Noteworthy Decision Summary

Decision: WCAT-2014-01468 **Panel**: L. Alcuitas-Imperial **Decision Date:** May 15, 2014

Meaning of employer – Section 5.1(1)(c) of the Workers Compensation Act – Policy item #C3-13.00 of the Rehabilitation Services and Claims Manual, Volume II – Section 5.1 exclusion

This decision is noteworthy for the interpretation of "employer" in the context of section 5.1(1)(c) of the *Workers Compensation Act* (Act) and policy item #C3-13.00 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II). An 'employer' for the purposes of section 5.1(1)(c) is an individual with direct supervision and control over working conditions, work performance, scheduling.

The worker, a registered nurse, had an argument with a co-worker. The worker applied for compensation under section 5.1 of the Act for a mental disorder arising from the workplace incident. The Workers' Compensation Board, operating as WorkSafeBC (Board), denied the claim on the basis that the incident involved labour relations issues. A review officer upheld the Board decision.

The worker appealed to WCAT. WCAT found that the criteria in section 5.1 of the Act were met, the section 5.1(1)(c) exclusion did not apply, and that the worker's claim for compensation for a mental disorder should be accepted.

WCAT determined that the claim was not excluded by section 5.1(1)(c) of the Act because the co-worker, a coordinator, was not the worker's employer. The panel considered the Act, policy, and dictionary definitions, and determined that an employer for the purposes of section 5.1(1)(c) is an officer with direct supervision and control over the worker's working conditions, work performance, and work schedules. In this case, the coordinator was simply a co-worker, as opposed to the worker's "employer".

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Panel: Luningning Alcuitas-Imperial, Vice Chair

Introduction

[1] The worker, a registered nurse, was working on April 20, 2012. At approximately 2:00 p.m., the worker and a co-worker (a personal care coordinator) had an argument. The worker applied for compensation from the Workers' Compensation Board (Board), operating as WorkSafeBC, for a mental disorder. The worker said she was shocked and traumatized by the April 20, 2012 work incident, as the coordinator yelled at her, blocked her attempt to leave an office, and grabbed her wrist.

[2] Subsequent to the worker's application for compensation, the Board received a physician's report from Dr. Robertson, family physician. Dr. Robertson had examined the worker on April 27, 2012 and diagnosed her with post-traumatic stress disorder (PTSD). The worker had described the April 20, 2012 work incident to Dr. Robertson. She recommended that the worker undergo counselling.

[3] On May 23, 2012, the Board denied the worker's claim, as the Board considered that the claim did not meet the criteria in the former version of section 5.1 of the *Workers Compensation Act* (Act). The Board found that the worker had an unconfirmed diagnosis of stress, resulting from a disagreement between herself and the coordinator on April 20, 2012.

[4] A review officer confirmed the Board's denial of the worker's claim on December 5, 2012. The review officer was not satisfied that the interplay between the worker and the coordinator on April 20, 2012 met the requirement for either a traumatic event or a significant work-related stressor under the current version of section 5.1 of the Act. The review officer found that, while the coordinator's conduct was clearly inappropriate, the interaction between the worker and the coordinator was an interpersonal conflict and the conduct fell short of being threatening or abusive. As well, the review officer was satisfied that this was an isolated incident, as opposed to something amounting to workplace bullying or harassment. The review officer found that no further investigation of the worker's diagnosis was required.

[5] The worker now appeals the Review Division decision to the Workers' Compensation Appeal Tribunal (WCAT).

[6] I held an oral hearing into this appeal. A lawyer from the worker's union represented the worker. A consultant represented the employer.

[7] The worker says that her claim should be accepted as her mental disorder met the criteria in section 5.1 of the Act. In support of her appeal, the worker submits the following medical evidence:

- A May 8, 2012 note from Dr. Robertson, which states that the worker required psychological counselling for personal growth.
- A May 10, 2012 note from Dr. Robertson certifying that the worker could not attend work from May 8, 2012 to May 31, 2012.
- Invoices from Dr. Behboodi (registered psychologist) for counselling sessions on May 10, 2012; May 24, 2012; and May 31, 2012.
- A June 4, 2012 note from Dr. Robertson certifying that the worker could not attend work from June 4, 2012 to June 12, 2012.

[8] As well, the worker submitted a July 7, 2013 medical-legal opinion from Dr. Behboodi that raises the following points:

- The worker sought counselling in order to address the distress she was experiencing following the April 20, 2012 workplace incident. Dr. Behboodi saw the worker on three occasions.
- The worker described that she had gotten into an argument with the coordinator. The argument escalated and the coordinator asked her to go to her office. The coordinator was harsh, pointing her finger at the worker, and was yelling at the worker to listen to her. When the worker attempted to leave the office, the coordinator blocked the door with her leg and grabbed the worker's wrist. The coordinator made the worker sit and talk to her. The coordinator then kicked the worker out. The worker said nothing to anyone but the coordinator spoke to head office staff. Although the head office staff spoke to the worker, they did not believe her side of the story.
- The worker reported that she felt shocked, anxious, and scared following the workplace incident. She described it as a horrible situation. She felt that the coordinator was constantly watching and judging her. The worker said that she feels that the coordinator is using her power over her, undermining her, and making the workplace stressful for her.
- The worker reported that, despite feeling emotionally exhausted, she pushed herself to continue working. She described herself as a strong person and that she could cope with it. However, she felt her psychological condition worsening. She felt anxious, agitated, and tearful. She suffered from sleep disturbances, headaches, lack of concentration, poor memory, and felt scared, insecure, and on guard.
- The worker denied having any history of mental illness, any significant psychiatric history, substance abuse, or alcoholism.
- Dr. Behboodi's initial impression indicated that the worker was suffering from an adjustment disorder with mixed anxiety and depression. Her psychological symptoms appeared to be in response to an identifiable work-related stressor. Her

symptoms were clinically significant and they developed within one month of the onset of the work stress.
- However, Dr. Behboodi was not able to provide a full psychological assessment under the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). There was not enough background information and the mandate of her consultations with the worker was treatment and symptom relief (as opposed to a psychological assessment).

[9] The employer says that the review officer's decision was correct.

Issue(s)

[10] The issue in this appeal is whether the worker's claim meets the criteria for compensation for a mental disorder.

Jurisdiction

[11] The worker filed this appeal under section 239(1) of the Act. WCAT must make its decision on the merits and justice of the case, but in doing so, must apply applicable policy of the board of directors of the Board. Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

[12] In an appeal respecting the compensation of a worker, the standard of proof is the balance of probabilities, except that, where the evidence supporting different findings on an issue is evenly weighted, WCAT must resolve the issue in the worker's favour (see section 250(4) of the Act).

Background and Evidence

Claim File Evidence

[13] As noted above, the worker filed her application for compensation in May 2012. The worker stated that she got into an argument with the coordinator. The coordinator asked the worker to go into her office. Once in the office, the coordinator began pointing her finger at the worker and yelling at her. After 10 to 15 minutes of arguing, the worker told the coordinator that they both needed to calm down as the conversation was going nowhere. The worker attempted to leave the office, but the coordinator blocked the door with her leg and prevented the worker from leaving the office. The coordinator grabbed onto the worker's wrist, but there was no physical injury. The worker reported feeling shocked and traumatized by the experience. She was left feeling fragile and scared. She was experiencing problems concentrating at work and was having sleep problems.

[14] Dr. Robertson's April 27, 2012 report was filed with the Board subsequent to the worker's application. The employer filed a report of injury with the Board, but protested acceptance of the worker's claim on the basis that the criteria in section 5.1 of the Act were not met.

[15] In a May 18, 2012, a Board officer noted that he left a message with the worker. The Board officer then conducted a file review, which I infer consisted of a review of the worker's application for compensation. It does not appear that the Board officer actually spoke with the worker to gather additional details about the April 20, 2012 work incident. The Board officer noted that the worker's claim would not be accepted, as the work incident involved labour relations issues. The Board officer noted that the worker's stress resulted from a disagreement between the worker and the coordinator. The Board officer noted that the typical stress-related claims accepted by the Board involved, for example, a worker being held up at gunpoint where one could incur serious or grave injury or, in another example, a worker witnessing a horrific accident first hand while at work.

[16] I note that the worker returned the Board officer's call on May 22, 2012, but was unable to reach the Board officer.

[17] As noted above, on May 23, 2012, the Board denied the worker's claim.

[18] The worker requested a review of the Board's May 23, 2012 decision. She argued that the interaction with the coordinator went beyond what would be expected as normal interplay between a worker and a co-worker. She submitted that the coordinator's conduct was improper, including the physical contact. She argued that the incident was no longer in the realm of reasonable decision-making in employment matters, but went into the realm of harassment and bullying. She argued that her PTSD was a reaction to a traumatic event arising out of and in the course of her employment. While she acknowledged that the diagnosis was provided by a physician, she submitted that the diagnosis should be confirmed by a psychologist or psychiatrist. She argued that the criteria in the new version of section 5.1 of the Act were met.

[19] The employer argued before the review officer that the worker's claim did not meet the criteria in section 5.1 of the Act, as there was no diagnosis from a psychiatrist or psychologist and the interaction in question was of an employment-related nature.

Oral Hearing Evidence and Submissions

[20] At the oral hearing, the worker testified that the coordinator began arguing with her on April 20, 2012 at the nursing station. She said that the coordinator pointed at her and was asking her about the nursing care of a particular patient. The worker told the coordinator that she had already completed the care and referred the coordinator to the patient's chart. However, the coordinator "commanded" the worker to go to an office, where they sat down and the argument continued. The worker said that the coordinator

continued to point her finger, was not listening to what the worker said, and kept interrupting the worker when she attempted to speak. The worker told the coordinator several times that her behaviour was not respectful. The worker estimates that this part of the argument (namely, in the office) lasted for approximately seven to eight minutes.

[21] The worker testified that when the argument heated up, she told her coordinator that she was leaving. She said that the coordinator then got up and put her leg in front of the door (which was open a crack) to block the worker's exit. The worker testified that she tried to reach her hand into the crack to open the door, but the coordinator grabbed her right wrist. The worker said that she then became distraught and told the coordinator that she was "trapping" her in the office. The worker testified that the coordinator replied that she should show her the bruises. The worker estimates that this part of the argument (namely, at the door of the office) lasted for approximately one minute.

[22] The worker said that they then sat down again to talk, but the conversation did not go anywhere. Eventually, the coordinator asked her to leave the office. The worker estimates that this part of the incident took about seven minutes.

[23] The worker testified that she viewed the coordinator's behaviour as abusive. It caused her to have a "mental block" where she could not think. In her ten years of work, she had never experienced such treatment. Although she felt she was "not mentally there" and she was fearful of making a mistake in her practice, she continued to work. Near the end of her shift, the manager called the worker into her office. The manager said that she had heard that the worker had accused the coordinator of grabbing her wrist. The manager advised that the coordinator could not do such a thing, as she did not even like to touch people. The worker testified that she began crying, as she felt that the manager was blaming her for the incident, that the manager did not believe her story, and that the manager did not listen to or support her. The worker said that the manager told her and the coordinator to shake hands.

[24] The worker testified that she returned home feeling distraught, intimidated[i], and frightened. She said that she "held herself in," but was unable to sleep and eat. Her daughter asked her what was wrong, but she said that she did not feel like talking to anyone about the incident as she felt humiliated and was worried about what her colleagues would think. She testified that she did not consider the work incident to be part of a normal workplace. She also stated that the coordinator's behaviour was not normal and this was the first time that they had engaged in an argument. She felt physically and mentally threatened by her coordinator. She testified that the employer did not take any corrective actions against her coordinator or herself.

[25] The worker testified that she sought treatment from her family physician, Dr. Robertson. She told her about the April 20, 2012 work incident and her difficulties with crying and sleep. Dr. Robertson diagnosed her with PTSD and prescribed her a sleeping medication.

[26] The worker testified that she continued to work until May 8, 2012 when she could no longer handle the situation (as she was constantly shaking and crying on the job). Although she continued to work with her coordinator, she tried to avoid interactions with her. She sought assistance through the employee assistance program (one face-to-face session), went for three counselling sessions with Dr. Behboodi, took her sleeping medications, and engaged in yoga and exercise sessions. She could not continue counselling with Dr. Behboodi as she could no longer afford it. She noted that Dr. Robertson prescribed her anti-depressant medication, but she refused to take it as she feared being stigmatized and labeled.

[27] The worker testified that she was away from work for four to five weeks. She returned to work on a graduated return-to-work program in early June or July 2012.

[28] In response to questions from the employer and from the panel, the worker said that she had regular contact with the coordinator, but that this coordinator was not her supervisor. The worker denied that Dr. Robinson's May 8, 2012 referral for counselling was aimed at "personal growth."

[29] At the oral hearing, the worker made oral submissions to support her appeal. She submitted that the April 2012 work incident was a traumatic event within the meaning of section 5.1 of the Act, as it was emotionally shocking for the worker to be trapped in an office and to be physically assaulted. The worker submitted that it was not a normal part of her duties to be exposed to this kind of event. The worker submitted that the April 2012 work event was of causative significance in producing her mental disorder. She denied having any pre-existing psychological conditions. She submitted that her reaction to the event was immediate and identifiable and that the event itself was of sufficient degree and duration to be of causative significance. She argued that I should accept the medical evidence of Dr. Robertson and Dr. Behboodi, give her consistent testimony of her symptoms weight, and consider that there was no contrary medical opinion available.

[30] In the alternative, the worker argued that the April 2012 work incident should be viewed as a significant work-related stressor. She submitted that the incident involved a physical assault and abusive behaviour that was beyond the normal environment of the workplace. She submitted that the April 2012 work incident could be viewed as workplace bullying and harassment. She cited *WCAT-2013-02516* in support of her argument, as the panel in that decision found that a single incident could constitute workplace bullying and harassment. As well, she cited *WCAT-2013-00675*, where the panel used the criteria in the Board's harassment policy to define workplace bullying and harassment under section 5.1 of the Act. The worker submitted that her supervisor's conduct constituted personal harassment, as it was designed to offend the worker and harm her.

[31] The worker submitted that her claim should not be excluded under section 5.1(c). Again citing *WCAT-2013-00675* in support of this aspect of her argument, the worker said that the coordinator did not communicate any decision to the worker or discuss the employer's policies during the April 2012 incident.

[32] In the further alternative, the worker asks that I seek assistance from an independent health professional if I would not allow her appeal based on the evidence available as of the date of the oral hearing.

[33] The employer made oral and written submissions to the panel. The employer said that it would be difficult to justify seeking an additional medical opinion on this appeal. The employer argued that I should deny the worker's appeal, as the work incident was an interpersonal conflict. The employer noted that there was no verbal threat to the worker or another type of sudden incident. He noted that Dr. Behboodi had not diagnosed the worker's condition. As such, the employer argued that the criteria in section 5.1 of the Act were not met, as this was an isolated incident involving interpersonal conflict. The employer denied that there was any evidence of workplace bullying and harassment in the worker's case.

Post-Oral Hearing Evidence

[34] After the oral hearing, I decided to seek assistance from an independent health professional under section 249 of the Act.

[35] Dr. Kramer, registered psychologist, completed a February 16, 2014 report based on terms of reference from WCAT, as well as a review of materials WCAT provided to him, a clinical interview of the worker and the results from a Personality Assessment Inventory (PAI) test. He noted that the worker presented during the clinical interview as genuine and she did not seem to provide rehearsed descriptions of events.

[36] The worker told Dr. Kramer about her personal, work, and medical history. Prior to coming to Canada, she was employed as a nurse in her country of origin. She became licensed to practice nursing in Canada in 2003. She was hired at one of the employer's hospitals in October 2003 (starting off as a casual worker but progressing to a full-time position in 2012). She works in a transition medicine ward, where they help people from acute care adjust to their condition before they are discharged home.

[37] The worker told Dr. Kramer that there were no complaints about her work prior to the April 2012 incident. When the coordinator left the employer recently, she filed a complaint against the worker accusing her of leaving a bottle of Tylenol next to a patient. The worker said that the coordinator tried to impugn her licence to practice as a nurse; but the employer conducted a review and found the worker to be an exemplary employee. The worker told Dr. Kramer that she believes the coordinator filed the complaint against her as a form of reprisal for the April 2012 work incident.

[38] The worker said she was healthy and had no medical problems, aside from some issues with her knees. Although her work is physical, she enjoys the social aspects of interacting with the patients. The worker denied ever being treated in the past for psychological issues. When asked by Dr. Kramer about any other possible events in the spring and summer of 2012, the worker mentioned that she was in a motor vehicle accident in July 2012 when she hurt her knee. She was not hospitalized and only missed work for a short time.

[39] In terms of the April 2012 work incident, the worker described to Dr. Kramer that she was working on her usual ward and engaged in the usual nursing duties. She thought that everything was fine, although she knew that the condition of one of her patients had declined.

[40] The worker said that the incident began when the coordinator came to her and asked about the patient whose condition had declined. The worker replied that she was very busy but the coordinator came to talk to her at least two more times. The worker told the coordinator that the chart was available and that she could check it. At that point, the coordinator asked her to come into her office. The worker entered and the coordinator closed the door. The worker described to Dr. Kramer the behaviour of the coordinator (pointed her finger at the worker) and her assessment that the coordinator was behaving very unprofessionally. She also told Dr. Kramer about how the conversation deteriorated, her attempt to leave the office, and the coordinator's blocking of the door and grabbing of her wrist. The worker told Dr. Kramer that she "just totally reacted then" and that she felt trapped and very bad inside her. The corordinator moved away from the worker and asked her to show her the bruises. The coordinator still would not let the worker leave and asked her to sit down and listen to her. Eventually, the worker left and returned to the nursing station. Although there were three other nurses there, she did not tell them about the incident as she felt that they would laugh at her. She returned to work.

[41] The worker told Dr. Kramer that her manager asked her for a meeting. The worker perceived that the manager was blaming her for the incident. She was told to shake hands with the coordinator and resolve the incident.

[42] The worker described that she felt she was holding everything in but felt very low. She returned home, took a shower, and went for a walk. She did not tell anyone what had occurred to her at work.

[43] The worker returned to work but felt more threatened while there. As well, she found that she was not eating or sleeping well, she was unable to concentrate and found herself crying. However, she still did not report her symptoms to her manager, as she was afraid of losing her licence to practice.

[44] A nurse clinician noticed her crying one day and took her to the office. The worker told Dr. Kramer that she was scared because her manager and the coordinator were present. Although she was given some extra help, she could not continue with her 12-hour shift and went home.

[45] She continued to have sleeping and eating problems and felt depressed. Dr. Robertson prescribed her a sleeping medication, but it did not seem to help her.

[46] The worker told Dr. Kramer that she felt a lot of fear at that time. She decided to go to a counsellor through the employee assistance program. However, she found that the employee assistance program was not helpful, so she saw Dr. Behboodi on her own initiative and paying for her own sessions.

[47] After the Board denied her claim, the worker reported the April 2012 incident to her union. An emergency meeting was set up and the manager apologized to her, but the worker still felt the apology was insincere. Although the union wanted her to change her work unit, the worker refused as she felt that the manager and coordinator would take other forms of reprisal against her. Another meeting took place with the coordinator and they agreed to let the incident go. When she returned to work after an absence of four weeks, the coordinator welcomed her back. At first, she still felt withdrawn but she eventually discussed her situation with some other co-workers and this made her feel better.

[48] The worker told Dr. Kramer that she was not interested in pursuing her appeal for the financial gain but the union urged her to pursue it on principle.

[49] Dr. Kramer then noted the worker's results on the Structured Clinical Interview for DSM-IV (four edition) Axis I Disorders (SCID-CV). Aside from these questions, Dr. Kramer had also asked the worker a few questions relating to the diagnosis of PTSD under DSM-V (fifth edition). He noted that the SCID-CV did not contain any validity measures. The worker also completed the PAI, but her responses were inconsistent. Dr. Kramer noted there was no reason to believe that the worker deliberately attempted to complete the test inconsistently, but that she likely got fatigued and lost her concentration about halfway through the test. He noted that the PAI was administered as the last activity in a five-hour assessment.

[50] In response to my questions, Dr. Kramer opined that the worker met the criteria under both the DSM-IV and DMS-V for diagnosis of Major Depressive Disorder (single episode) shortly after the April 2012 work incident. She did not meet the criteria for any other diagnosis under DSM-IV. He noted that the worker's Major Depressive Disorder was in partial remission, as she continued to have a periodic depressive response.

[51] In terms of causation of the mental disorder, Dr. Kramer noted that the worker reported no prior psychological problems. He also noted that the worker reported to be living well prior to the incident and there did not appear to be any historic problems with

substance abuse. Although the worker was involved in a July 2012 motor vehicle accident, she only suffered minor physical injuries and did not require hospitalization. The psychological reactions noted on file all occurred shortly after the work incident and before the motor vehicle accident. Thus, Dr. Kramer thought it reasonable to conclude that the only cause of the worker's psychological problems was the April 2012 work incident. There were no other possible causes.

[52] Dr. Kramer's report was disclosed to the parties for their comments. The worker submitted that Dr. Kramer's report supported the worker's position on this appeal. The employer reiterated its argument that the April 2012 work event was neither a traumatic event nor a significant work-related stressor within the meaning of item #C3-13.00 of the RSCM II. In rebuttal, the worker disagreed with the employer's submission in its entirety.

Reasons and Findings

[53] As noted by the review officer, section 5.1 of the Act provides guidelines for the compensation of a mental disorder that does not result from an injury for which the worker is otherwise entitled to compensation.

[54] The key policy in this appeal is item #C3-13.00 of the RSCM II. It identifies five questions or areas of inquiry to provide guidance on the adjudication of claims for mental disorders (which are acknowledged to be complex) under headings A to E.

A. Does the worker have a DSM diagnosed mental disorder?

[55] The policy states in heading A that section 5.1 requires more than the normal reactions to traumatic events or significant work-related stressors. It requires that a worker's mental disorder be diagnosed by a psychiatrist or a psychologist. The Board may obtain expert advice to review the diagnosis but also considers all of the relevant medical history, including prior medical history, attending physician reports, and expert medical opinion.

[56] Having reviewed the evidence, I find that the worker had a DSM diagnosed mental disorder, namely Major Depressive Disorder (Single Episode), after the April 2012 work incident. This diagnosis was provided by Dr. Kramer, a registered psychologist. I make no comment on the duration of the mental disorder, although I acknowledge that Dr. Kramer opined that the worker still has this mental disorder, but that it is in partial remission.

[57] Dr. Kramer provided extensive reasons in support of his diagnosis, citing the worker's clinical interview results and the diagnostic criteria in both the DSM-IV and DSM-V. I accept and rely upon his expert opinion in relation to the worker's diagnosis. I note that there is no contrary expert opinion.

[58] I acknowledge that part of the review officer's reason for denying the worker's request for review was that the diagnosis of PTSD was not made by a psychiatrist or psychologist. I note that Dr. Kramer opined that the worker did not meet the criteria for such a diagnosis. He provided detailed reasons for his analysis and I accept them. Therefore, I do not find it necessary to analyse further whether the worker's PTSD meets the criteria in section 5.1 of the Act.

B. Was there an event?

[59] The policy notes in heading B that in all cases, the event must be identifiable. The worker's subjective statements and response to the event are considered; however, this question is not determined solely by the worker's subjective belief about the event. The Board also verifies the events through information or knowledge of the event provided by co-workers, supervisory staff, or others.

[60] I consider that the event of April 20, 2012 (the verbal argument and physical confrontation between the worker and the coordinator) is identifiable. I rely upon the worker's testimony of the event. As well, I infer that the employer does not dispute that the April 20, 2012 event is verifiable and that it occurred, but makes arguments about the proper characterization of the event under heading C. I will deal with these aspects of the employer's arguments below.

C. Was the event "traumatic?"

[61] The policy provides in heading C that a "traumatic" event is an emotionally shocking event, which is generally unusual and distinct from the duties and interpersonal relations of a worker's employment. The policy notes that all workers are exposed to normal pressures and tensions at work which are associated with their duties and interpersonal relations connected with the worker's employment.

[62] Although it is not binding on me, I considered the Board's Practice Directive #C3-3 useful as it assists in clarifying the Board's approach to heading C of item #C3-13.00. The practice directive notes that the policy does not define "emotionally shocking" or "traumatic." The practice directive goes on to review several dictionary definitions of those terms and concludes that, common to the definitions of those terms is an element of emotional intensity, as well as distinctiveness from the ordinary course of events. For example, the practice directive states that *Black's Law Dictionary* defines "shock" as "a profound and sudden disturbance of the physical or mental senses, a sudden and violent physical or mental impression."

[63] The practice directive goes on to discuss how an event can be considered distinct from the ordinary course of events in an occupation with reference to several examples. While it would be commonplace and predictable for an operating room nurse to see blood, a police officer getting shot would still be an uncommon occurrence (and would also involve an element of danger or intensity that would go towards the event being

characterized as "emotionally shocking"). The practice directive also recognizes the direction in item #C3-13.00 that employment in a high stress occupation is not a bar to compensation.

[64] I find that the weight of the evidence establishes that the April 20, 2012 event was traumatic. I rely upon and accept the worker's testimony of the emotional intensity of the situation when she was physically confronted by the coordinator and blocked from leaving the coordinator's office. I consider that a reasonable person would view this event as emotionally shocking. My reasons for this conclusion follow.

[65] As a registered nurse, I accept that the worker's occupation involves a considerable degree of interaction with others, including patients, their families, and co-workers. It is likely predicted that the occupation of nursing would involve negative interactions, particularly with patients and their families, given that they may have to communicate decisions about treatment that will have a significant impact on the health and well-being of their patients.

[66] As for negative interactions with co-workers, I also accept that it is reasonable to predict that such events would be commonplace. The subject matter of such negative interactions may involve disagreements over treatment or practice options. They may also rise to the level of interpersonal conflicts, as noted by the employer.

[67] Thus, I consider that the portions of the April 20, 2012 event that involved a verbal altercation between the worker and the coordinator were not traumatic. The subject matter of the argument involved the worker's decisions about nursing care for a patient. I find that this type of disagreement would be commonplace in the worker's occupation.

[68] However, I am unable to find that the aspects of the April 20, 2012 event that involved a physical confrontation (grabbing of the worker's wrist) and a blocking of the office door (which prevented the worker from leaving the coordinator's office) were predictable or commonplace for the worker's occupation. I consider that not only was the use of physical force inappropriate, it involved an element of intensity that made the event distinct from the ordinary course of events in the nursing occupation.

[69] I disagree with the review officer that the coordinator's actions were only aimed at stopping the worker from leaving the office to keep her engaged in the argument (as opposed to abuse the worker or threaten her) and that the coordinator's grabbing of the worker's wrist was not painful and did not cause injury.

[70] I accept that the objective elements of an event must be examined to determine whether an event is traumatic. I also acknowledge that Dr. Kramer concluded that the event was not traumatic, in reference to the criteria outlined in the DSM (which emphasize the life-threatening nature of a traumatic event).

[71] However, in my view, the subjective elements or reaction to an event must also be considered in adjudicating whether an event is traumatic or not. In this case, I accept the worker's testimony that she advised the coordinator that she wished to leave the office and that when she was prevented from doing so, the worker became visibly distraught and advised the coordinator that she felt "trapped." In my view, these aspects of the worker's testimony establish that the worker felt a profound and sudden disturbance of her physical and mental senses. Thus, I consider that the latter portion of the April 20, 2012 event rose to the level of being traumatic and the criteria in heading C are met.

D. Causation: Was the mental disorder a reaction to a traumatic event arising out of and in the course of the worker's employment?

[72] The policy notes in heading D that there are two elements to this question. The first part (namely, "arising in the course of the worker's employment") refers to whether the traumatic event happened at a time and place and during an activity consistent with, and reasonably incidental to, the obligations and expectations of the worker's employment. The policy also refers to the second part of the causation test (namely, "arising out of the worker's employment"). This refers to the cause of the mental disorder. Both employment and non-employment factors may contribute to the mental disorder. However, in order for the mental disorder to be compensable, the traumatic event has to be of causative significance, which means more than a trivial or insignificant cause of the mental disorder.

[73] The policy also notes that the Board reviews the medical and non-medical evidence to consider whether:

- there is a connection between the mental disorder and the traumatic event, including whether the traumatic event was of sufficient degree and/or duration to be of causative significance in the mental disorder;
- any pre-existing non-work related medical conditions were a factor in the mental disorder; and
- any non-work related events were a factor in the mental disorder.

[74] The policy notes that the Board is required to determine whether there is sufficient evidence of a traumatic event that is of causative significance in the mental disorder. Where there is insufficient evidence that the traumatic event arose out of and in the course of the worker's employment, the mental disorder is not compensable. A speculative possibility that the traumatic event contributed to the mental disorder is not sufficient.

[75] Having reviewed the evidence, I find that the weight of the evidence establishes that the worker's mental disorder (namely, Major Depressive Disorder) arose out of and in the course of the worker's employment on April 20, 2012.

[76] In reaching this conclusion, I examined the non-medical and medical evidence about whether there is a connection between the mental disorder and the April 20, 2012 event, including whether the event was of sufficient degree and/or duration to be of causative significance. I acknowledge that the latter portion of the April 20, 2012 event involving the physical confrontation between the worker and the coordinator would have been of a brief duration (the worker estimated that this lasted only one minute). However, I accept the worker's subjective perception and view of the degree of emotional intensity of the event, particularly that she felt trapped in the office and that the argument carried on for another seven minutes following the physical confrontation at the office door.

[77] I also accept Dr. Kramer's analysis of the causative significance of the April 20, 2012 event in producing the worker's Major Depressive Disorder. I find that his analysis is consistent with the remainder of the file evidence, particularly that the worker had no prior psychological problems, her reaction to the event was immediate, and that there was no other possible cause for the mental disorder. I found his analysis persuasive as it was based on a thorough review of the file evidence and a detailed clinical interview. He also provided detailed reasons to support his analysis. Although Dr. Kramer acknowledged that the worker's test results on the PAI were inconsistent, he also provided a reasoned analysis for this inconsistency and I accept his opinion that the worker did not deliberately attempt to complete the test inconsistently.

[78] I note that there is no contrary expert opinion on the matter of causation to weigh against Dr. Kramer's opinion.

E. Section 5.1(1)(c) exclusions

[79] The policy provides under heading E that there is no entitlement to compensation if the mental disorder is caused by a decision of the worker's employer relating to the worker's employment. The Act provides a list of examples of decisions relating to a worker's employment which include a decision to change the work to be performed or the working conditions, to discipline the worker, or to terminate the worker's employment. This statutory list of examples is inclusive and not exclusive. Other examples may include decisions of the employer relating to workload and deadlines, work evaluation, performance management, transfers, changes in job duties, layoffs, demotions, and reorganizations.

[80] The Board's practice directive provides there may be situations that fall outside these "routine" employment issues that give rise to a compensable mental disorder, such as targeted harassment or another traumatic workplace event. It is important to consider the specific facts of each case. An employer has the prerogative to make decisions regarding the management of the employment relationship, but this does not mean that decisions can be communicated in any fashion.

[81] The Board's practice directive goes on to state that the fact that decisions of the employer were communicated in a manner that was upsetting to the worker is not determinative of the issue. Heated exchanges or emotional conflict at work over matters such as discipline, performance, or the assignment of duties are not uncommon. In order for the conduct of the person communicating the decision of the employer to fall outside routine employment issues, one should consider if the conduct was in some way abusive or threatening.

[82] Having weighed the evidence, I find that the worker's claim for compensation for a mental disorder is not excluded by virtue of section 5.1(1)(c) of the Act. My reasons for this conclusion follow.

[83] I consider that the April 20, 2012 work event and the actions of the coordinator cannot be considered "a decision of the worker's employer relating to the worker's employment" within the meaning of section 5.1(1)(c) of the Act.

[84] The term "the worker's employer" in section 5.1(1)(c) is not defined in the Act, policy, or in the practice directive. Although there is a general definition of "employer" in section 1 of the Act (namely, every person having in their service under a contract of hiring or apprenticeship a person engaged in work), there is no further explanation of who constitutes the worker's employer for the purposes of section 5.1(1)(c).

[85] However, after reviewing several dictionary definitions of the term "employer" and considering the definition of section 1 of the Act, I consider that the coordinator was and is not the worker's employer. The definition in section 1 of the Act implies that to be an employer, the employer-employee relationship of contract of service should exist and that the employer has control of that relationship. The *Black's Law Dictionary* definition emphasizes the element of control in defining who is an employer. In the 7th edition of *Black's Law Dictionary*, "employer" is defined as "a person who controls and directs a worker under an express or implied contract of hire and who pays the worker's salary or wages."

[86] In this case, the worker testified that the coordinator is not her supervisor. The employer did not challenge that portion of the worker's testimony. While I accept that the employer in this appeal is a large entity that would have many officers acting on behalf of the employer in any given instance, I consider that the "worker's employer" for the purposes of section 5.1(1)(c) of the Act would be one of the officers that would have direct supervision and control over the worker's working conditions, work performance, work schedules, *et cetera*. The weight of the evidence is that the coordinator is a co-worker of the worker, as opposed to her employer.

[87] Moreover, I am not persuaded by the weight of the evidence that the coordinator's actions on April 20, 2012 were an attempt to communicate a "decision" of the employer. I acknowledge that the policy takes a broad approach to what constitutes decisions relating to a worker's employment, as decisions can touch on many aspects of a

worker's employment and are not restricted to such fundamental areas of a worker's employment such as continuation of employment, discipline, or salary. I accept that the subject matter of the April 20, 2012 work event involved patient care and the worker's treatment decisions and work performance. However, I consider that the coordinator's actions on April 20, 2012 were not an attempt to communicate any "decision" of the employer but appeared to be an attempt to bring a concern to the worker's attention, which then escalated into a negative interpersonal conflict and physical confrontation/blocking of the office door.

Conclusion

[88] I allow the worker's appeal and vary the review officer's December 5, 2012 decision. I find that the worker has a mental disorder (namely, Major Depressive Disorder) that was a reaction to a traumatic event that arose out of and in the course of the worker's employment on April 20, 2012. I find that the criteria in section 5.1 of the Act are met and that the worker's claim for compensation for a mental disorder should be accepted.

[89] It was reasonable for the worker to have sought Dr. Behboodi's July 7, 2013 medical-legal opinion in connection with this appeal. I order the Board to reimburse the worker's union $250 for this expense, upon presentation of proof of payment.

[90] There was no request for reimbursement of any other appeal expenses and accordingly I make no additional order in that regard.

Luningning Alcuitas-Imperial
Vice Chair

LA/gw

[i] Minor formatting correction made