DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

WCAT Decision Number: A1700538
WCAT Decision Date: August 29, 2018

Introduction

[1] While employed as a casual hospital laundry worker, on August 21, 2015, the worker was crushed by mechanical equipment in the laundry room and was lifted off the floor. He suffered serious injuries; both physical and psychological.

[2] A Workers' Compensation Board (Board), operating as WorkSafeBC, case manager in a June 10, 2016 decision letter advised the worker that temporary disability wage loss benefits ended on June 5, 2016, as both the physical and psychological conditions were no longer considered temporary. The case manager mentioned the Board accepted a number of permanent conditions – post-traumatic stress disorder (PTSD), left shoulder chronic pain, and chest/trunk chronic pain. Additionally the case manager indicated the Board considered the worker unable to return to work in the laundry department and the claim would be referred to the Board's Vocational Rehabilitation Services Department for consideration of further assistance.

[3] As well after considering an opinion provided by a Board medical advisor – Dr. McGinness, the case manager could not relate the worker's neck complaints to the mechanism of injury, as a compensable consequence. She also denied an aggravation of the worker's pre-existing degenerative cervical condition. Finally the case manager advised the worker was entitled to a permanent partial disability pension assessment, under the loss of function method as described in section 23(1) of the *Workers Compensation Act* (Act). She could not determine if the worker was also entitled to a loss of earnings pension assessment, at that time.

[4] The worker requested a review of that decision by the Board's Review Division.

[5] A review officer, after considering submissions, denied the worker's request for a review, confirming the Board's decision letter.

[6] She agreed with the Board's decision not to accept a neck injury as a result of the August 2015 work injury. She also found the physical and psychological injuries did not continue to cause any temporary disability beyond June 4, 2016. Accordingly the worker was not entitled to any additional wage loss benefits beyond that date.

[7] The worker now appeals to the Workers' Compensation Appeal Tribunal (WCAT). He believes the claim should also be accepted for a neck injury and accordingly he should be provided with appropriate compensation benefits.

[8] During the WCAT appeal process the worker was represented by legal counsel. The employer participated and was represented by management consultant.

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[9] The worker provided direct evidence at an oral hearing on September 20, 2017. The employer's representative participated via a teleconference call.

[10] Before that hearing legal counsel provided additional information. At the hearing I received further information. After the hearing I requested additional medical information from the worker's treating neurosurgeon – Dr. Govender. In due course I also received a copy of the Board's incident investigation report (with a brief video clip).

[11] After disclosure, both parties were given the opportunity to provide further submissions. In late July 2018 a WCAT appeal coordinator determined that all submissions were complete and the appeal was returned to me for a decision.

Issue(s)

[12] The issue in this appeal relates to the compensability of the worker's neck complaints, as arising out of and in the course of the worker's employment on August 21, 2015, pursuant to section 5(1) of the Act.

[13] I also need to consider whether the worker is entitled to additional compensation benefits, if the neck complaints are compensable.

[14] While the review officer considered the issue from the perspective of whether a neck injury should be accepted as a compensable consequence, I am satisfied this matter is better adjudicated as I have identified.

[15] According to item #3.3.1 from WCAT's *Manual of Rules of Practice and Procedure* (MRPP) WCAT general restricts its decision to the issues raised by the appellant; the appellant is entitled by right to a decision on the issues expressly raised.

[16] Because the worker through legal counsel did not take issue with any other matter, I did not consider other matters over which I had jurisdiction, emanating from the originating June 10, 2016 decision letter.

Jurisdiction

[17] The worker appeals a January 12, 2017 Review Division finding (*#R0212198*) pursuant to section 239(1) of the Act.

[18] WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (see section 250(1) of the Act). WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the board of directors of the Board that is applicable in the case. WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal before it (section 254 of the Act).

[19] This is a rehearing by WCAT. WCAT reviews the record from previous proceedings and can hear new evidence. WCAT also has enquiry power and the discretion to seek further evidence, although it is not obligated to do so.

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[20] The standard of proof required in this appeal is proof on a balance of probabilities, subject to section 250(4) of the Act. That section provides that where the evidence supporting different findings on an issue in an appeal respecting the compensation of a worker is evenly weighted, the issue must be resolved in a manner that favours the worker.

[21] The policy relevant to this appeal is found in *Volume II* of the Board's *Rehabilitation Services and Claims Manual*.

Background and Evidence

[22] Because of the scope of this appeal, there is no need for me to review the entire history of the worker's claim; that information is well known to both parties. Therefore I will only refer to information which provides a context for my finding.

[23] In a May 20, 2016 discharge report, occupational rehabilitation 2 (OR2) staff, in part, identified the worker's return to work barriers, noting he was able to return to work with limitations, upon discharge.

[24] Program staff also provided a clinical findings summary, including cervical spine range of motion. The worker's range of motion was comparatively reviewed from January 11, to May 11, 2015, when the worker demonstrated cervical spine range within functional limits, but experienced some end of range pain, with left side flexion and left rotation.

[25] Shortly thereafter the Board case manager asked Dr. McGinness to review the worker's claim and provide an opinion, in part, on whether the medical evidence supported a conclusion that the worker sustained a neck injury, as of a resulted of the accepted mechanism of injury. The case manager noted specifically that no neck injury had yet been accepted, but the worker felt that he must of injured his neck while trying to "fight off" the machine, as it was pinning him.

[26] The worker then participated in a cervical MRI scan, on June 17, 2016.

[27] A radiologist noted the reason for the scan related to the worker's history of C-6 radiculopathy. After describing the scanning results, the radiologist formed the impression of mid-cervical spondylosis, most marked at C4-5, within associated moderate spinal stenosis and foraminal stenosis.

[28] By this time the worker's attending physician, in a May 30, 2016 progress report to the Board, diagnosed the worker with neck degenerative changes and foraminal stenosis. That physician pointed out that when the worker was injured he was suspended above ground on a conveyer and lost consciousness.

[29] Dr. McGinness then reviewed the claim on June 9, 2016.

[30] As set out in the corresponding clinical opinion memorandum, Dr. McGinness noted that she had previously reviewed and provided opinions on the claim. After briefly referring to some of the medical information, including a prior cervical CT scan, Dr. McGinness stated there was no evidence of any neck injury; as the worker did not report pain in the neck for some time after the accident; and when he did this related to interior neck pain, in association with anterior shoulder

pain. Originally the worker reported upper back/trapezius area occipital pain as part of a more general pain process. That pain appeared to be persistent, but not specifically related to a neck injury. Dr. McGinness also provided an opinion with respect to the worker's reported limitations.

[31] The worker's new attending physician, Dr. Lange, then in July 25, 2016 progress report to the Board, referred to the cervical MRI scan, which showed nerve impingement. Dr. Lange noted the worker had been referred to Dr. Govender after already seeing another neurosurgeon. The worker experienced neck pain and left arm pain when he lifted an object. Dr. Lange referred to the worker's attempts at returning to work and the worker's PTSD symptomatology. He also mentioned the worker was "going for ING to neck."

[32] By this time the Board case manager had issued the June 10, 2016 decision letter under appeal.

[33] Subsequently Dr. Lange continued to provide progress reports to the Board.

[34] In October 2016, Dr. Lange mentioned the worker continued to present with neck pain, with left arm symptoms and would be seeing Dr. Govender. The worker felt "like something" was pinching the right side of his neck and shoulder area, as he experienced neck and arm pains and numbness.

[35] Dr. Lange also mentioned the worker had shown him a couple of letters from the Board and Dr. Lange could not understand why the worker was not "being covered for the neck injury."

[36] In submissions to the Review Division, the worker's representative provided a copy of an August 2016 psychological assessment report, completed for pension purposes.

[37] Dr. Dorward, noted that when the worker described the incident (at page 14) the worker remembered that the conveyer lifted him up and crushed his chest and he recalled being on the ground with a "code blue" team around him. There was some arguing between team members about how to put a neck brace on.

[38] In her January 12, 2017 finding, the review officer noted that scanning of the worker's neck showed evidence of a pre-existing degenerative condition, which was not aggravated by the August 2015 work injury, because scanning did not show any acute changes. She also considered that Dr. Lange, in April 2016, did not diagnose a neck injury, nor did he relate the degeneration to the August 2015 work incident. While the worker had other injuries that were being treated, the review officer was also not persuaded it would take the worker a few months to identify neck symptoms. Also, there was no neck injury diagnosis. She therefore agreed with the Board's decision not to accept a neck injury as a result of the August 2015 work injury, after referring to policy item #C3-22.00 (Compensable Consequences).

[39] The review officer also accepted the opinions provided by both Dr. McGinness and by a Board psychological advisor, concluding the compensable physical and psychological injuries did not continue to cause any temporary disability beyond June 4, 2016. The worker therefore was not entitled to any wage loss benefits beyond that date. In the result, she denied the worker's request for review and confirmed the Board's June 10, 2016 decision.

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[40] Dr. Lange in a further March 21, 2017 progress report to the Board referred to the worker's chronic pain condition and return to work options. In June 2017 Dr. Lange noted the worker also had carpal tunnel syndrome.

Evidence at WCAT

[41] On September 28, 2017 the legal counsel submitted the following:

- A copy of her medical-legal request letter to Dr. Lange (which included part of her written submission to the Review Division)
- A medical-legal letter from Dr. Lange (with addendum) dated August 25, 2017

[42] Briefly, Dr. Lange after noting that he initially met the worker in late July 2016, and that he based this report on the results of his office visits and specialist's reports he had access to (which he summarized) indicated there was no doubt the worker sustained a traumatic crush injury of the thoracic cage. But there was no evidence the worker's left arm and neck pain resulted from nerve impingement from the neck. The left shoulder maybe "contributing some" as the worker was only able to abduct the left shoulder from about 100 degrees (whereas normal was 180 degrees). Because Dr. Lange thought there might be some left shoulder impingement he provided a steroid injection in February 2017. Some weeks later the worker told him that the left shoulder felt better for only a few days after that procedure.

[43] Dr. Lange then wrote:

> From all of this we are left with (the worker) suffering from a chronic pain condition involving the soft tissue (muscles, fascia, and tendons of the left shoulder and neck) and some of the smaller joints (cervical facet joints). There is no convincing proof of a nerve impingement of any of the cervical nerve roots. This seems to have as a result of the crush injury he suffered on August 21, 2015.
>
> Addendum:
> Despite his having degenerative changes on the MRI, he didn't have pre-existing pain problems from the neck or shoulder area prior to the crush injury, so I do think his chronic pain condition did arise as a result of the crush injury.
>
> [reproduced as written]

[44] At the oral hearing I also received the following additional information:

- Legal counsel's written submission
- A copy of a September 2015 physiotherapy report
- A copy of claim data report referring to a Board team meeting on March 23, 2016
- Dr. Lange's corresponding invoice dated August 30, 2017 (with a copy of legal counsel's cheque to Dr. Lange).

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[45] Legal counsel sought acceptance for a permanent neck injury, as well as wage loss and treatment from June 5, 2016 forward. After referring to claim file information and Dr. Lange's reference to Dr. Govender's review, she identified a number of concerns with Dr. McGinness's clinical opinion. Legal counsel pointed out that Dr. McGinness is a family physician who did not examine the worker, nor was she provided with video surveillance footage demonstrating the mechanism of injury. Dr. McGinness was also provided with no medical documentation to support the worker's experienced neck pain before the work injury and she also made no reference to the physiotherapist's initial assessment – which referred to neck pain, occurring nine days post-incident. Dr. McGinness appeared to ignore all reports of neck pain and related symptoms, including treatment provided specifically for neck pain. Most notably Dr. McGinness also made no reference to a prior opinion contained in team meeting notes – March 23, 2016, when Dr. McGinness indicated it was possible that the worker's neck degenerative changes were temporarily aggravated by the work incident; and that a pain clinic referral for injections was medically reasonable for the temporary aggravation of the pre-existing neck issues.

[46] Legal counsel submitted the worker had sustained a traumatic injury and the muscles in the shoulder area are also connected to the muscles in the neck. Symptoms of neck pain post accident are all documented – within nine days post-injury. Based on the medical evidence it is clear the worker has specific or non-specific chronic pain; either way his neck pain is "incident related." The worker should receive wage loss benefits and or treatment, from June 5, 2016 forward.

[47] In his direct evidence, the worker briefly described the mechanism of injury, confirming he tried to push away with both hands as his chest was being crushed. He noted he spent seven days in the hospital and received a spinal epidural. When that was removed he experienced increasing pain overall. The worker then briefly described some of the treatment he received thereafter, noting that he still continues to have neck pain.

[48] During questioning the worker confirmed that he saw Dr. Govender at least once and he received a number of injections into the neck area.

[49] After some discussion with respect to legal counsel's reference to video evidence and an incident investigation report, I asked the employer's representative to collect this information, if possible. I also asked an appeal coordinator to obtain relevant consultation reports from Dr. Govender's office.

[50] In October 2017 the employer's representative referenced the field investigation video surveillance, conducted in December 2016. She suggested that if legal counsel had information that a video exists for the accident itself, or as a result of the accident investigation, then she would appreciate a copy.

[51] In mid-October 2017 WCAT received two reports from Dr. Govender's office;

- In a brief March 9, 2016 letter to the worker's attending physician (Dr. Adams) Dr. Govender noted the worker had features of right sided C-6 radiculopathy (with a traumatic event proceeding the symptoms). The results of a private MRI scan revealed decreased cervical

lordosis with a central and lateral recess stenosis, due to disc protrusions – C4-5 and C5-6. Dr. Govender did not expect the worker had features of myelopathy.

- In an October 19, 2016 consultation to Dr. Lange, Dr. Govender noted the worker reported diffuse pain, including left sided neck pain, with diffuse parasthesia and numbness in both hands; worse on the left versus the right. After describing his examination results Dr. Govender noted MRI scanning revealed degenerative changes at multiple levels, but an adequately "patent" spinal canal. There was some stenosis at C4-5 and C5-6, with lateral recess on the left side, more than the right. The signal within the spinal cord was normal.
- Clinically Dr. Govender did not feel the worker presented with neural impingement, he had mainly soft tissue symptoms. The worker presented with very diffuse decreased sensation in the entire left upper limb and upper chest area; this was in keeping with a focal neural problem from the cervical spine.

[52] Also in October, legal counsel provided two pages of the incident investigation report, which referenced video footage, witness interviews and written records used to determine the sequence of events on August 21, 2015. She looked forward to receipt of the video camera footage.

[53] In due course WCAT received the complete June 2016 Board incident investigation report, with an accompanying video clip.

[54] The crush incident was described in some detail – pages 9 to 11. The worker was lifted completely off the ground, remaining trapped; he then lost consciousness. A co-worker and a witness "threw themselves repeatedly" against the frame of the shuttle causing it to move slightly. They managed to free the worker and laid him on the ground. A code blue team arrived and attended to the worker. He was then treated at the hospital for fractures and soft tissue damage from the mid-section of the torso down.

[55] The remainder of the report refers to the Board's inspection findings and resulting inspection "reports," pursuant to a number of violations of the *Occupational Health and Safety Regulations*.

[56] Upon disclosure of all the new information collected by WCAT, the employer's representative filed a brief July 4, 2018 submission.

[57] While legal counsel at the oral hearing suggested the video evidence would better demonstrate the method of injury, this was not the case. The video provided was of poor quality and the incident itself was "hardly viewable." There is nothing contained in this evidence that would support a variance of the review officer's decision. Similarly Dr. Govender's reports do not contain any new evidence "which would support a variance".

[58] Legal counsel in a brief of July 20, 2018 submission noted the information contained in the video footage and Dr. Govender's medical reports are self-explanatory. The worker relied on previous submissions.

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Reasons and Findings

[59] Section 5(1) of the Act provides for compensation for a personal injury, which arises out of and in the course of a worker's employment.

[60] Board policy item #C3-12.00 mentions that a personal injury is defined as any physiological change resulting from some cause. A personal injury also includes an aggravation of a pre-existing non-compensable disease, attributable to a specific event or trauma. It is not a bar to compensation if an injury results from a series of incidents, rather than from a specific incident. Rather, to be compensable as an injury, the evidence must warrant a conclusion that there was something within the employment that had causative significance in producing the injury; a speculative possibly is not enough. The etiology of a disabling condition is always relevant and the presence or absence of a specific incident may have some evidentiary value.

[61] Board policy item #C3-14.00 provides that the reference to arising out of the employment, refers generally to the cause of the injury and the focus is on whether the worker's employment was of causative significance. Both employment and non-employment factors may contribute and the employment factors need not be the sole cause. However, in order for an injury to be compensable, the employment has to be of causative significance – more than a trivial or insignificant aspect of the injury. In considering the medical evidence the Board considers whether there was a physiological association between the injury and the employment activity; whether there was a temporal relationship between the work activity and the injury; and whether any non-work related medical conditions were a factor. The Board also considers any other relevant medical evidence.

[62] Board policy item #C3-16.00 provides that if a worker's pre-existing condition is a deteriorating condition, the medical evidence is examined to determine whether or not, at the time of the injury, the pre-existing deteriorating conditions was at a critical point, at which it was likely to result in a manifest disability. If the injury is one the worker would have sustained whether at work, at home, or elsewhere, regardless of the employment activity, then the employment was not of causative significance; the injury is considered to have resulted from the pre-existing deteriorating condition and is not compensable. In all cases, the medical and factual evidence is considered together.

[63] Board policy item #35.30 mentions that as a result of section 31.1 of the Act, the Board terminates temporary total or temporary partial wage loss benefits, under sections 29 or 30 of the Act, once a worker's temporary disability ceases. A temporary disability ceases when it either resolves entirely, or stabilizes as a permanent impairment, when the worker is to be assessed for a permanent partial disability award.

[64] Board policy item #34.54 mentions that a condition will be deemed to have plateaued, or become stable, where there is little potential for improvement, or where any potential changes are in keeping with the normal fluctuations in the condition, which can be expected with that kind of disability. If the potential change is likely to resolve relatively quickly (generally within 12 months) the condition will be considered temporary and the worker is maintained on temporary wage loss benefits. However, if the potential change is likely to be protracted (generally over 12 months), the condition will be considered permanent and a further disability award will be assessed.

[65] Finally, Board policy #C14.101.01 mentions that the need to adjudicate new matters not previously decided and make a decision on those matters, may occur at various points during the adjudication of a claim. Situations in which the Board may make a new decision on a matter not previously decided includes, but is not limited to the acceptability of additional medical conditions identified during the adjudication of a claim, or acceptance of a further injury that arises as a consequence of a work injury. The Board also has broad discretion to make decisions regarding entitlement to health care, over the course of a claim.

[66] I find the overwhelming weight of the evidence indicates the worker sustained a soft tissue neck injury, which arose out of and in the course of the employment activity on August 21, 2015, pursuant to section 5(1) of the Act. I also find the compensable neck condition stabilized or plateaued, by June 4, 2016, as a permanent condition, pursuant to applicable Board policy. The worker is therefore not entitled to any additional wage loss benefits, but the resulting chronic pain neck condition should be considered by the Board for a potential permanent partial disability pension assessment and medical treatment. I allow the worker's appeal to this extent and I vary the review officers January 12, 2017 finding (*#R0212198*).

[67] I have the definite benefit of a retrospective review of the worker's situation, given not only the worker's direct evidence, but also additional factual and medical evidence, as well as submissions from both parties.

[68] Based on my weighing of the evidence I am satisfied the worker sustained a soft tissue neck injury as of a result of the mechanism of injury on August 21, 2015. This is described in more detail in the Board's incident investigation report. In my view a soft tissue neck injury, is entirely consistent with the mechanism of injury, notwithstanding any delay in the worker's report of specific neck symptomatology, given the overall constellation of his other more serious symptoms at that time.

[69] I am also satisfied the medical evidence supports a soft tissue compensable neck injury and not a compensable aggravation of a pre-existing cervical degenerative condition.

[70] I place some weight on Dr. Lange's medical opinion evidence, after a review of the relevant specialist's reports. Dr. Lange concluded the worker had not sustained any neural impingement and presented with what was described as a non-anatomic sensory loss. Dr. Lange reasoned that via the traumatic crush injury, the worker sustained soft tissue injury in the neck and other areas.

[71] Dr. Lange then went on to mention that the worker suffers from a chronic pain condition, resulting from the crush injury. Despite the degenerative changes identified on the MRI scan, the worker had no pre-existing neck problem before the crush injury, so the worker's chronic pain condition likely resulted from the crush injury.

[72] In my view, Dr. Lange's assessment is consistent with Dr. Govender's view formed in October 2016. Dr. Govender clearly mentioned the worker did not present with a neural impingement, but had mainly soft tissue symptoms – as described.

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[73] Given my review of the medical evidence, I give little weight to Dr. McGinness's clinical opinion, which formed the basis for the Board's originating June 10, 2016 decision. Dr. McGinness did not have the benefit of reviewing the subsequent MRI scan, or subsequent specialist reports, including those of Dr. Govender. Moreover her June 2016 review, wherein Dr. McGinness mentioned there was no evidence of any "neck injury" is sharply contrasted by her reported comments at a March 2016 team meeting - when she mentioned the work incident resulted in a temporary aggravation of the worker's neck condition. At that point Dr. McGinness approved a pain clinic referral for injections, as reasonably necessary for the temporary aggravation of the worker's pre-existing neck issues. While I appreciate that Dr. McGinness's team meeting comments can be characterised as hearsay evidence, those comments were neither referenced nor considered in Dr. McGinness's direct subsequent June 9, 2016 clinical opinion memo. As a result, I am not persuaded the June 9, 2016 clinical opinion deserves much weight.

[74] Additionally upon considering Board policy #35.30 and #34.51, I find the worker's compensable neck soft tissue injury likely stabilized and became permanent, by June 5, 2016. There is no compelling medical evidence that the worker's now compensable neck condition was at that time was going to resolve relatively quickly (and certainly not within 12 months).

[75] In this regard I am mindful that Dr. Lange mentioned the work suffers from a chronic pain condition and as the worker did not have pre-existing pain problems, the chronic pain condition arose as a result of the crush injury.

Conclusion

[76] For the above-noted reasons I allow the worker's appeal and I vary the review officer's January 12, 2017 finding (*#R0212198*). I find the worker sustained a compensable neck soft tissue injury, which arose out of and in the course of the employment activity on August 21, 2015, pursuant to section 5(1) and applicable Board policy. I also find that compensable soft tissue neck injury stabilized or plateaued by June 4, 2016, such that the worker is not entitled to any additional temporary disability wage loss benefits. However, I find the worker has soft tissue chronic neck pain and the Board should consider a permanent partial disability pension assessment and provide medical treatment if warranted.

[77] According to item #16.1.3 from WCAT's MRPP, generally WCAT will order reimbursement of expenses related to the introduction of written evidence, regardless of the result in the appeal, where that evidence was useful or helpful or was reasonable for a party to have brought such evidence in connection with the appeal.

[78] Item #16.1.3.1 of the MRPP, also provides that WCAT may direct reimbursement for different types of expert evidence.

[79] I also find the worker is entitled to be reimbursed for the expense of Dr. Lange's medical-legal report – August 25, 2017 and September 18, 2017 addendum, as set out in the August 30, 2017 statement of account and legal counsel's copy of a cheque written to Dr. Lange (in the amount $500.00).

[80] I make this additional finding pursuant to section 7 of the *Workers Compensation Act Appeal Regulation*. I am not aware of any other relevant appeal expenses.

Dana Brinley
Vice Chair

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