

Workers' Compensation Appeal Tribunal

Decision #183

Claim No.: 3000-4878

Date of Notice of Appeal: December 6, 2010

Date Notice received at the Tribunal: December 10, 2010

Date of Oral Hearing: March 9, 2011

Date of Decision: May 6, 2011

Appeal Committee Members appointed under s. 64 (1) of the *Workers' Compensation Act*, S.Y. 2008, c. 12

Committee Chair:	H. Leenders
Member representative of employers:	H. Hermanson
Member representative of workers:	W. C. Gryba

In attendance: The Worker
The worker's spouse
The worker's representative – Derek Holmes
Observer - Mark Hill, Director, Corporate Services, YWCHSB
Recorder - Vernna Johanson

Location: Room #201, 419 Range Road
Whitehorse, Yukon Territory

Introduction

The worker was employed as an apprentice carpenter. On August 25, 2009 he filed a claim at the Yukon Workers' Compensation Health & Safety Board (the "board") for an electrical shock injury he suffered to his left hand on August 21, 2009 while rolling up an electrical cable that had a cut in the insulation. It was raining at the time and he was standing in a puddle of water. The claim was accepted by the board and he was provided with one week's wage loss and medical benefits.

A case manager (adjudicator) notified the worker by letter dated November 9, 2009 that his ongoing symptoms did not arise out of his employment. The worker provided new medical reporting and a further decision letter was provided by the adjudicator on April 13, 2010. She found that the shock injury did not accelerate nor aggravate the worker's non-compensable pre-existing disorder and he was not entitled to further compensation benefits.

The worker appealed to a hearing officer. On November 26, 2010 the hearing officer confirmed the adjudicator's decision and denied further compensation.

The worker asks the tribunal to reverse this decision because, he believes, the medical evidence was not correctly weighed and his post-traumatic stress disorder was a condition that flowed directly from the accident. He requests acceptance of the claim and retroactive re-instatement of compensation benefits.

[1] The worker and his wife attended the hearing and testified by affirmation. He was represented by the Workers' Advocate. The employer was notified of the appeal but did not attend. The proceedings were recorded.

Evidence

[2] The appeal committee considered the worker's and his wife's testimony, the advocate's submissions, board policies as noted below, and the entire claim record as provided by the board.

Jurisdiction

[3] On December 10, 2010 the worker submitted an appeal of the hearing officer's November 26, 2010 decision to the tribunal under s. 53 of the *Workers' Compensation Act*, S.Y. 2008 (the "Act"). The review (appeal) should be determined according to the *Workers' Compensation Act*, S.Y. 2008, c. 12. Section 65(1) of the *Act* gives the appeal tribunal jurisdiction to hear and decide this appeal.

[4] The worker filed a claim for an injury which occurred on August 21, 2009. Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. In this instance the *Workers' Compensation Act*, S.Y. 2008 should be used to determine the issues of entitlement.

[5] The board provided the following policies to the tribunal as relevant to this appeal under the authority of section 64 (4) of the 2008 *Act*:

- Policy EN-02, Merits and Justice of the Case
- Policy EN-09, Adjudicating Psychological Disorders

Evidence from the Record

There are two Workers' Report of Injury/Illness and two Employers' Report of Injury/Illness. The worker filed a further report of injury while employed as a front desk manager which noted the date of injury as May 11, 2010. When questioned about the second report, the worker stated he first experienced symptoms on August 21, 2009. We will address the original incident only.

- [6] The Workers' Report of Injury/Illness dated August 25, 2009 states he injured his left hand as follows:

During heavy rainfall, I was reeling up a 220 volt cable. The cable had a split in it and end of cable was in water. Felt electrocution for at least 3 seconds knocking me backwards.

The worker reported that he initially felt symptoms but they got progressively worse over time.

- [7] The first aid attendant completed a report on August 21, 2009. He noted the nature of injury/illness as "shaky, dizziness, trouble breathing, trouble speaking (at one point)". The attendant states he immediately went to the worker and brought him to the first aid trailer. He spoke with him and observed him for 10 to 15 minutes. The first aider decided the worker needed to go to the hospital so he drove him there.

- [8] The file contains a report dated August 9, 2004 by Dr. A. Wilson, Medicine and Neurology, Canmore, Alberta to Dr. Dale Lintott, Lake Louise, Alberta. Following are excerpts from the report:

This thirty-two year old right-handed man complains of symptoms that have been present for about thirteen years. He has spells that he described as involuntary muscle reactions. The spells occur two or three times per day and last from 1.5 to 10 hours at a time. Anywhere from thirty seconds to ten minutes after the onset of his symptoms, he develops spasms in the head, neck arms, and legs. The description of the symptoms would be consistent with either a multifocal myoclonus or a multiple tic type of movement abnormality.

He has been tried on SSRI types of therapies for treatment of anxiety.

Two years ago he had an EEG done in the Vancouver General Hospital. To his knowledge, that test was normal.

[The worker] describes an episodic multiple tic or multiple myoclonus-like disorder.

- [9] A further report by Dr. Wilson dated August 11, 2004 states in part:

After reviewing the literature regarding [the worker's] movement disorder, I would conclude that the primary problem could be explained by a

complex tic syndrome. . . . It is possible that [the worker] may have a form of Tourette's.

I cannot explain the description of his symptoms of multifocal myoclonic disorder. The fact that [the worker] can somewhat suppress the abnormal movements is more in keeping with a tic abnormality. When a person has a movement disorder of the nature that he has described for a period of greater than twelve months, then it is considered to be a chronic state.

- [10] Dr. Jamieson's August 21, 2009 Doctor's First Report and accompanying Functional Abilities Form (FAF) states the worker attended with complaints of a tingling left hand. Dr. Jamieson wrote: "Inspected – no entrance or exit burns, hand exam normal. ECG shows normal rhythm, patient was monitored x 2 hours – no arrhythmia." He diagnoses "electric shock left hand, no injury." The FAF notes "patient has no functional limitations – off work today to recover then return to full duties."
- [11] Dr. Ahmed completes another FAF on August 24, 2009. He reports, "continued rest advised due to ongoing amnesia, tremulousness, left hand tingling." The estimated duration of functional limitations is noted as 7 days.
- [12] An Ambulatory Care Form from Whitehorse General Hospital dated August 24, 2009 at 1:10 p.m. states:
- Electrocuted on Friday. ECG done – normal. Still having pain on left hand. Blurred vision. Very emotional.
- History: Electrocuted three days ago. Loss of memory 36 hours after. Crying for no reason. Tingling of left hand. 2 second exposure – see WCB form. Hand appears normal – normal strength. Mild tremor right hand not left hand. Observe for a few days – off work – X7 – follow-up with family physician.
- [13] On September 2, 2009 an adjudicator writes a lengthy note to file after speaking with the worker. The worker said:
- He took Risperidone .5 mg. as a daily therapy and .5 mg Clonazepam (not daily)
 - He had a seizure while being shocked; he had not had one for years.
 - The seizures previously could last anywhere from 5 minutes to 36 hours.
 - He was scared about returning to work as he was now "gun shy".
- [14] The worker attended the board's chief medical consultant on September 9, 2009. The medical consultant rendered a report on September 10, 2009. Following are excerpts:
- [The worker] reports that he has been diagnosed with chronic multifocal myoclonus. This first started when he was in Britain and developed "seizures" which he describes as uncontrolled muscle jerking, particularly

in his neck, but in other muscle groups as well. He also feels a buzzing in his head and ears.

Both times that he tried returning to work, he noted a pounding heart and rapid breathing, along with muscle tightness and difficulty in concentrating. This made him even more tense as he works around saws and was increasingly vigilant about the possibility of a further injury.

On examination today he was a pleasant co-operative man who had quite obvious tremors in both hands, which he controlled by holding the arms of the chair. There were no obvious myoclonic jerks in the hour that I spent with him. Both he and [his wife] note that the spasms are episodic, sometimes lasting an hour at a time, but overall, they are less frequent than immediately after the electric shock.

He has no pain on axial loading and no evidence of non organic pain signs.

Although he describes a pounding heart, his heart rate is 72 and regular.

Reflexes were normal.

- [15] The worker attends Dr. Chau on September 14, 2009. Reporting of the same date indicates subjective complaints by the worker that he was recently electrocuted at work. Since then he has become more anxious. A history of myoclonus is noted for which he takes clonazepam and risperidone, although these are not controlling his symptoms. The worker reports that his depression is getting worse and he cannot return to work. He is not suicidal. Dr. Chau notes, "He has an addictive behaviour and is very wary of being started on any new medications or having his medications increased." He advises a "STAT psych referral and neuro referral."
- [16] On September 16, 2009 the worker sees Dr. Charles Tai, Neurology and Internal Medicine, for an assessment. Dr. Tai reports:

Assessment: [The worker] describes electrical shock in his left arm. I do not see any burns. I do not have an explanation for his symptoms such as forgetfulness, dysosmia, depression, loose stool and blurry vision. Clinically, I cannot explain electrical shock causing these symptoms.

He has long-standing movement disorder and I'm suspicious of tics rather than myoclonic epilepsy. We do not use haloperidol or risperidone for myoclonic epilepsy. These medications are typically used for tics.

It is important to clarify whether or not [the worker] has a seizure disorder. He is having recurrent body jerks on a daily basis. If he has a clear history of myoclonic seizure, we should treat these as potential seizures and his driving should be withheld. If his neurological diagnosis was tics, I would not be concerned. If this diagnosis was unclear, I suggest a repeat EEG.

Clinically, I have difficulties attributing his complaints to neurological injury relating to electrical shock.

- [17] Dr. Chau's progress report dated September 18, 2009 notes the worker is feeling much improved since his last visit. He did not find a therapeutic alliance with Dr. Tai; he found "the encounter rather disturbing". The worker has an appointment to see Dr. Laureijs "this a.m. (morning)."
- [18] On September 18, 2009 the worker sees Dr. P. Laureijs for a psychiatric assessment. Following in part is her report:

Current Challenges: [The worker] reports that his current mental health difficulties began in early May 2009. Apparently, he had been shot in the wrist with a nailer, attended Emergency Services, and was back to the worksite two hours later. He notes that he became aware of other safety incidents on the jobsite with other workers. He began to ruminate about same, and became progressively more fearful for his own life, particularly in light of his impending marriage next year.

Past Psychiatric History: [The worker] describes his past psychiatric history, dating to 16 years ago, when he experienced panic attacks that he would have daily. He was briefly on Paxil for a month, and I'm unclear as to how this was discontinued. But he reports that, over the years, the frequency of his panic attacks was reduced to one to two per year, in large part due to the effect of the risperidone. There has been no formal psychiatric assessment in the past.

He has a past history of heavy, sustained alcohol abuse. He describes that he has been drinking fairly heavy since the age of 17 years and has a history of blackouts, but no withdrawal symptoms. He describes that last year, in the context of having some emotional stressors, that he was consuming approximately 13 ounces of alcohol per day and 40 ounces on the weekend. He notes that he has curtailed this pattern of drinking since last November. He drinks one or two Caesars each night, when his partner returns home.

Impression: . . . He certainly appears to have longstanding challenges with anxiety and panic disorder that have quite likely responded to his antipsychotic medication over the past years.

Unfortunately, his neurological situation is not entirely clear, although Dr. Tai appears to have ruled out many of his current somatic complaints as having a neurological basis at this time. Certainly, some of those symptoms could be exacerbated by, or attributed to, his increased anxiety and his panic symptoms, including his tremulousness,

his confusion, and his blurred vision. . . . Certainly, at the present time, he appears to meet the minimum baseline criteria for a major depressive episode, of moderate intensity, with significant comorbid anxiety and panic.

Historically, he also appears to have challenges with anxiety, but it is not clear whether he would have met the criteria for a panic disorder or generalized anxiety.

As well, there appears to be a history of alcohol abuse and dependence, which he advises is no longer a concern, although he continues to consume alcohol regularly.

He does not meet the minimum baseline criteria for a psychotic disorder.

Differential Diagnosis:

Axis I: Major depressive disorder – moderate, with significant comorbid anxiety and features of panic, nonpsychotic, and no active suicidal ideation. There would appear to be a historical diagnosis of alcohol abuse/dependence that is in remission.

Axis II: Deferred.

Axis III: “Electrocution”

Axis IV: Parent/child relationship issues, financial stressors, vocational stressors.

Axis V: GAF (Global Assessment of Functioning): 45 to 55.

- [19] Dr. Chau’s progress report of September 24, 2009 states he spoke to Dr. Laureijs after the worker’s recent visit. She stated that the worker suffers from “classic panic attack and generalized anxiety disorder.” A Functional Abilities Form completed by Dr. Chau on September 24th states the worker can return to work at reduced hours; he has limitations due to medications. Dr. Chau reports:

Due to mental status, patient has been advised to be removed from the workplace environment and needs two weeks off until he is reassessed by myself and Dr. Laureijs. The workplace seems to be exacerbating his symptoms so removal will be of benefit. To consider retraining in a different line of work.

- [20] Dr. Chau’s progress report of October 8, 2009 states the worker was in for a follow-up visit. He has found that Celexa is helping to control his depression, his mood is improved and his tics are less frequent. The worker stated he was afraid of the workplace and is looking for other employment.

- [21] An October 9, 2009 case manager's note to file states she had a telephone conversation with the worker. He stated that since Dr. Wilson's 2004 diagnosis he has been asymptomatic; he believes this is because of his risperidone medication. Previously, his symptoms included panic attacks, chest tightness, unable to breathe, blurred vision, tingling in his left arm and hand, confusion, involuntary spinal, leg and arm movement and constant tremors in his hand. The worker stated that all the symptoms were present prior to the 2004 diagnosis but since then he had not experienced any until the electrical shock. Since the shock he said he experiences all the symptoms, but to a greater degree. He no longer enjoys some recreational activities as he did before the incident. The worker "feels he cannot return to work with . . . because he doesn't trust he won't keep his co-workers safe because of his current symptoms."
- [22] The worker attends Dr. Laureijs on October 15, 2009 for a follow-up appointment. She notes his current psychiatric medications as: risperidone 0.5 mg do; clonazepam 0.5 mg prn; Celexa 10 mg pox do for two weeks (increased to 20 mg when he attends Dr. Chau). Dr. Laureijs reports:
- Impression: [The worker] appears to be tolerating the antidepressant well. Although subjectively he voices some improvement in his symptoms, objectively he presents fairly similar to his initial assessment, with significant anxious and depressive ruminations.
- As he [should be we] discussed, he is a good candidate to be off work for the next three months or so, while he continues to regain some sense of normal functioning and day-to-day routine.
- Dr. Laureijs suggestions and recommendations include:
1. Increase his Celexa to 20 mg pox do; in two weeks increase to 30 mg. "with his significant anxious co-morbidity".
 2. Engage in non-pharmacological measures including personal care, regular physical activity, sunlight exposure and leisure pursuits.
 3. The role of alcohol was discussed and the fact that chronic use can have depressant effects. The worker said he would work on minimizing his use.
 4. A follow-up visit in a month's time. The worker planned on self-referring to Mental Health Services for additional therapeutic support.
 5. A referral to his previous neurologist in Calgary.
- [23] Dr. Chau refers the worker to Dr. Wilson on October 16, 2009. A medical EI form is completed. The worker's Celexa dosage is increased to 20 mg. daily.
- [24] The case manager writes a note to file on October 20, 2009 stating the worker has been offered a job in the hospitality industry starting later that week at a maximum of 8 hours per day. He will start with low key contacts and will complete menial tasks.
- [25] Dr. Torie Carlson, registered psychologist, reports on November 9, 2009 in response to a request from the case manager for an opinion on whether the worker's ongoing psychological symptoms are suggestive of a diagnosis of Post-Traumatic Stress Disorder (PTSD) with

respect to a work-related electric shock. Dr. Carlson reviews the medical documentation provided and reports as follows:

Impression:

1. There is adequate documentation of pain disorder and anxiety since the accident in August 2009. However, these diagnoses are documented in this file back to 2004 at which time he was seen by the neurologist, Dr. Wilson. This indicates at the very least, a pre-existing condition in regards to symptoms of anxiety and panic.
2. The reports from Dr. Laureijs, an expert in psychiatric disorders, does not discuss the possibility of PTSD and instead diagnoses Major Depressive Disorder – moderate, with significant co-morbid anxiety and features of panic, non psychotic, and no active suicidal ideation.
3. It is unclear to me what symptomology is being observed that is consistent with PTSD. In reviewing the symptoms documented here he does not meet criteria for PTSD specifically criteria A which indicates that the person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, (2) the person's response involved intense fear, helplessness, or horror. There is no evidence in the file that [the worker] experienced any of these symptoms immediately following the incident. There are reports that he was angry and threw the power cord at his boss. He then presented to the ER where he spent two hours being assessed and was discharged with reassurance that he was fine to return to work.
4. It appears clear that [the worker] has a Tic Disorder. These are usually first diagnosed in Infancy, Childhood, or Adolescence. According to the Diagnostic and Statistical Manual of Mental Disorders IV, a tic is a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization. It is experienced as irresistible but can be suppressed for varying lengths of time. All forms of tic may be exacerbated by stress and attenuated during absorbing activities. Tics are usually markedly diminished during sleep. The onset for all tic disorders is before age 18 with the exception being a Tic Disorder Not Otherwise Specified.

Based on all of the reports and documentation reviewed, I do not feel that the diagnosis of PTSD would be the most responsible. A psychiatric professional who has met with [the worker] on two occasions has not made this diagnosis

and as noted above, he does not meet the criteria for such a diagnosis. Instead, he does appear to have ongoing symptoms of depression, anxiety, panic and tics. All of these, with the possible exception of depression, were present prior to the incident. It is unclear how prominent they were prior to the incident however or if they were in remission.

Recommendations:

. . . I would also encourage him to connect with a mental health worker to address his ongoing issues of anxiety and panic in order to learn strategies to manage these symptoms for long term psychological health. As [the worker] has been out of the workforce now for over two months, some sort of Return to Work plan looking at hours and duties may be beneficial to maximize his chances of success. The longer he remains withdrawn from the workforce, the more difficult it will be to return to it.

[26] The case manager provides a decision letter to the worker on November 10, 2009. She found that the whole body of medical evidence suggests “the electric shock injury of August 21, 2009 neither accelerated nor aggravated” the worker’s pre-existing non-compensable disorder. His claim for compensation is closed.

[27] Dr. Chau’s January 8, 2010 progress report notes the worker attended for follow-up. He is currently working at a local hotel for 5 hours per day, which he feels, is the maximum he can tolerate at this time. Dr. Chau mentions Dr. Wilson’s “note” which states the worker did have a minor traumatic injury to his head with brief loss of consciousness. Dr. Chau reports, “Dr. Wilson’s consultation indicates that suffering minor traumatic brain injury could exacerbate his underlying disease and hence may be the cause of his current symptoms.”

[28] Dr. Wilson reports on November 19, 2009 to Dr. Chau. Following is part of his report:

His blood pressure is 130/90. No bruits were audible in the head or neck. The cranial nerves were normal. . . . I did not observe any multiple tics or abnormal movements when he was sitting quietly. He exhibited a rhythmic tremor of his right arm and hand when it was held out in front. The tremor was much less but was also slightly evident involving the left arm. Finger-nose test and finger-nose-finger testing was normal with a slight degree of an intention tremor. Heel shin testing was normal. . . . With Romberg’s test he tended to step and almost fell backwards but he maintained his posture. . . . Sensory testing was normal.

Many of the emotional aspects of the symptoms could be attributed to a minor traumatic brain injury. He stated that he fell backwards and had a loss of consciousness when he was shocked. Those types of symptoms can persist for a number of months and could aggravate his underlying movement disorder. I did not think of this possibility until I was preparing this report.

The treatment for a mild traumatic brain injury is symptomatic. In that context I would recommend that he continue with his present therapies and psychological therapy is planned.

[29] The case manager asks 4 questions of Dr. Wilson on January 21, 2010. Dr. Wilson responds on February 15, 2010 as follows:

1. I would not consider it medically reasonable for the electrical shock that was documented to exacerbate [the worker's] pre-existing symptoms to the degree and duration that has evolved up to the time of my previous examination in November 2009.
2. The electrical shock would not cause a head injury. I was advised by [the worker] that he fell and struck his head. A fall could have caused a minor head injury. In view of the fact that there is no objective evidence that he sustained a head injury I would have to conclude that a head injury did not occur.
3. The psychological and psychiatry evaluations concluded that there were features of anxiety, depression, panic attacks and tics but no PTSD. As I have stated in my response to question #2, based upon the information that is now available I would conclude that a mild traumatic brain injury did not occur. I would not relate a minor electrical shock to specifically causing depression, anxiety, panic attack or tics. I would relate an accentuation of tics occurring as a result of depression, anxiety and panic attacks.
4. The involuntary muscle spasms or tics that had been present for 13 years and a possible seizure disorder would not have been pathologically accentuated but may have been psychologically accentuated by the injury. The long list of symptoms that are documented in my November 19, 2009 letter were obtained directly from [the worker]. He related an accentuation of those symptoms. In my opinion those symptoms are due to an exaggeration of his underlying psychological difficulties.

[30] The worker attends Dr. Chau on March 9, 2010 for a follow-up visit as "his symptoms are starting to worsen again". Dr. Chau's report follows, in part:

Patient states that he is in no condition to come off the clonazepam. He has started drinking alcohol again. He has a history of addiction and does not want to return to that state. He is seeing a counsellor at ADS (Alcohol & Drug Services) which helps. Apparently, WCB has sent a psychologist to come up from Alberta to do an assessment. Report not available. Patient now on wait list for MHS (Mental Health Services) which he feels will be helpful.

Treatment plan and medication

1. Start remeron 15 mg PO HS and increase to 30 mg PO HS in one week.
2. Continue ADS counselling.
3. Given number to Sean Hopkins for counselling until he can get into MHS. Feels counselling is best course at this time.
4. Await counselling with Mental Health. Patient does not feel that returning to Dr. Laureijs would be of benefit at this time.

[31] The worker is assessed by Dr. T. Carlson, psychologist on January 26, 2010. Following are excerpts from his March 30, 2010 report:

[The worker] is currently taking Clonazepam 0.5 mg. one to two times per day. Risperidone 0.5 mg two to three times per day. Bromocriptine 2.5 mg two to three times per day.

Summary and Conclusions

Currently [the worker] does NOT currently meet diagnostic criteria for posttraumatic stress disorder (PTSD) as previously queried. . . . Following the current assessment, there is no data to support a diagnosis of PTSD.

According to the DSM-IV, the individual must develop characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2). [The worker] DOES NOT appear to meet Criterion A1 based on his emotional response and cognitive processing of the event in that he did not feel his life was in danger. Criterion A2 also appears clear, in that I was unable to find specific references to "intense fear, helplessness, or horror" and was unable to document those in the interview.

The characteristic symptoms resulting from the exposure to the extreme trauma included persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D).

[The worker] DOES currently report persistently re-experiencing the traumatic events (Criterion B). Specifically, when he has a muscle spasm or tic episode he has psychological (Criterion B4) as well as physiological activity (Criterion B5).

[The worker] DOES NOT meet Criterion C fully in that while he does report avoidance of some stimuli associated with the trauma, he does have enough of the symptoms.

In terms of Criterion D, [the worker] did report a history of anxiety-like symptoms that complicate the picture. To meet this criterion, the persistent symptoms of increased arousal must not be present before the traumatic event. It remains unclear as to whether these symptoms existed prior to the 2009 event.

In the weeks following the incident, Dr. Laureijs, an expert in psychiatric disorders, diagnosed [the worker] with a Major Depressive Disorder – moderate, with significant co-morbid anxiety and features of panic, non psychotic, and no active suicidal ideation. At the time of the current assessment, [the worker] was reporting less of the depressive symptom and more of the anxiety symptoms. He does not currently meet full criteria for this diagnosis.

Therefore, at this time, given the questionnaire and interview data, as well as the review of the medical records, I feel that the most responsible diagnosis is a generalized anxiety disorder.

Etiology

There does not appear to be evidence of significant pre-existing or co-existing psychological, occupational, and substance use difficulties.

Limitations and Restrictions

There does not appear to be any physical limitations or restrictions but I leave that to the purview of [the worker's] physicians. [The worker] is not currently psychologically restricted from any occupational activities in my opinion. He would likely find benefit for his anxiety disorder specifically tailored to assist him in returning to full employment.

Prognosis and Treatment Recommendations

[The worker's] previous functioning, personality, love of the outdoors, and reported job success are strong prognostic indicators. To my knowledge [the worker] has not engaged in significant mental health resources designed to assist him in learning to address the anxiety issues and symptoms of depression.

The biggest barrier to return to work is his confidence and negative thinking.

[32] The case manager writes to the worker on April 13, 2010 after considering Dr. Wilson's February 15, 2010 and Dr. Carlson's March 30, 2010 reports. She re-affirms her November 9, 2009 decision in which she found his ongoing symptoms did not arise out of his employment.

[33] A report dated August 15, 2010 by Sara Jungen, M.A., Registered Psychologist states the worker travelled to Calgary for “about 9 days to receive counselling services due to the alleged prohibitive wait-times for Mental Health services in his hometown of Whitehorse.” She reports in part as follows:

My provisional diagnosis of [the worker] based on self-reports and corroborating evidence from his wife, is that he has Post-Traumatic Stress Disorder (PTSD) resulting from electrocuting himself at work in August 2009.

[The worker] was treated for PTSD using Eye Movement Desensitization and Reprocessing (EMDR) from July 21 to July 26, 2010 for a total of 7.5 hours. [The worker] responded well to the EMDR treatment with Subjective Units of Distress (SUDS) being virtually eliminated for the incident of electrocution and earlier traumas.

[34] The case manager requests via letter dated September 8, 2010, that Ms. Jungen provide her confirmed DSM/PTSD assessment/diagnosis and her professional credentials as a clinical psychologist or psychiatrist. There is nothing contained on file which indicates Ms. Jungen provided either.

[35] The worker appealed the case manager’s decisions to the hearing officer. A hearing was held on November 9, 2010 and a decision was rendered on November 26, 2010. The hearing officer was in “total agreement” with the case manager that the worker’s ongoing symptoms were not due to the electric shock of August 21, 2009; his ongoing symptoms did not arise out of his employment.

The Worker’s Testimony

[36] The worker spoke about the anxiety he had several years before the incident in August of 2009. He said he was working at a high-end resort in the Rockies. He worked long hours, sometimes up to 16 hours per day and it was a very high pressure job. He said if he did not get enough sleep or if he worked 6 to 7 days a week, towards the end of the day, he would experience pressure in his chest and a “panic attack”. He attended Dr. Oshry at Lake Louise, he believes in the spring of 2004 who prescribed a low dose of medication. Within 4 days to a week, the worker said he did not experience any more symptoms after taking the medication.

[37] The worker testified that the day of the accident, August 21, 2009, it was pouring rain all day. He was working on the new Correctional Centre and needed to get an electrical cable in order to plug in a tool. He was reeling in a 220 volt cable from a power box that was attached to a 10,000 volt cable. He remembers the end of the cable was in a puddle. There was a slice in the part of the cable that brushed against his hand. He felt “immense, blinding heat”. He said he told his co-workers who were standing nearby that he thought he had been electrocuted. He went directly to the First Aid Station which was about 50 to 60 ft. away and collapsed against a vehicle. He was taken to the lunch area but was soon taken to the hospital.

- [38] The worker said after the incident, there was a “cloud of confusion”. He felt hopelessness and a lot of confusion; he was constantly shaking, sometimes quite violently. He had convulsions and sometimes nightmares, had difficulty sleeping, had mood changes and behaved erratically towards his wife. He did not know what was wrong with him.
- [39] The worker testified that his family physician, Dr. Chau, advised him to take more time off work as he thought the worker had PTSD. The worker said this is the reason he went to ADS (Alcohol Drug Services) because Krisztian Kalasz is a specialist in PTSD. The worker said he has been a great source of help to him.
- [40] The last time he spoke to board staff, he said he was told in a very rude manner, that if he thought something was wrong with him, he should see someone who would say there is something wrong with him. He would call every day crying and begging for help. He did not know what was wrong with him. He was going through a very difficult time, crying constantly for no reason. All he was told to do was to go back to work. He stopped calling the board because he realized that he had to help himself because he was not getting help anywhere else.
- [41] The worker said he found Sara Jungen via an internet search. He flew to Calgary to visit her and to receive treatment for his PTSD. The cost of treatment including his travel and accommodation costs were approximately \$3700. Ms. Jungen diagnosed him with PTSD and he underwent EMDR treatments. The worker said this is a psychological process to deal with emotional trauma and to basically “get the right brain talking to the left brain” and to get people back on their feet and functioning.
- [42] After his treatment with Ms. Jungen he said he felt relief for about a week to 10 days and then he started regressing again. He would call Ms. Jungen on the mornings he was feeling particularly bad and she would “talk him through” and “calm him down”. Other ways to alleviate his symptoms would be for him to listen to Buddhist chanting, meditate and undertake breathing exercises. This allowed him to return to work, at first for a couple of hours per day, until October of last year when he was working almost full-time again.
- [43] When asked to compare the symptoms that developed after the accident to those symptoms when he was first diagnosed with the “minor anxiety” previously, the worker compared the previous symptoms as having a paper cut to the post-accident symptoms as terminal cancer. He said the symptoms kept on evolving and getting worse. The convulsions, tics and shaking got worse. He was moody and had an attitude toward everything. He said that he became suicidal.
- [44] He said before the accident he was unaware of what PTSD was; however, 2 days post-accident he testified he was back in the Emergency Department because he was constantly shaking. A gentlemen in the Emergency Department, (the worker could not remember who it was), suggested it was PTSD and told him to see his doctor. His doctor advised him to remain off work for 3 weeks.

- [45] The worker said that Krisztian Kalasz used to work for the Ontario government specializing in treating people with trauma and PTSD. Mr. Kalasz is now employed as an Addictions/Mental Health Counsellor at Alcohol Drug Services in Whitehorse. The worker has been seeing him one or two times a week since the incident.
- [46] When questioned about Dr. Laureijs, the worker testified that he stopped seeing her because he felt her reports were not correct. He said that he has never taken Paxil as Dr. Laureijs noted in one of her reports. When he mentioned to his family doctor that he did not want to see Dr. Laureijs, Dr. Chau “made” him go see Dr. Heredia, a local psychiatrist.
- [47] The worker testified that when he was 23 years old, for a period of 5 or 6 days he tried an anti-depressant. He said, “I’m not depressed. This is not me. I don’t have a problem with depression.” He believes that Dr. Laureijs took that in the wrong context. He reiterated that her reports were not 100% accurate. Another reason he stopped seeing her was that she said he was a manic-depressive. He did not feel that he was although he did get depressed sometimes. The worker said Dr. Heredia also suggested he take anti-depressants. He refused because Dr. Laureijs had him taking 12 to 16 pills a day. He stopped seeing her because he did not think she was being helpful. He prefers to do things “mentally”; he likes sitting down and talking to someone rather than taking pills.
- [48] The worker said Dr. Oshry in Lake Louise prescribed low dosages of risperidone and clonazepam. He stopped taking these medications in December 2010. He does however take 30 mg. of Propranolol prescribed by Dr. Heredia. He says that this drug helps to alleviate his anxiety and tenseness. This has helped him to function and return to work full-time.
- [49] The worker testified that his education focussed on International Resort Management. He started in the hospitality industry in 1993. Every hotel he has worked at has been in the top 5 either in North America or in the world – high-end hotels or resorts. He has always been employed in either management or supervisory positions. His last position was as Manager of Revenue Management, based out of Calgary, with offices all over the world. He controlled 2350 hotels around the world with a team of 80 people.
- [50] After that job ended he said he stayed with a friend in Vancouver. He said he went up and down the West Coast looking for a job and ended up back in the Rockies looking for work in the hospitality industry. He said he could not get a job because he was over-qualified. The only positions available to someone with his experience and qualifications would have been a General Manager. Those positions very rarely become vacant. He did have job offers from lower-end hotels, but with his experience in a 5-star luxury hotel environment, he did not feel that he could take pride in working in these establishments. The worker said he “wandered around BC and Alberta for about 4 months”.
- [51] The worker said his mother lives in the Yukon and suggested he get a job in carpentry. He applied on a position and was hired the same day. He said that he really enjoyed the work and his co-workers. He testified that he was enrolled at Yukon College in his third year as an apprentice carpenter when the accident happened.

[52] He said he is currently working at a vehicle sales organization. His days off are split so he does not work 5 days in a row. It works perfectly for him. The employer has been very supportive and welcoming. He testified that he has been at this job for 3 weeks and he is doing fine.

The Worker's Wife's Testimony

[53] The worker's wife testified they have been together for 2 years but she has known him for 12 years. She said that before the accident the worker had a joy for life. He was active socially and physically. He was always out doing something new to challenge himself. He was happy. After the incident, the worker does not have the same joy for life. They no longer socialize and do not do things they used to enjoy such as hiking or rock climbing. She was beginning to lose hope. She said that the worker is finally starting to feel better.

[54] She said that she has taken an active role in her husband's recovery. She has attended many of his counselling sessions, especially in the beginning because she had concerns with her husband recounting things in the way they actually happened.

The Workers' Advocate's Submission

[55] The advocate submits the concept of the thin skull doctrine applies in this case. The board needs to take the worker as they find him. From the medical documentation on file, the worker did have a history of anxiety. The advocate says this is characterized by non-medical professionals as moderate and controlled. In the legal sense of the thin skull doctrine, that underlying condition was asymptomatic; it had no impact on the worker's day-to-day performance of his duties or the way he was living his life. This changed when he was electrocuted in the workplace by 220 volts.

[56] He says after the electrocution the file indicates a psychological deterioration. The residual effects of the injury were quickly mitigated but the psychological deterioration, characterized by some experts as anxiety and diagnosed by Sara Jungen as PTSD, continued. The advocate submits that a diagnosis of anxiety and PTSD overlap.

[57] They ask that the tribunal focus on the impact of the psychological deterioration. He asks, but for the accident, would the worker have been disabled from being at work on a full-time basis in the intervening period? But for the accident, would the worker have developed the symptomology, all the issues he had while he was not working? The advocate contends the evidence on the file indicates this is not the case.

[58] The advocate says the worker has tried to mitigate his damages. He attended ADS (Alcohol Drug Services) counselling just to get some sort of support so he could return to work. He has co-operated fully with all of the advice that he has been given. The advocate submits the worker should have received psychological support for his injury. He submits the worker took longer to recover from his injury and therefore did not return to work as soon as he could have if had received support.

- [59] He says the medical reporting indicates there was an underlying condition. The condition was asymptomatic prior to the accident. The worker's life changed for the worse markedly on the day of the accident. It is only recently that he has been able to return to work full-time.
- [60] The advocate submits the worker was injured while working as a carpenter. He got out of that industry because he knew he was petrified of power equipment and returned to the hospitality industry. This resulted in a cut to the worker's wages. He was able to only work half-time initially. Currently he is working for a vehicle sales organization on a full-time basis where he is able to take time off between his shifts.
- [61] The advocate submits the board did not properly apply Policy EN-09, "Adjudicating Psychological Disorders". Had they looked at the claim holistically as opposed to trying to draw a thin and artificial line on whether or not it was anxiety or PTSD, he says, but for the accident, the worker would not have experienced the difficulties and would not have incurred the losses of income that he did.
- [62] The advocate submits the worker has a confirmed diagnosis from three medical professionals that he suffers from PTSD. Those professionals are Sara Jungen; his family physician, Dr. Chau; and Krisztian Kalasz. He also mentions the chief medical consultant's report which notes that if the worker's symptoms persist, the diagnosis would be PTSD.

Relief Requested

- [63] The worker asks the appeal committee to reverse the hearing officer's November 26, 2010 decision and to find that his ongoing symptoms are work-related.
- [64] He requests that he be provided with the psychological treatment he requires to help him recover from the effects of the workplace injury and to restore him to the quality of life he had prior to the accident. He also asks for wage loss for the time he has missed work due to the condition.

Issue: Are the worker's ongoing symptoms work-related?

Answer: No

Analysis

- [65] The Notice of Appeal states the Reasons for Appeal as, "The medical evidence was not correctly weighed and as a result, the worker's PTSD diagnosis, a condition that flowed directly from the accident, was disregarded by the Board."
- [66] The workers' advocate introduced the aggravation or exacerbation of a pre-existing condition theory triggered by the workplace incident.
- [67] The appeal committee will consider the issue under the following headings:

I The worker's physical and psychological condition past and present

II The workplace incident

- Severity
- Aggravation or exacerbation of a pre-existing condition?
- Induce PTSD?
- Induce an Anxiety Disorder?

I The worker's physical and psychological condition past and present

[68] It is evident from the file and the worker's personal testimony that he had some sort of physical disorder for many years.

- Neurologist Dr. A. F. Wilson on the 9th of August, 2004 states:

This thirty-two year old right-handed man complains of symptoms that have been present for about thirteen years. He has spells that he describes as involuntary muscle reactions. The spells occur two or three times per day and last from 1.5 to 10 hours at a time. Anywhere from thirty seconds to ten minutes after the onset of his symptoms, he develops spasms in the head, neck, arms and legs. The description of the symptoms would be consistent with either a multifocal myoclonus or a multiple tic type movement abnormality.

At the onset of his spells, his vision becomes blurred and it is hard to focus. The visual blurring persists for about one hour. He will lose coordination and have difficulty concentrating at that time. His speech will be slurred and he will stutter. He will also have difficulty breathing and his heart rate will increase.

He cannot think of any particular process or activity that will induce the symptoms. When the symptoms are occurring he also feels a generalized shaking inside his body in addition to the spasms or movements that have been described. Recently, he has had a sharp, stabbing-like pain occurring in his head that lasts for about thirty seconds. That pain occurs with the symptoms.

He has been tried on SSRI types of therapies for treatment of anxiety.

He describes an episodic multiple tic or multiple myoclonus-like disorder.

- On the 11th of August, 2004, Dr. Wilson makes the following observation:

After reviewing the literature regarding [the worker's] movement disorder, I would conclude that the primary problem could be explained by a complex

tic syndrome. The hallmark of that type of disorder is a Gilles de la Tourette's syndrome. It is possible that [the worker] may have a form of Tourette's.

I cannot explain the description of his symptoms by a multifocal myoclonic disorder. The fact that the worker can somewhat suppress the abnormal movements is more in keeping with a tic abnormality. When a person has a movement disorder of the nature that he has described for a period of greater than twelve months, it is considered to be a chronic state.

- [69] From the foregoing it is evident that the worker had a movement disorder described by Dr. Wilson as a complex tic syndrome. A similar diagnosis by neurologist Dr. Tai in September 2009 was not as clear as he too was unable to relate the worker's symptoms to myoclonic epilepsy and concluded a probable tic disorder.
- [70] What is a tic disorder or Tourette's syndrome (TS)? The National Institute of Neurological Disorder and Stroke (NINDS) defines it as a neurological disorder characterized by repetitive, stereotyped, involuntary movements and vocalizations called tics.

The following are selected passages from the NINDS's website www.ninds.nih.gov/disorders/tourette/detail_tourette.htm

Although the symptoms of TS are involuntary, some people can sometimes suppress, camouflage, or otherwise manage their tics in an effort to minimize their impact on functioning. However, people with TS often report a substantial buildup in tension when suppressing their tics to the point where they feel that the tic must be expressed. Tics in response to an environmental trigger can appear to be voluntary or purposeful but are not.

People with TS have also reported problems with depression or anxiety disorders, as well as other difficulties with living, that may or may not be directly related to TS. Given the range of potential complications, people with TS are best served by receiving medical care that provides a comprehensive treatment plan.

Although tic symptoms tend to decrease with age, it is possible that neurobehavioral disorders such as depression, panic attacks, mood swings, and antisocial behaviors may increase.

From the mdguidelines contained on the website after the heading "complications", "stressful situations can aggravate tics."

- [71] The board chief medical consultant saw the worker on September 10, 2009. He noted the worker reported that he has been diagnosed with chronic multifocal myoclonus. This first began when he was in Britain and developed "seizures" which he describes as uncontrolled

muscle jerking, particularly in his neck, but in other muscle groups as well. He also feels a buzzing in his head and ears.

[72] On September 18, 2009 the worker saw psychiatrist, Dr. Laureijs, MD, FRCPC who diagnosed a major depressive disorder – moderate with significant comorbid anxiety and features of panic, nonpsychotic, and no active suicidal ideation. A follow-up visit with Dr. Laureijs on October 15, 2009 indicated no change in her diagnosis.

[73] Dr. T. Carlson, Ph. D., registered psychologist, was asked by the board to review the worker's medical records and comment on the same. On November 9, 2009 he reported:

Impression:

1. There is adequate documentation of pain disorder and anxiety since the accident in August 2009. However, these diagnoses are documented in this file back to 2004 at which time he was seen by the neurologist, Dr. Wilson. This indicates at the very least, a pre-existing condition in regards to symptoms of anxiety and panic.
2. The reports from Dr. Laureijs, an expert in psychiatric disorders, . . . diagnoses Major Depressive Disorder . . .
4. It appears clear that [the worker] has a Tic Disorder.

[74] Dr. Wilson's February 15, 2010 response to the case manager's queries notes the following:

- He would not consider it medically reasonable for the electrical shock that was documented to exacerbate the worker's pre-existing symptoms.
- The electrical shock would not cause a head injury or mild traumatic brain injury.
- The involuntary muscle spasms or tics that had been present for 13 years and a possible seizure disorder would not have been pathologically accentuated but may have been psychologically accentuated by the injury.

[75] The worker was formally assessed by Dr. T. Carlson on January 26, 2010. He states:

[The worker] recalled that in 1992 . . . he saw some medical doctors for what were thought at the time to be panic attacks. He noted that his symptoms then were worse during times of increased stress. He noted that over the years the "panic attacks" appeared to become conditioned to occur in the same places. For example, he stated that he had one of these attacks in a movie theatre once, that the next time he was in the theatre the chances of him having one increased. He reported that these attacks lasted from one to eight hours.

The worker also denies any suicidal ideation currently or in the past.

[76] Dr. Carlson rules out post traumatic stress disorder (PTSD) as the worker does not meet the diagnostic criteria as outlined in the Diagnostic and Statistical Manual of Mental Disorders

published by the American Psychiatric Association (DSM-IV is the latest version). He also rules out an Anxiety Disorder Due to a General Medical Condition upon Dr. Wilson's prognosis. Finally, Dr. Carlson concludes that the most responsible diagnosis is a generalized anxiety disorder.

[77] The committee, having reviewed the diagnoses of experts in this field of medicine, takes their findings as evidence that the worker has been and is still suffering from a generalized anxiety disorder. He also has a tic disorder.

[78] The workers' advocate submits the worker was asymptomatic prior to receiving the electrical shock at work. The worker testified that after he started taking the medicine Risperidone in 2004 he had been symptom free until the workplace incident in 2009.

[79] In a note to file on October 9, 2009, the case manager states:

Previously, his [the worker's] symptoms included panic attacks, chest tightness, unable to breathe, blurred vision, tingling in his left arm and hand, confusion, involuntary spinal, leg and arm movement and constant tremors in his hand. The worker stated that all the symptoms were present prior to the 2004 diagnosis but since then he had not experienced any until the electrical shock.

[80] At the hearing, the worker was asked to compare the symptoms that developed after the accident to those symptoms when he was first diagnosed with "minor anxiety" previously. He compared the previous symptoms to having a paper cut with the post-accident symptoms as terminal cancer. He said the symptoms kept on evolving and getting worse. The convulsions, tics and shaking got worse. He was moody and had an attitude toward everything. He said that he became suicidal.

[81] The file contains the following statement made by the worker to Dr. Laureijs on September 18, 2009:

But he reports that, over the years, the frequency of his panic attacks was reduced to one to two per year, in large part due to the effect of the risperidone.

[82] Also in the September 18, 2009 report by Dr. Laureijs the worker reported to her that his current mental health difficulties began in early May 2009. Apparently, he had shot himself in the wrist with an air-nailer, attended Emergency Services, and was back to the worksite two hours later. He noted he became aware of other safety incidents on the jobsite with other workers. He began to ruminate about this and became progressively more fearful for his own life, particularly in light of his impending marriage next year.

[83] Although the worker discounted some of the statements in Dr. Laureijs' report, the committee believes what the doctor reported to be true, with regards to the worker's reactions to the incidents on the jobsite.

[We note a number of inconsistencies in the worker's reporting of his condition and the manifestation of his symptoms.]

II The Incident - - Severity

- [84] The worker received an electrical shock when coiling up a 220 volt cord at his workplace. The file contains conflicting evidence as to the actual effect on the worker however, the worker testified that as far as he can recollect he received a severe shock, but was not knocked down, nor did he hit his head. He felt "immense, blinding heat". He testified he told his co-workers who were standing nearby that he thought he had been electrocuted. He went directly to the First Aid Station which was about 50 to 60 ft. away and collapsed against a vehicle. He was taken to the lunch area but was soon taken to the hospital.
- [85] Dr. Jamieson's Doctor's First Report, completed on the date of the incident, diagnoses electric shock to left hand; no injury and no limitations were noted. A Functional Abilities Form (FAF) by Dr. Jamieson that same day, indicated the worker was to take the rest of the day off to recover then return to full work duties. A further FAF completed by Dr. Ahmed on August 24, 2009 advises the worker to take 7 days of rest due to ongoing symptoms.

II The Incident - - aggravation or exacerbation of pre-existing condition?

- [86] Attending physicians commented on the likelihood of the electric shock exacerbating the worker's previously diagnosed condition as follows:
- Dr. Tai's assessment on September 16, 2009:
[The worker] describes electrical shock in his left arm. I do not see any burns. I do not have an explanation for his symptoms . . . I cannot explain electrical shock causing these symptoms. Clinically, I have difficulties attributing his complaints to neurological injury relating to electrical shock.
 - Dr. Carlson reports on November 9, 2009:
It is evident anxiety can exacerbate tics and the worker currently has anxiety which is incapacitating him. It is possible that the shock exacerbated his symptoms and he is catastrophizing about it. However, it is difficult to say with any certainty that the incident is responsible for this exacerbation due to the history of anxiety and panic.
 - Dr. Wilson states on February 15, 2010 that he would not consider it medically reasonable for the electric shock to exacerbate the worker's pre-existing symptoms. He also reports that the involuntary muscle spasms or tics that had been present for 13 years and a possible seizure disorder would not have been pathologically accentuated but may have been psychologically accentuated by the injury.
- [87] It is evident from the doctors' reports the incident left no neurological damage; however, the worker's symptoms are more likely due to an exaggeration of his previous psychological problems.

II The Incident – Induce PTSD?

- [88] None of the attending doctors after the incident report any physical or neurological damage.
- Dr. Jamieson’s Doctor’s First Report, “no entrance or exit burns, hand exam normal. ECG shows normal rhythm, pt was monitored x 2hrs – no arrhythmia. Electric shock (L) hand, no injury.”
 - The medical consultant, “I explained that I was unable to identify any serious structural damage from the electricity.”
 - Dr. Tai, neurologist, “[the worker] describes electrical shock in his left arm. I do not see any burns. Clinically, I have difficulties attributing his complaints to neurological injury relating to electric shock.”
- [89] The appeal committee, on the basis of the reports from the attending doctors, finds that the electrical shock experienced by the worker was not severe enough to do any physical damage.
- [90] The medical consultant noted that if the worker’s symptoms lasted for more than a month, he would fit the criteria for having post traumatic stress disorder. Dr. Carlson tested the worker using the prescribed PTSD 5-axis differential diagnoses defined in the DSM-IV and concluded the worker did not meet the criteria required to clinically diagnose him as having PTSD. Dr. Wilson stated that the psychological and psychiatric evaluations concluded there were features of anxiety, depression, panic attacks and tics but no PTSD.
- [91] The worker, of his own accord, found Ms. Sarah Jungen, a registered psychologist, on the internet and booked sessions over twelve days with her in Calgary in July 2010. Ms. Jungen reported on August 15, 2010 that her provisional diagnosis of the worker, based on self-reports and corroborating evidence from the worker’s wife was that he had Post Traumatic Stress Disorder resulting from electrocuting himself at work in August 2009.
- [92] Ms. Jungen’s treatment using eye movement desensitization left the worker with a feeling of being in control. Evidence of being in control was supplied in that the worker was able to eat dinner in a busy restaurant and go to the cinema for the first time in years.
- [93] The medical consultant opined that type of evidence showed improvement from a generalized anxiety disorder and not specifically from the symptoms of PTSD. Moreover, he pointed out it appears no DSM-IV diagnosis was confirmed or defined as required by Policy EN-09. Although Ms. Jungen was asked by the board for both her credentials and evidence that she used DSM-IV diagnoses in ascertaining the worker was suffering from PTSD, no reply was received. The appeal committee does not discount her findings, but considerable less weight will be attached to her diagnosis.
- [94] Two qualified medical people administered the DSM-IV differential diagnosis test for PTSD to the worker and concluded that he was not suffering from that disorder. Ms. Jungen, a registered psychologist, concluded the worker had PTSD, but was unable to produce the test results to back up her diagnosis. Board Policy EN-09 states:

The YWCHSB will consider a claim for Post Traumatic Stress Disorder when:

- a) there is objective and documented evidence confirming that, on a balance of probabilities, the facts as related by the worker can be corroborated and confirmed that the disorder arose out of and in the course of the worker' employment:
- b) there is a confirmed diagnosis by a Clinical Psychologist or Psychiatrist; and
- c) the diagnosis is defined in the DSM.

We find on the basis of the balance of probabilities, the worker does not have PTSD.

- [95] Did the incident specifically induce the symptoms of generalized anxiety disorder in the worker or were these symptoms present before the incident if not to the extent they manifested themselves after the incident?

We are unaware of the extent of the worker's symptoms when he was first diagnosed many years ago except from reports contained in the file. The worker related to his case manager in October 2009 that his symptoms then included panic attacks, chest tightness, unable to breathe, blurred vision, tingling in his left arm and hand, confusion, involuntary spinal, leg and arm movement and constant tremors in his hand. The committee submits that the worker once again experienced exactly the same symptoms in his latest bout with anxiety.

- [96] The worker commented to the board's medical consultant that he had suffered four other injuries in the previous three months which he did not file a report of injury to the board. The committee takes that statement and couples it with what he told Dr. Laureijs, on September 18, 2009, when he reports that his current mental health difficulties began in early May 2009. Apparently, he had been shot in the wrist with an air-nailer, attended Emergency Services, and was back to the worksite two hours later. He noted that he became aware of other safety incidents on the jobsite with other workers. He began to ruminate about these, and became progressively more fearful for his own life, particularly in light of his impending marriage the following year.

- [97] The worker appears to have become more anxious over a number of months. He received an electrical shock on August 21, 2009 and some time after that began exhibiting tic-like symptoms, depression, and panic attacks. As indicated earlier, stressful situations can aggravate tics. The incident at work became the "last straw" towards a full-blown episode of the worker's pre-existing condition. The committee does not view that specific incident as initiating the symptoms.

- [98] Also the "thin skull" condition as argued by the workers' advocate would be reasonable if the incident was the sole contributor to the worker's symptoms.

- [99] The worker also reported to Dr. Laureijs that, over the years, the frequency of his panic attacks was reduced to one to two per year, in large part due to the effect of the Risperidone. That statement contradicts his testimony to the panel where he stated that he had been symptom-free since 2004.

[100] The committee refers to Dr. Wilson's statement wherein he notes;

I would not relate a minor electrical shock to specifically causing depression, anxiety, panic attack or tics. I would relate an accentuation of tics as a result of depression, anxiety, and panic attacks.

And from the National Institute of Neurological Disorders and Strokes:

Although tic symptoms tend to decrease with age, it is possible that neurobehavioral disorders such as depressions, panic attacks, mood swings, and antisocial behaviours may increase.

Conclusion

[101] We conclude the worker is suffering from a long-standing tic-like disorder which was diagnosed as a general anxiety disorder by Dr. Carlson.

[102] The worker does not meet the criteria for PTSD according to differential diagnosis and multiaxial assessment as required by the DSM-IV.

[103] The workplace incident did not aggravate or exacerbate a pre-existing condition.

[104] The committee understands the worker is suffering from a debilitating disorder, however, we cannot relate the disorder to the workplace incident.

Decision

The worker's appeal is denied. The hearing officer's November 26, 2010 decision is confirmed.

Dated this **6th day of May 2011** in the City of Whitehorse, Yukon Territory.

W. C. Gryba, Member

H. Leenders, Committee Chair

H. Hermanson, Member