him to complete suicide risk assessments on a daily basis and after several months, with ongoing exposure to high risk patients and some very complicated cases, his PTSD was once again triggered. As an example of a complicated case, he described a situation in April 2004 where he had been given a referral to contact a client without information about the referral. He discovered that he had been given the wrong number and by the time he contacted the client she could barely talk, although she was revived. He said that with several incidents like this, his PTSD was again triggered and he became quite immobilized by anxiety and fear. That was when he had filed his (first) application for compensation.

The consultation report by Dr. O'Neill and Dr. Passey also describes the onset of symptoms after the suicide in November 2002. They describe a number of work

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traumas prior to the hanging death but state that this incident marked the onset of symptoms which became increasingly severe so that in August 2003 the panic attacks began to occur on a daily basis; the worker's concentration became impaired and he was unable to make decisions. In September 2003 one of the clients with whom the worker's team had frequent contact committed suicide by wheeling her wheelchair into an oncoming train. By November 2003, the worker's anxiety had become extreme; he was irritable, angry and saw danger everywhere. In mid-April 2004 there were a number of minor incidents where critical client information was misplaced and clients could have died as a result. The worker became overwhelmed and frightened and thought he was going crazy when he urinated into a trashcan instead of the toilet one day. He started sick leave in May 2004.

Drs. O'Neill and Passey concluded that the worker's symptoms were initiated by the suicide in 2002 but were made significantly worse by the September 2003 suicide. Further work-related events and the worsening of PTSD combined to make employment impossible by May 2004.

Finally, the review officer had also reviewed the email correspondence between Dr. Passey and the worker's representative. The representative had asked for Dr. Passey's opinion as to whether PTSD could impair the ability to make appropriate decisions with respect to filing claims; whether the worker's symptoms were a barrier to his ability to deal with the administrative issues about a compensation claim; and whether the worker remained disabled from work due to PTSD.

Dr. Passey replied that the worker had a delayed onset chronic PTSD following exposure to a number of traumatic events during his employment. He said that the suicide in September 2003 was the incident that caused the symptoms to become debilitating. Since the worker had a *bona fide* medical disorder secondary to his employment exposure and he had filed a claim within a year of being unable to work, Dr. Passey felt there should be no problem with the WCB claim.

On March 3, 2005 the worker submitted his second application for compensation. This time he stated that he had developed PTSD due to a series of work-related traumas between November 21, 2002 and March 2004, which he felt had caused debilitating psychological symptoms. He listed those, starting with the suicide by hanging on November 21, 2002.

He stated that in the summer of 2003, two other patients had committed suicide by overdosing and both of them were well known to him. Then, on August 25, 2003 (previously identified as the September suicide), a patient who was well known to the worker committed suicide by wheeling her wheelchair in front of an oncoming train. This caused increased further symptoms. On March 24, 2004 the worker received a referral regarding another suicidal patient and discovered that he had been given the wrong telephone number for the patient. Although he was able to reach her in time for

her to be revived, he experienced a recurrence of symptoms. This was the last incident described in his application for compensation.

A Board officer requested an independent psychological assessment of the worker by Dr. Buch, registered psychologist. In his report of May 14, 2005, Dr. Buch addressed the impacts of the various incidents described by the worker in the application for compensation, as requested by the Board psychologist. His report was based on a review of the worker's claim file(s), an interview with the worker, and psychometric testing. In addition, the worker had provided a list of work-related critical incidents at Dr. Buch's request.

This list described thirteen critical incidents, dating back to 1987. The two last incidents, which were described in considerable detail, were the incident on March 24, 2004 when the worker had been given the wrong contact number for a patient who had taken an overdose by the time he was able to contact her and an incident on May 4, 2004 when there had again been lack of proper communication and a patient had taken an overdose before he was able to contact her. She also was successfully treated.

Dr. Buch noted that the worker's claim for compensation with respect to the hanging suicide in November 2002 had been denied because he had not submitted his application within the one-year period required by the Act. Dr. Buch said this left the worker in the rather awkward position of seeking compensation for subsequent workplace events that were never envisaged as the original injury. The question he was to address was "whether these subsequent incidents are sufficient, either independently or perhaps cumulatively, to result in psychological-related work impairment."

Dr. Buch agreed with the worker that the primary causal incident was the patient hanging of November 21, 2002. Dr. Buch noted that "the DSM-IV [*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition] provides considerable latitude regarding the kind of incident that qualifies as sufficiently traumatic for a PTSD diagnosis: there is an emphasis on victim perceptions of trauma as opposed to some notion of objective trauma". Dr. Buch also wondered whether the worker had inherited a family or genetic predisposition to anxiety and had chosen a profession that would lead to full expression of this vulnerability in keeping with the notion of a "thin skull." If this were the case, he did not consider it was significant in comparison to the traumatic workplace events.

Dr. Buch also ruled out the suicide by hanging as simply one more trauma in a series of traumas with accumulating impact. The worker claimed that he had had no difficulties following a number of other seemingly equally traumatic incidents prior to the suicide. Dr. Buch described this as the index trauma and stated that subsequent critical incidents triggered and reinforced the worker's post-traumatic response.

He said that "In WCB claims terminology, one could consider the several subsequent critical work incidents as exacerbations of the November 2002 index trauma." He noted that this was the opinion of Drs. Passey and O'Neill who found that the August/September 2003 wheelchair suicide made the symptoms significantly worse. Dr. Buch noted that the worker was not actually present at that suicide. It appeared that this exacerbation was short-lived since his symptoms had remitted sufficiently to no longer require counseling after January 15, 2004.

Then, within approximately two months the worker had had a "close call" with another patient who had barely survived a self-administered drug overdose. This "rekindled" the worker's post-traumatic anxiety and depressive symptoms. Two weeks after that, there was a similar incident on May 4, 2004 which further reinforced the worker's fears of a completed suicide on his watch. These two incidents were sufficient to undermine the brief but promising treatment of the post-traumatic symptoms associated with the index incident in November 2002 and the exacerbation of September 2003.

Drs. Passey and O'Neill had noted, in passing, that the worker had reported a depressive episode of about six months in 2000. Dr. Buch also noted this and said that he could not account for the major depressive episode of 2000. He suspected though that the worker had had numerous exacerbations of depression beginning with the index trauma and subsequent similar traumas.

In addition, Drs. Passey and O'Neill had noted in their report of June 28, 2004 that the worker was living with his partner. Dr. Buch, in his report of May 14, 2005, noted that the worker's 17-year relationship with his partner had ended the previous year. The worker had acknowledged sadness about the end of this relationship but he had been unhappy in the relationship for years and the ending, which was amicable, was also expected. Dr. Buch noted that this would doubtless have been a significant psychosocial stressor at the time but he did not indicate that it had played any causal role in the development or maintenance of the worker's symptoms.

Another opinion was provided by a Board psychology advisor in a memo dated May 26, 2005. He stated that Dr. Buch's causal analysis and opinion in relation to both the PTSD and major depressive disorder (MDD) appeared reasonable and supported by all the available information. The psychology advisor subsequently provided a list of factors and their relative contributions to the worker's PTSD and MDD as follows:

- patient suicide November 21, 2002 – major contribution to PTSD, major moderate contribution to MDD

- three suicides (2003) – moderate contribution to PTSD, moderate contribution to MDD

- two overdoses (2004) – moderate contribution to PTSD, moderate contribution to MDD
- eight prior work events – minor contribution to PTSD, minor contribution to MDD
- genetic/family predisposition to anxiety – minor contribution to PTSD, not applicable to MDD
- initial depressive episode (2000) – not applicable to the PTSD, moderate contribution to the MDD
- break-up of 17-year relationship – not applicable to PTSD, minor contribution to MDD.

After receiving this opinion, a Board officer decided that the worker had sustained an exacerbation of his pre-existing PTSD and pre-existing MDD at the time of the March 24, 2004 and May 4, 2004 incidents at work. He stated that these incidents and the worker's reactions met the criteria for compensation for mental stress under section 5.1 of the Act.

The employer requested a review of this decision. The review officer said that he did not have the jurisdiction to address the compensability of symptoms related to the three patient suicides in 2003, none of which were witnessed by the worker, since this issue had not been addressed by the Board. If the worker wanted to have these adjudicated, he would have to return to the Board.

Turning to the two incidents which the Board officer had adjudicated: the incident of March 24, 2004 and the incident of May 4, 2004, the review officer described these as "communication issues." He did not consider that either of these incidents satisfied the requirement for a traumatic event as interpreted by the policies. Accordingly, he found that the worker's circumstances did not satisfy the criteria for compensation for mental stress and he varied the Board officer's decision. The worker appeals this decision.

Law and Policy

Section 5(1) of the Act establishes that compensation is payable for personal injury arising out of and in the course of employment. The policy at item #13.20 of the *Rehabilitation and Services Claims Manual, Volume II* (RSCM II), confirms that "personal injury" includes psychological impairment.

Section 5.1 of the Act, establishes criteria for compensation for psychological impairment that is unrelated to a compensable physical injury. It introduces the term "mental stress" and provides that compensation is payable for mental stress only if the criteria set out in section 5.1 of the Act are satisfied. Section 5.1 provides, in part:

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(1) Subject to subsection (2), a worker is entitled to compensation for mental stress that does not result from an injury for which the worker is otherwise entitled to compensation, only if the mental stress

(a) is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of the worker's employment,

(b) is diagnosed by a physician or a psychologist as a mental or physical condition that is described in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and

(c) is not caused by a decision of the worker's employer relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment.

(2) The Board may require that a physician or psychologist appointed by the Board review a diagnosis made for the purposes of subsection (1) (b) and may consider that review in determining whether a worker is entitled to compensation for mental stress.

In this case, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, was the version current at the time the incidents occurred. I have referred to it as the DSM IV in this decision.

The policy at item #13.30 of the RSCM II provides direction on the interpretation of an event that is considered traumatic for the purposes of section 5.1 of the Act. It provides, in part:

Under subsection 5.1(1)(a), the Act establishes a two-part test:

1. There must be an acute reaction to a sudden and unexpected traumatic event.

2. The acute reaction to the traumatic event must arise out of and in the course of employment.

An "acute" reaction means – "coming to crisis quickly", it is a circumstance of great tension, an extreme degree of stress. It is the opposite of chronic. The reaction is typically immediate and identifiable. The response by the worker is usually one of severe emotional shock, helplessness and/or fear. It may be the result of:

- a direct personal observation of an actual or threatened death or serious injury;
- a threat to one's physical integrity;
- witnessing an event that involves death or injury; or,
- witnessing a personal assault or other violent criminal act.

For the purposes of this policy, a "traumatic" event is a severely emotionally disturbing event. It may include the following:

- a horrific accident;
- an armed robbery;
- a hostage-taking;
- an actual or threatened physical violence;
- an actual or threatened sexual assault; and,
- a death threat.

In most cases, the worker must have suffered or witnessed the traumatic event first hand.

In all cases, the traumatic event must be

- clearly and objectively identifiable; and
- sudden and unexpected in the course of the worker's employment.

This means that the event can be established by the Board through information or knowledge of the event provided by co-workers, supervisory staff, or others, and is generally accepted as being traumatic.

Where a worker has a job which involves frequent exposures to traumatic events, the policy provides:

> It is recognized that some workers, due to the nature of their occupation, may be exposed to traumatic events on a relatively frequent basis (e.g., emergency workers). If such a worker has an acute reaction to a sudden and unexpected traumatic event, compensation for mental stress may be provided even if the worker was able to tolerate past traumatic events.

To provide further direction to the decision-maker, the policy provides specific examples of instances where entitlement may flow from section 5.1. These include examples such as a person committing suicide by jumping in front of a bus and the bus driver subsequently developing a psychological condition; a worker directly witnessing a very serious accident to a co-worker and subsequently developing post-traumatic stress disorder; a guard being held hostage by inmates during a prison riot and subsequently developing a mental condition; or, a worker being sexually assaulted by a supervisor at work and subsequently developing a mental condition. In each case, there must be a DSM diagnosis of the mental condition.

Submissions

The submission of the worker's representative is focused on the need to adjudicate the impact of all of the workplace trauma, at least the trauma occurring after the hanging suicide in November 2002, which cannot be adjudicated. He submits that the worker listed all of the incidents occurring since November 2002 in his application for compensation. The Board officer, however, chose to limit his review to only two incidents, one that occurred in March 2004 and the other in May 2004. He states that the file reveals substantial information regarding the worker's ongoing efforts to file an appropriate claim with respect to his "late diagnosed PTSD." Asking the worker to apply for compensation again would be very frustrating and would provide more opportunity for miscommunication.

He submits that the facts are clear enough that the worker's total work-related incidents and subsequent medical difficulties are compensable. He requests that WCAT direct the Board to adjudicate the incidents of 2002/2003 if the WCAT panel agrees with the review officer that jurisdiction is an issue.

The employer's representative relies on his previous submissions to the Review Division and submits that the worker's difficulties are the cumulative result of general workplace stressors and the general nature of his employment over a lengthy period of time. He does not dispute that the worker's psychological condition is due to his employment but he submits that the worker's circumstances do not meet the requirements under the Act and policies; therefore, the worker is not entitled to compensation for mental stress.

I note the employer's representative's submission to the Review Division involved an extensive review of the incidents described by the worker and the medical evidence. He noted, among other things, that the worker had not described an incident on May 4, 2004 until he provided his list of critical incidents to Dr. Buch in May 2005. There was no reference to a May 4, 2004 incident in either application for compensation nor in his physician's first report to the Board, which is dated May 4, 2004, nor in the conversation with the worker recorded by the Board officer on May 13, 2004.

The employer also notes that most references to the March 2004 incident both in the worker's statements and in the psychological and psychiatric reports describe the incident as a relatively minor incident. He submits that neither of these incidents satisfies the requirement for a sudden and unexpected traumatic event.

Reasons and Decisions

A fundamental difficulty with the worker's case is that the legislation provides that compensation for mental stress (psychological injury) is payable only where certain criteria have been met and it appears that mental stress that is caused by the cumulative effect of repeated exposures to traumatic events will generally not meet the criteria.

Section 5.1 of the Act, which was enacted on June 30, 2002, was part of a substantial package of amendments to the Act contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). These amendments were made subsequent to the March 11, 2002, "Core Services Review of the Workers' Compensation Board" (Core Review)[1], which provided recommendations for amendments to the Act, the majority of which were implemented to greater or lesser degree in Bill 49.

The author of the Core Review, Alan Winter, devoted a chapter specifically to the issue of compensation for "chronic stress", which he defined as "claims for psychological impairment caused by mental stimuli acting over time (ie: where no traumatic workplace event has occurred)." He stated that his comments and recommendations concerning chronic stress were "not intended to apply to psychological impairments which are caused by a traumatic event, such as post-traumatic stress disorder." He then went on to examine the reasons for and against providing compensation for chronic stress. As reasons for excluding chronic stress claims, Mr. Winter cited the following:

- Stress is ubiquitous and illness due to chronic stress generally arises from a multitude of interacting factors, some of which are employment related and others personal. There is no clear reason to hold the workers' compensation system responsible for paying benefits in these circumstances.

[1] Accessible at http://www.labour.gov.bc.ca/ wcbreform/WinterReport-Complete.pdf.

- Many bona fide employment decisions cause stress. Since these are an inherent aspect of employment and unavoidable, the workers' compensation system should not bear the costs if a worker has a disabling reaction to the stress associated with decisions such as lay-offs.

- Chronic stress claims have a significant element of subjectivity and can more readily involve issues of exaggeration or embellishment.

- The acceptance of chronic stress claims will likely make the workers' compensation system more litigious and adjudication more complicated, with chronic stress claims involving allegations of fault against employer and/or worker and a closer scrutiny of personal factors which might by held responsible for the disability.

- The concern that the number of such claims may well increase if these claims were generally acceptable and this could have substantial cost implications.

In counterpoint to these arguments against compensating for chronic stress, Mr. Winter gave the following reasons for providing compensation benefits for such claims:

- One of the fundamental purposes of workers' compensation legislation is to compensate for disabilities which are "truly work-caused"; therefore, it is the causal relationship between the employment and the harm sustained by the worker that should determine entitlement to compensation, not the nature of the harm caused.

- There were concerns in other Canadian jurisdictions which had amended their legislation to make a "traumatic event" a prerequisite to entitlement to compensation. As an example, in Ontario, where the legislation provided for compensation for mental stress that is an acute reaction to a sudden and unexpected traumatic event, there had been concerns that conditions caused by a series of traumatic events were excluded from coverage.

> For instance, police and firefighters in Ontario have raised concerns that they face a number of traumatic events in their work life, and that it is the cumulative effect of this series of traumatic events that may finally trigger the acute stress reaction. Another example involves claims for mental stress resulting from the cumulative effect of traumatic workplace harassment. As a result of these concerns, the Board of Directors of the Ontario Workplace Safety & Insurance Board have proposed amendments to its policies to recognize that each traumatic event in a series of events may affect a worker psychologically, even if the worker does not have the acute stress reaction until after the most recent event.

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Mr. Winter went on suggest that, once it has been accepted that the prerequisite for a "traumatic event" includes a series of traumatic events, the door may well be open to accepting chronic stress due to workplace stimuli overtime, in any event.

- Arguably if claims for chronic stress were excluded from coverage, a worker thus afflicted may be entitled to sue the employer. This would significantly undermine the "historic compromise".

- There was a question of the lawfulness of provisions that exclude claims for chronic stress under the Canadian Charter of Rights and Freedoms.

Ultimately, Mr. Winter recommended against excluding claims for chronic stress because he did not believe that claims should be excluded from coverage because of the difficulties inherent in the adjudication of those claims and because the exclusion of chronic stress claims would "be inconsistent with the purpose and intent of the fundamental principles, which led to the establishment of the workers' compensation system, as reflected in the 'historic compromise.'"

He went on to state the following: "If there was absolutely no doubt that a worker's claim for chronic stress arose out of and in the course of his/her employment, why should his/her claim for compensation benefits be automatically denied? I simply do not have a satisfactory response to this question."

He recommended, however, that the Act be amended to address some of the problems he identified regarding the adjudication of chronic stress claims. He recommended that:

- there be an objective standard for impairment, such as a diagnosis by a psychiatrist or psychologist of a condition recognized in the DSM or other widely acknowledged source

- that the condition must be a response to objectively verifiable stressors that were and excessive or unusual in comparison to stresses typically experienced in that occupation

- that compensation for conditions caused by bona fide employment decisions or generic work processes be excluded from coverage

- that the workplace stressor was a "predominant cause" of the condition.

These recommendations were not carried into the subsequent legislative amendments. Instead, section 5.1 of the Act was enacted, which closely mirrored the existing provision with respect to compensation for mental stress in section 13(4) and (5) of the Ontario Workplace Safety and Insurance Act. It provided:

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> *Exception, mental stress*
>
> (4) Except as provided in subsection (5), a worker is not entitled to benefits under the insurance plan for mental stress.
>
> *Same*
>
> (5) A worker is entitled to benefits for mental stress that is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment. However, the worker is not entitled to benefits for mental stress caused by his or her employer's decisions or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment.

When Bill 49 was introduced in the Legislature on May 13, 2002 by the Honourable Mr. Graham Bruce, he stated "This bill clarifies coverage for mental stress, explicitly stating that coverage will only be provided for mental stress when it is an acute reaction to a sudden and unexpected traumatic event or the result of injury or disease for which the worker is entitled to compensation."

In this case, the employer does not dispute that the worker's illness is work-related. The representative states "the worker's difficulties were the accumulative result of general work place stressors and the general nature of his employment over a lengthy period of time." He submits though that the worker is not entitled to compensation because his situation does not meet the requirements under the Act for compensation.

I agree that the legislation, on its face, imposes strict limitations on compensation for mental stress. I also consider that this is the purpose and intent of section 5.1 of the Act. The author of the Core Review, which was commissioned by the government, specifically identified the implications of the existing Ontario legislation for emergency workers. He stated that it excluded compensation for the cumulative effect of repeated workplace traumas. Subsequent to the release of the Core Review, section 5.1 of the Act, which mirrors the Ontario provisions, was enacted in this jurisdiction. Accordingly, it is very difficult to find that the legislature did not intend to exclude compensation coverage for emergency workers suffering from the cumulative effects of trauma. Clearly, that is the intent.

In view of the above, in adjudicating this appeal, I believe that I am limited to assessing whether each specific incident and the worker's reaction satisfy the criteria under section 5.1.

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In addition, the term "traumatic event" has been defined by policy in such a way as to exclude consideration of the worker's perception in determining whether an event was "traumatic." Dr. Buch has noted that there is considerable latitude when it comes to determining whether an event was traumatic for the purpose of establishing a diagnosis of PTSD. Medically, consideration is given to whether the worker perceived the event as traumatic and this is taken into account in deciding whether the worker has developed PTSD.

Under the policy at #13.30, however, an event must be one that is generally accepted as traumatic in order to satisfy the criterion of a traumatic event. Accordingly, if a worker has an acute reaction to an event that is not generally accepted as traumatic, this does not meet the criterion of an acute reaction to a sudden and unexpected traumatic event. There is no exception provided for the worker who perceives a situation as traumatic because he or she has become sensitized due to prior exposures to workplace trauma.

Since the medical standard for a traumatic event is different from the policy standard for a traumatic event, a worker may well be diagnosed as suffering from PTSD as a result of a workplace event that is medically recognized as traumatic but not legally recognized as traumatic. In such a case, the worker is likely not entitled to compensation.

In this case, the events which immediately preceded the worker's disability are the incidents which are described as occurring on March 24, 2004 and May 4, 2004. Accordingly, I am required to apply the policy in order to determine whether either of these events was a "sudden and unexpected traumatic event."

Turning to the incident of March 24, 2004, the worker described this incident in his second application for compensation. He said that he had received a referral from a nurse in psychiatry with a wrong number and no risk assessment regarding the urgency of the call. After unsuccessfully trying to contact the patient at the number provided, he became concerned because this patient had a history of severe overdose attempts. He eventually realized that he had been given the wrong telephone number and when he did contact the patient she could barely speak. The patient had taken a potentially fatal overdose but the worker was able to get medical assistance to her and she survived.

In the month following this incident, the worker stated that his anxiety progressively increased. He had intrusive, recurring images of the hanging victim, his depressive symptoms increased and his suicidal thoughts returned. He was very fearful.

This is a very serious incident and there is no question that it would be extremely stressful. I do not find, however, that it is a "severely emotionally disturbing event" "that is generally accepted as traumatic". Although there was a threat of death involved, it appears that the worker's contact with the patient was over the telephone and so there

was no direct personal observation of an actual or threatened death or serious injury. The worker did not witness an event that involved death or injury although he was aware that the patient was likely in a life-threatening situation. Even if this were characterized as a traumatic event, I cannot find that it was "sudden and unexpected." The worker became concerned about his inability to contact the patient because of her self-injuring history. Accordingly, it cannot be said that discovering she had taken an overdose was a sudden and unexpected event. As a result, I find that this event does not satisfy the requirement of a sudden and unexpected traumatic event under section 5.1 of the Act.

Turning to the second incident, the incident on May 4, 2004, I have noted the employer's representative's concerns regarding this incident and that it does not appear to have been identified by the worker until May 2005, when he saw Dr. Buch. The representative has also noted though that there appears to be a missing page to the worker's application for compensation. At the end of the worker's description of the March 24, 2004 incident, he indicates that there is additional information on a second page but there is no second page on his file. The employer's representative noted this in his submission to the Review Division but no second page has been submitted.

The worker's account of this May 4, 2004 incident in the critical incidents list that he provided to Dr. Buch indicates that this incident also involved a referral of a suicidal patient to the worker. The worker did not receive the call because of problems with the pager system. Eventually, he received the referral, written on a yellow sticky. When he contacted the patient, she had taken an overdose. In this case as well, the worker did not have direct contact with the patient and the patient survived. Accordingly for the same reasons as I provided above I am unable to find that this incident satisfies the criteria for a traumatic event as that incident is described by policy.

As I have previously indicated, I do not believe that there is provision for considering the effects of the worker's pre-existing symptoms when determining whether these events were traumatic for the purpose of section 5.1 of the Act. Although the medical evidence is that he became disabled following these two incidents because he had developed a heightened sensitivity as a result of his prior exposures to trauma, the legislation does not provide for compensation unless the ultimate event that results in disability meets the requirements under the Act. This applies equally to emergency workers as it does to any other worker.

I have also considered the worker's representative's submission that WCAT consider whether the incidents during the summer of 2003 satisfy the requirements under section 5.1 of the Act. I agree with the review officer, however, that this has not been adjudicated by the Board and, as a result, neither the Review Division nor WCAT has the jurisdiction to address the effects of these incidents.

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The worker's representative has also requested, in the alternative, that WCAT direct the Board to adjudicate the worker's entitlement to compensation as a result of these events. WCAT, however, has very limited powers to direct or order the Board to undertake activities. Under section 253(1) of the Act, WCAT is empowered to "confirm, vary or cancel." There is no general power to direct the Board to take particular actions.

Finally, I have considered whether I should refer the adjudication of the 2003 incidents to the Board under section 246(3) of the Act. Under this section, WCAT has the ability to refer a matter back to the Board for determination where "the appeal tribunal considers there to be a matter that should have been determined but that was not determined by the Board." I find though that there are too many outstanding decisions to properly utilize this provision. My reasons follow.

The two suicides by overdose and the subsequent suicide by the wheelchair bound patient, which has been characterized as particularly significant by Drs. Passey, O'Neill, Buch and the Board psychology advisor, all occurred sometime prior to September 2003. The worker, however, did not submit his application for compensation with respect to these incidents until March 3, 2005. The case in which the patient committed suicide by wheeling her wheelchair into an oncoming train occurred in either August or September 2003 (both dates have been given at different times) and the two overdose suicides occurred before that. None of these incidents were identified in the worker's application for compensation in May 2004; they were identified in his application for compensation of March 2005 – more than a year and a half after the last suicide occurred.

The worker's application for the adjudication of these incidents was therefore out of time and, as a result, a preliminary decision is required as to whether there were special circumstances that precluded the worker from submitting his application for the effects of the 2003 suicide(s) within one year of their occurrence. But, an adjudication under section 246(3) of the Act, as to whether there were special circumstances that precluded the worker from submitting his application within one year of the suicides in 2003, would not necessarily assist in expediting the appeal process. If the Board officer concluded that there were no special circumstances, he or she would not go on to consider the merits of the application.

I have also considered requesting the Board to make the preliminary decision regarding special circumstances and to determine whether the worker was entitled to health care benefits subsequent to those incidents, regardless of the outcome of the adjudication on special circumstances. However, the policy at item #93.22 of the RSCM II which provides direction on the adjudication of applications for compensation that are out of time states that "The application cannot be considered on its merits if no such special circumstances existed…" I have considerable doubt that WCAT has the authority to request the Board to make a decision on the merits in the face of policy which is binding on all adjudicators.

Even if this were considered procedural or administrative policy and potentially not binding, a further adjudication would still be required in order to obtain the remedy sought by the worker, which is wage loss as of May 4, 2004. A request to make these decisions places the Board officer in the untenable position of having to make all decisions based on his or her judgment of the merits and then to also make each decision in the alternative.

In view of the above, I do not consider it appropriate to return the matter to the Board under section 246(3) because of the nature of the decision(s) involved. If the worker wants consideration to be given to the workplace events in 2003, he will have to request the Board to adjudicate that matter.

In view of all of the above, I find that the worker is not entitled to compensation for mental stress under section 5.1 of the Act in relation to the incidents that occurred on March 24, 2004 and May 4, 2004.

Conclusion

I confirm *Review Division Decision #R0051674*, dated November 9, 2005. The worker is not entitled to compensation for mental stress under section 5.1 of the Act.

No expenses were requested, and it does not appear from a review of the file that any expenses were incurred related to this appeal. I therefore make no order regarding expenses of this appeal.

Marguerite Mousseau
Vice Chair

MM/gw