Tribunals Ontario
**Licence Appeal Tribunal**

Tribunaux décisionnels Ontario
**Tribunal d'appel en matière de permis**

Ontario

**Citation: Abdi v. TD General Insurance Company, 2021 ONLAT 19-008845/AABS**

**Licence Appeal Tribunal File Number: 19-008845/AABS**

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

Between:

**Hilded Abdi**

**Applicant**

and

**TD General Insurance Company**

**Respondent**

# DECISION

**ADJUDICATOR:** **Deborah Neilson**

**APPEARANCES**:

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| For the Applicant: | Hilded Abdi, Applicant<br>Corey Sax, Counsel<br>Jillian Carrington, Counsel |
| For the Respondent: | Derek Greenside, Counsel |
| Court Reporters: | Athavan Jeya, Fiona Castillo, Maniyaran Ajith |

**HEARD by Videoconference:** **November 23 to 27, 2020, January 26, and February 1, 2021**

## OVERVIEW

[1] The applicant was involved in an automobile accident on **June 29, 2017** and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* (the *"Schedule"*) from which he sustained non-displaced pelvic fractures, a right ear laceration and a mild traumatic brain injury. He has received statutory accident benefits from the respondent as a result of his injuries. He applied to the respondent for catastrophic impairment determination under the *Schedule* in order to receive enhanced accident benefits. The respondent denied that he sustained a catastrophic impairment, and the applicant submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal").

[2] The parties disagree on whether the applicant's traumatic brain injury meets the definition for catastrophic impairment under the *Schedule.* At issue is the timing of determining his level of disability and to what extent the applicant's other injuries affect his function.

[3] Based on the testimony and evidence before me, I find that the applicant failed to prove that he sustained a catastrophic impairment under the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale as a result of his minor traumatic brain injury. While there are other grounds upon which the applicant likely could have successfully applied for catastrophic impairment determination, they were not before me.

## ISSUES

[4] The issue before me is whether the applicant sustain a catastrophic impairment as defined under criterion 4(ii) c of s. 3.1(1) of the *Schedule;* a traumatic brain injury that when assessed in accordance with the Glasgow Outcome Scale (the "GOS") and the Extended Glasgow Outcome Scale (the "GOS-E") results in a rating of Severe Disability six months or more post-accident or a Lower Moderate Disability one year or more post-accident.

[5] In order to determine whether the applicant sustained a catastrophic impairment, I must address the following disagreements between the parties:

a. My role or the adjudicator's role in applying the GOS-E;

b. The timing of when the GOS-E assessment is to be applied;

c. Whether psychological injury and non-traumatic brain physical injury should be factored out when determining the GOS-E.

## ANALYSIS

[6] An insured person will be entitled to enhanced accident benefits if he or she sustains a catastrophic impairment. A designation of catastrophic impairment does not mean that a person is entitled to all the benefits he or she seeks. It means that the policy limits are increased from $65,000 or five years, whichever comes first for medical, rehabilitation and attendant care benefits to $1,000,000 for life. Upon catastrophic impairment determination, an insured also obtains coverage for benefits not otherwise available, such as housekeeping benefits and case manager services.

[7] The applicant submits that he sustained a catastrophic impairment as defined under s.3.1(1)4(ii) of the *Schedule* on the basis he sustained a traumatic brain injury ("TBI"). Under s.3.1(1)4, the applicant must meet a two-part test to prove on a balance of probabilities that he sustained a catastrophic impairment as defined in the *Schedule*:

a. There must be diagnostic evidence of brain trauma and, depending on when the accident occurred; and

b. He must have at least a at least an Upper Severe Disability (Upper SD or Upper SD*) or Lower Severe Disability (Lower SD or Lower SD*)[1], six months or more after the accident or a Lower Moderate Disability (Lower MD or Lower MD*) one year or more after the accident under the Glasgow Outcome Scale ("GOS") and the Extended Glasgow Outcome Scale ("GOS-E") when assessed in accordance with Wilson, J., Pettigrew, L. and Teasdale, G., *Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use*, *Journal of Neurotrauma*, Volume 15, Number 8, 1998 (the "*GOS-E Guidelines* ").[2]

[8] The GOS-E ratings are as follows:

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|---|---|
| 1 -Dead | |
| 2 – Vegetative State (VS) | Condition of unawareness with only reflex responses but with periods of spontaneous eye opening |

[1] The Asterix in Upper SD*, Lower SD* and Lower MD* denotes the patient was not fully independent before the injury

[2] Section 3.1(1)4(ii) A of the *Schedule* states that an insured person who sustains a Vegetative State (VS or VS*) under the GOS-E one month or more after the accident is catastrophically impaired. I did not need to consider it as there was no evidence that the applicant in this case was ever in a vegetative state.

| | |
|---|---|
| 3 – Low Severe Disability (SD-)<br>4 – Upper Severe Disability (SD+) | Patient who is dependent for daily support for mental or physical disability, usually a combination of both. If the patient can be left alone for more than 8 hours at home it is upper level of SD, if not then it is low level of SD. |
| 5 – Low Moderate Disability (MD-)<br>6 – Upper Moderate Disability (MD+) | Patients have some disability such as aphasia, hemiparesis, or epilepsy and/or deficits of memory or personality but are able to look after themselves. They are independent at home but dependent outside. If they are able to return to work even with special arrangement it is upper level of MD, if not then it is low level of MD |
| 7 – Low Good Recovery (GR-).<br>8 – Upper Good Recovery (GR+) | Resumption of normal life with the capacity to work even if pre-injury status has not been achieved. Some patients have minor neurological or psychological deficits. If these deficits are not disabling then it is upper level of GR, if disabling then it is lower level of GR. |

[9] The parties agree that the applicant meets the first part of the test because there is diagnostic evidence that he received a brain trauma from the accident. Where the parties disagree is whether the applicant meets the second part of the test, specifically whether, when assessed in accordance with the GOS and the GOSE, the injury results in a rating of Severe Disability six months or more after the accident or a Lower Moderate Disability one year or more after the accident. The parties also disagree on the following:

a. My role in applying the GOS-E;

b. The timing of when the GOS-E assessment is to be applied; and

c. Whether psychological injury and physical injury other than TBI should be factored out when determining the GOS-E.

**The Adjudicator's Role in Determining the GOS-E**

[10] The applicant submits that it is for the medical experts to determine the applicant's GOS-E. My role is to choose which expert's opinion has more weight. Once I make that determination, the applicant submits that I must accept the opinion of the expert that carries more weight to determine whether the applicant has the requisite GOS-E to be catastrophically impaired.

[11] The respondent submits that I am the trier of fact. This means that I must look at each part of the GOS-E checklist and determine whether the applicant could participate in the activity absent a non-brain physical injury or psychological injury. If the applicant is unable to participate in activities because of his minor TBI, then I must include that in the GOS-E scale.

[12] The applicant's approach accepts that the medical experts are the triers of fact and that the test for a TBI in s.3.1(1)4(ii) is a medical test, not a legal test. He relies on the wording in the *Schedule* that requires the assessment to be done "in accordance with" the *GOS-E Guidelines*.[3] He also relies on s.45(2) of the *Schedule*, which states that an assessment or examination in connection with a determination of catastrophic impairment shall be conducted only by a physician or, if the impairment is a TBI only, by a neuropsychologist. He submits this means that the *Schedule* incorporates the *GOS-E Guidelines* as part of the regulation. The *GOS-E Guidelines* recommend that some background knowledge is necessary to administer the GOS-E. The applicant submits that the only people involved in this matter with the requisite background are the physicians and neuropsychologists.

[13] I prefer the respondent's reasoning for the following reasons. It is supported by the Supreme Court of Canada in *R v. Mohan*, which held that experts must not be permitted to usurp the functions of the trier of fact causing a proceeding to degenerate to a contest of experts.[4] The applicant submits that the decision is distinguishable because it deals with criminal law. I disagree. *R v. Mohan* has been adopted as a leading decision on the admission and use of expert evidence in numerous civil law cases.[5] While my determination of whether the applicant sustained a catastrophic impairment involves the consideration of medical opinions, it is trite law that the test for catastrophic impairment is a legal test and not a medical test.[6]

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[3] Section 3.1(1)4(ii)
[4] *R. v. Mohan*, 1994 CanLII 80 (SCC), [1994] 2 SCR 9 at page 24, para.h
[5] *Bruff-Murphy v. Gunawardena*, 2017 ONCA 502 (CanLII), *Armstrong v. Centenary Health Centre*, 2005 CanLII 20712 (ON CA), *Taylor v. Sawh*, 2000 CanLII 5652 (ON CA), *Meady v. Greyhound Canada Transportation Corp.*, 2015 ONCA 6 (CanLII), *Sagl v. Chubb Insurance Company of Canada*, 2009 ONCA 388 (CanLII) to name a few.
[6] *Security National Insurance Company v. Hodges*, 2014 ONSC 3627 (CanLII) (Ont. Div. Ct.) at para.20, Security *National Insurance Co. v. Allen, 2017* ONSC 6779 (CanLII) (Ont. Div. Ct.) at para.44 approving the determination that "... the adjudication is not restricted to merely choosing impairment ratings offered by the experts..." and citing *Liu v. 1226071 Ontario Inc. (Canadian Zhorong Trading Ltd.)*, 2009 ONCA 571 (CanLII) at para.18.

[14] If I had accepted that the experts are the triers of fact and my role is only to weigh which expert's opinion carries the most weight, then I would have found that the opinion of the applicant's experts carry little weight for the following reasons.

[15] According to the applicant, the GOS-E must be done in accordance with the *GOS-E Guidelines* under s.3.1(1)4(ii). Under s.45(2) of the *Schedule*, the GOS-E assessment must be conducted only by a neuropsychologist or a physician. The neurologist or physician under s.45(2) may be assisted by other regulated health practitioners. In this case, the GOS-E assessment that the applicant relies upon was administered by an occupational therapist, Nikita D'Souza. She reported that the applicant sustained a Lower Severe Disability on the GOS-E.

[16] Dr. David Kurzman, a neuropsychologist, testified that he and Dr. Tobi Lubinsky, another neuropsychologist, assessed the applicant together with Ms. D'Souza. Dr. Kurzman reported that the applicant sustained a GOS-E score of 3, which reflects a Lower Severe Disability rating at 6 months or longer after the accident.[7] Dr. Kurzman testified that the assessment consisted of a neuropsychological assessment by Dr. Lubinsky followed by a GOSE-E assessment done by Ms. D'Souza. He did not recall meeting the applicant. If he did, it was only briefly in the reception room. The applicant was interviewed on October 15, 2018 by Dr. Lubinsky, and neuropsychological tests were administered by a psychometrist that same day. The assessment took about 6 hours. Dr. Lubinsky's diagnosed the applicant with a complicated mild to moderate TBI with Mild Neurocognitive Disorder due to Multiple Factors (TBI, Bodily Pain, and Emotional Distress), Major Depressive Disorder, Moderate, with anxious distress, and a Somatic Symptom Disorder with Predominant Pain.

[17] Dr. Kurzman testified that he reviewed the neuropsychological test results, the reports from Dr. Lubinsky and Ms. D'Souza, he looked at the criteria under the *Schedule* to see if the applicant is catastrophically impaired, then he prepared an executive summary report to which he attached Ms. D 'Sousa's GOS-E assessment.

[18] The *GOS-E Guidelines* state that the GOS-E is deliberately detailed to allow the scales to be used by the non-specialist.[8] I do not take this to mean that a GOS-E assessment administered by an occupational therapist complies with the *GOS-E Guidelines* or the *Schedule,* but means a physician who is a general practitioner for the following reasons. In addition to four rules that require the exercise of judgement, the *GOS-E Guidelines* require further consideration for the effect of

[7] Exhibit 3: Executive Summary report of Dr. Kurzman dated December 11, 2018
[8] GOS-E Guideline, p.576

head injury versus effects of other injuries. This requires judgement or an opinion on causation. While there is no doubt that an assessment by an occupational therapist to determine a person's disabilities and handicaps is a very useful tool for the physician or neuropsychologist doing a GOS-E assessment, an occupational therapist is not qualified to provide an opinion on causation[9]. This, no doubt, is the reason why under the *Schedule*, a catastrophic impairment determination is to be done by a physician or, in the case of brain injury, a neuropsychologist. Accordingly, I find that a GOS-E assessment administered by an occupational therapist does not comply with the *Schedule* or the *GOS-E Guidelines*. The applicant relies on the GOS-E conducted by Ms. D'Souza, who is neither a physician nor a neuropsychologist. Accordingly, this GOS-E assessment does not comply with either the *GOS-E Guidelines* or the *Schedule*.

*[19]* The *GOS-E Guidelines* also recommend that the complete questionnaire be normally administered, because sometimes responses to later items can indicate the need to go back and question more thoroughly on earlier points or re-evaluate the significance of earlier answers. [10] Ms. D'Souza testified that she did not administer the complete questionnaire. She administered an abbreviated version. There is nothing in the *GOS-E Guidelines* that allows for an abbreviated interview. Accordingly, the GOS-E Ms. D'Souza administered was not done in accordance with the *GOS-E Guidelines*. This means that even if an occupational therapist can comment on causation, and that I am not the finder of fact, I could not give any weight to Dr. Kurzman's report as the GOS-E assessment attached to his report was not conducted in accordance with the *GOS-E Guidelines*.

*[20]* If I am wrong and an occupational therapist is the best qualified to conduct an assessment, I would still give little weight to Dr. Kurzman's opinion for the following reason. The last question of the Structured Interview for the GOS and GOS-E ("structured Interview") asks "what is the most important factor in outcome." Ms. D'Souza answered that it was the effects of illness or injury to another part of the body. Dr. Kurzman testified that this was an error. Otherwise, he would have never filled out the catastrophic impairment application. However, Ms. D'Souza testified on cross-examination that the applicant declined doing a number of tasks because of fear of reinjury and his musculoskeletal physical injuries. This is consistent with her determination on the structured interview that the most important factor was the applicant's physical injuries to other parts of the body. It is not consistent with an error as alleged by Dr. Kurzman. It is also consistent with Dr. Lubinsky's diagnosis of Mild Neurocognitive Disorder due to Multiple Factors (TBI, Bodily

[9] Exhibit 6: rebuttal report of Dr. Kurzman dated December 11, 2018, p.2 and the testimony of Dr. Curt West, neuropsychologist.
[10] GOS-E Guideline, p.575, para.4(d)

Pain, and Emotional Distress). Therefore, I find that it is more likely than not that Dr. Kurzman did not review the structured interview completely in formulating his opinion as he missed a number of errors in Dr. Lubinsky's report, which I discuss below.

**Timing of the GOS-E**

[21] The applicant submits that the GOS-E is a temporal test, so I need to look at the timing of the GOS-E assessment. He submits that an assessment that is conducted two or more years after the accident is of no relevance. The applicant submits that the relevant time period for determining if a person sustained a Lower MD is at the time of the initial assessment. He relies on the *GOS-E Guidelines*, which state that the GOS-E is to be determined only by looking at a person's current status and that it should be done after the person is discharged from the hospital.

[22] The respondent submits that if the *Schedule* were interpreted the way suggested by the applicant, it would preclude an insurer from ever being able to assess an insured person via an insurer's examination under s.44 of the *Schedule* ("IE").

[23] The applicant submits that if there are two possible meanings to the *Schedule*, I must interpret the *Schedule* in a way that favours the applicant. [11] The applicant submits there is no good reason that an insurer cannot conduct its IEs within a reasonable time period of receiving a catastrophic impairment application. Delaying IEs is tantamount to bad faith. The respondent's argument presupposes that delayed IEs are reasonable, which is not the case.

[24] The *Schedule* and the *Insurance Act* are silent on the timing of IEs. I find that there is some merit to the applicant's submissions because insurers that unreasonably delay the scheduling of IEs could be subject to a *Regulation 664* award,[12] or could be required to proceed to a hearing without the benefit of IEs to support a denial of benefits. However, as long as an insurer provides the requisite responses to claims within the regulated time limits, the applicant's reasoning about IEs and the timing of the GOS-E fails. There is no penalty explicitly set out in the *Schedule* for insurers who delay scheduling IEs. This is unlike the previous regime, the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996*, O. Reg. 403/96 (the "*SABS*"), which required insurers to schedule IEs and serve the IE reports within a specific period of time, failing which insurers were required to pay benefits until the reports were served.[13] For these reasons and the reasons

[11] *July v. Neal* 1986 CanLii 149 (ON CA)
[12] Section 10, *Regulation 664*
[13] See s.35(14), s.38(17), s.40(8), ss.42(5) and (11)

that follow, I am unable to agree with the applicant that I am constrained to look only at the timing of the initial assessment.

[25] The section on timing in the *GOS-E Guidelines* states that the GOS-E is intended for use after discharge from hospital, and that reports should always include the timing of assessment. The section is silent on how soon after discharge the GOS-E should be administered. The context in which the *GOS-E Guidelines* state that only the person's current status should be considered refers to the person's status at the time of the assessment and not to the hopes or anticipation that the persons status will improve at some future point. Nor should the severity of the person's earlier status compared to their current status be considered. There is no prohibition on conducting an assessment two years after release from hospital.

[26] The *Schedule* is not silent on timing. The purpose of the GOS-E is to determine outcome after a head injury. The GOS-E has been incorporated in the *Schedule* as a legal test. The *Schedule* states that the GOS-E assessment is to be conducted in accordance with the *GOS-E Guidelines* to determine the rating. However, the timing of that assessment is set out in ss. 3.1(1) 4 (ii) A to C of the *Schedule.* On a plain meaning, an insured person will have sustained a catastrophic impairment if he or she sustains an Upper Severe Disability or Lower Severe Disability six months or more after the accident,[14] or a Lower Moderate Disability one year or more after the accident.[15] In other words, an adjudicator is required to determine if an insured person meets the test associated with the specific period, regardless of how much longer the assessments were conducted after the 6 month period in s.3.1(1)4(ii)B or the one year period in s.3.1(1)4(ii)C of the *Schedule*. I find there is any no conflict between the *GOS-E Guidelines* and the *Schedule.* Even if I there were a conflict, I find that the *Schedule* takes precedence as it is the governing legislation.

[27] The issue of timing was dealt with by the Divisional Court in *Security National Insurance Co. v. Allen*.[16] In that case, the insured appealed a Financial Services of Ontario ("FSCO") decision on catastrophic impairment that held the applicant's medication use should not be included in the determination because, as of the hearing date, he was no longer taking medication. The Arbitrator relied on the principle that evidence will be presumed as current to the date of the hearing unless evidence to the contrary is presented. The Arbitrator found that the applicant's testimony that he stopped medication at the moment rebutted the

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[14] Section .3.1(1)4(ii)B of the *Schedule*
[15] Section .3.1(1)4(ii)C of the *Schedule*
[16] *Security National Insurance Co. v. Allen*, 2017 ONSC 6779 (CanLii) (Ont. Div. Ct.)

presumption. The Director's Delegate allowed the appeal. The Divisional Court upheld the Director's Delegate's decision on a standard of reasonableness.

[28] The Divisional Court found that the Director's Delegate considered the relevant authority and s.2(2.1)(b) of the *Schedule* as it was then, which stated that an insured could not apply for catastrophic impairment under two of the categories until two years had passed or the insured's conditions were stable. The Director's Delegate found that, rather than a rigid approach, a more flexible approach to timing was appropriate. He held that to narrowly tie an assessment to the four corners of a narrow artificial period is simply to encourage repeated applications for catastrophic impairment designation to the detriment in time and money to both parties.

[29] Although *Security National Insurance Company v. Allen* dealt with a different test for catastrophic impairment, the reasoning is applicable to the GOS-E. Accordingly, I find that a flexible approach together with the *Schedule* requires that I do not look at the applicant strictly at the one-year mark, but also his condition more than one year after the accident. A flexible approach also means that an IE assessment that is done a few years down the road may be of limited value or receive little weight. However, since the timing of IEs are not legislated under the present *Schedule*, that is the risk an insurer takes if it does not conduct timely assessments. That does not mean that the Tribunal cannot or should not consider an IE assessment that is not conducted within a month to six months of the catastrophic impairment application.

**The Role of Psychological and Physical Injury in the GOS-E**

[30] The parties disagree on whether psychological or other factors are to be considered when assessing an insured person under the GOS-E. The applicant submits that the applicant's psychological impairment is a result of his traumatic brain injury. The respondent submits that the applicant's psychological impairments are addressed under other sections of the *Schedule* and that only the impairments from the TBI are to be considered when assessing the GOS-E.

[31] The GOS-E is designed to assess changes and restrictions that have taken place as a result of head injury. The *GOS-E Guides* state that the scale reflects disability and handicap rather than impairment; that is, it focuses on how the injury has affected functioning in major areas of life rather than on the particular deficits and symptoms caused by injury (World Health Organization, 1980).[17]

[17] *GOS-E* Guideline p.574

[32] According to the *GOS-E Guides*, the disability must be a result of the TBI and not other psychological or physical injuries. The *GOS-E Guides* state that the injury is an event that has occurred at a particular time, but not all changes that have taken place following the event will be due to the injury. Thus, if a patient is capable of performing the activity but does not do it for some reason, they are not considered disabled. Although the scale is directed at the effect of brain injury, it does not itself distinguish changes due to injury to the brain from disability caused by injury to other parts of the body. Some patients with multiple injuries may have lost functioning due to injuries to the limbs. The *GOS-E Guides* further state that, depending on the purpose for which the scale is used, it may be important at the time of the interview to distinguish any such effects from those caused by brain injury; that it is usually relatively easy to discount any minor effects of injury to other parts of the body but when such injuries are severe, it may be difficult to assign a GOS that reflects only the effects of head injury. "Therefore, this should be noted appropriately when reporting the GOS."[18]

[33] Dr. Curt West conducted an insurer's examination at the respondent's request on June 10, 2019. He testified that the GOS-E scale was designed to assess impairment from brain injury, not physical or psychological injury. Therefore, one must look at whether there is a non-neuropathological cause to the applicant's complaints. Dr. Kurzman did not agree that one should look only at the TBI under the GOS-E for determining catastrophic impairment because he believed that nowhere in the *Schedule* does it say that. He testified that one should look at the both the insured's physical and cognitive abilities if one cannot parse them out. However, he agreed that any impairment that is not due in part to a TBI is not included in a GOS-E assessment. Dr. Kurzman agreed the applicant's self-limiting behaviour should not be considered in the GOS-E unless it is due to the TBI. He also agreed that only cognitive impairment symptoms that are factors of a TBI should be considered in the GOS-E. He initially testified that the TBI must contribute at least an equal amount to the other factors when doing the GOS-E. He then changed his answer to not equally, but significantly and that the applicant's impairments at the time of his assessment were not due to psychological impairments, but to multiple factors. Although Dr. Kurzman was not as definite as Dr. West, I find from the testimony of both neuropsychologists that neuropsychologists understand the GOS-E Guides require the assessment to be based on the TBI related impairments and not those caused by other physical injuries or psychological impairments.

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[18] *GOS-E Guideline* p.575-576

[34] Up until June 1, 2016, the *Schedule* defined a catastrophic impairment as a brain impairment with a Glasgow Coma Score ("GCS") of 9/15 or less within a reasonable period of time after the accident. That definition was revoked. Now the applicant must have a traumatic brain injury as evidenced by diagnostic film and his score on the GOS-E.

[35] *Security National Insurance Company v. Hodges*, 2014 ONSC 3627 (CanLII) is a Divisional Court decision that addressed the Legislative intent of the GCS definition of catastrophic impairment in the pre-June 1, 2016 *Schedule.* The Divisional Court held that it was a proxy measurement of injury that was meant to weed out the weakest claims at an early stage. In that case, the applicant sustained a brain injury and about 4 days after the accident, his GCS went down to 9/15. The respondent's expert stated that the lower GCS was due to about ten factors related to the insured's recent surgery, not his brain injury. In rejecting this submission, the Divisional Court held that the Legislature could not have intended that seriously injured individuals would fail to receive a catastrophic impairment designation simply because their GCS score was confounded by the severity of their other injuries or treatment.

[36] The underlying assumption of Security National's position in that case was that a brain injury itself must cause a GCS score of 9 or less. The Divisional Court pointed out that was not the way the pre-June 2016 *Schedule* read. It focused on measuring brain impairment, not brain injury, and it used a GCS score as the determinative measure. The GOS-E definition of catastrophic impairment under the present *Schedule*, however, focusses on brain injury, unlike *Security National v. Hodges.*

[37] I find that to determine catastrophic impairment under the GOS-E, the *Schedule* requires the assessor to assign a GOS-E that reflects only the effects of the brain injury. Otherwise, the *Schedule* would not incorporate the *GOS-E Guidelines.* Nor would the *Schedule* refer to "brain injury," but would have retained the wording "brain impairment" that was in place prior to the June 1, 2016 amendments. Further, in keeping with the *Schedule's* purpose of consumer protection, psychological injury is already considered together with other injuries under s.3.1(1)8 and on its own under s.3.1(1)7 of the *Schedule.* There are TBIs that, because of what part of the brain was injured and due to the severity of the injury, cause psychological impairments or physical impairments. In those cases, the disability resulting from those impairments will be considered in the GOS-E. If the effect of other types of physical or psychological injury cannot be parsed out from

the effects of the TBI, then in accordance with the *GOS-E Guidelines*,[19] they are to be considered in administering the GOS-E. Otherwise, for the reasons given above, I agree with the respondent that psychological and physical impairments that are not related to or caused by the TBI are not considered in the GOS-E.

**The GOS-E Rating**

[38] There is no dispute that the applicant sustained non-displaced pelvic fractures that were treated conservatively. He was hospitalised for 8 days and released to West Park Healthcare Centre where he remained for just over three weeks. The parties disagree on what effect the applicant's TBI has had on his functional abilities and whether it was mild or mild to moderate. Both parties submit that little weight should be given to the opposing party's experts' opinions.

[39] Dr. Kurzman and Dr. Lubinsky diagnosed the applicant with a complex mild to moderate TBI, a Mild Neurocognitive Disorder due to Multiple Factors (TBI, Bodily Pain, and Emotional Distress), Major Depressive Disorder, Moderate, with anxious distress, and a Somatic Symptom Disorder with Predominant Pain. Dr. Kurzman determined that the applicant sustained a catastrophic impairment because he had an Upper Severe Disability under the GOS-E within six months or more after the accident.[20]

[40] The respondent relies on the opinion of Dr. Curt West, neuropsychologist, who conducted an insurer's examination ("IE") of the applicant. Dr. West diagnosed the applicant with an Adjustment Disorder, Unspecified; Chronic (mild) and likely a mild TBA. Dr. West's opinion was that, on a generous reading, the applicant sustained at most an Upper Moderate Disability (Upper MD) or a level 6 on the GOS-e scale Both neuropsychologists confirmed that the "complex" part of Dr. Kurzman's diagnosis refers to the diagnostic film results.

[41] Although the Tribunal allows hearsay evidence, the weight to be given the evidence is dependant upon how reliable it is. Where they differ, I give more weight to Dr. West's opinion than Dr. Kurzman's and Dr. Lubinsky's because: Dr. Kurzman did not meet the applicant or, if he did, it was only briefly; the number of errors made in Dr. Lubinsky's report and by Dr. Kurzman; and because they were lacking information about the applicant's ability to play video games, use a computer, and about his pre-accident success at university. Further, the testing administered by Dr. Lubinsky may not accurately reflect the applicant's maximum cognitive abilities. The applicant's test results may have been higher if he made a

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[19] *GOS-E Guidelines* p.576

[20] Exhibit 3: Executive Summary report by Dr David Kurzman, Dr. Tobi Lubinsky and Nikita D'Souza dated December 11, 2018

greater effort and if he was not so tired. Dr. Kurzman's evidence was contradictory in that he relied on a nonphysician to conduct the GOS-E, claiming she was best suited to do so, then failed to heed her determination on the effect of the applicant's non-TBI physical and psychological injuries.

[42] Dr. West's opinion of a mild TBI is mirrored by the opinion of Dr. Westreich, a psychiatrist with the Sunnybrook Brain Injury Clinic. Dr. Lubinsky reported that in his consultation report dated September 27, 2017, Dr. Westreich indicated that the applicant was still experiencing some residual TBI symptoms. Dr. Westreich determined that the applicant's disrupted sleep was undoubtedly affecting his concentration, mood, and the like. Dr. Westreich diagnosed the applicant with mild TBI and subsequently revised his opinion to a mild, but complicated TBI given the MRI findings dated September 21, 2017. He told Tony Le that the applicant sustained a mild TBI and that his headaches were medication rebound headaches. [21]

[43] Dr. Kurzman testified and criticized Dr. West on the basis that he minimized the applicant's complaints. The applicant testified that he still has pain to his knees and pelvis that affect his ability to sit, stand, walk, and climb stairs. The pain affects his sleep, so he sleeps on his stomach and his back. He gets about 4 to 5 hours of uninterrupted sleep per night but has difficulty falling asleep because he naps in the day. He naps in the day due to lack of sleep. Any activity aggravates the pain in his neck, back, and shoulders which he rates at 7/10 to 8/10 on a pain scale of 1 to 10, with 0 being no pain and 10 being the worst pain. He takes prescription medication for headaches and two Advil every second day for physical pain.

[44] The applicant also testified that he has a fear of leaving the house because he does not want people to see him. He has a foggy memory, a slower thought process, problems with concentration, gets flustered and has a lack of motivation. He spends two hours per day watching TV and one hour gaming on a computer most days before he loses interest. He spends about 30 minutes to one hour on the internet and the remainder of his time he talks to his siblings.

[45] The applicant's testimony of his complaints was fairly consistent with what he reported to various assessors including Dr. West. However, he was also found by Dr. Lubinsky, Dr. West and a psychologist who conducted a psychological

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[21] Exhibit 17: clinical notes and records of Tony Le dated December 6, 2017 from meeting with Dr. Neal Westreich

assessment at the respondent's request, Dr. Mohammad Nikkhou, to have performed poorly on validity testing for effort and/or malingering.[22]

[46] Dr. West determined that the applicant's praxis,[i] executive and higher cognitive function, visuospatial processing and nonverbal function, verbal and non-verbal memory were intact and unimpaired. On neuropsychological tests where the applicant had impaired scores, Dr. West found that it was likely because of the applicant's suboptimal levels of effort/motivation/engagement. Dr. West also noted that the applicant did not report any significant difficulties or problems in this regard and attributed his subjectively decreased concentration, attention, and memory to ongoing and persistent severe headaches. I find this explains why Dr. West minimised the applicant's cognitive and psychological complaints.

[47] Dr. Lubinsky reported in her summary that the applicant's test results suggest ongoing cognitive sequela in most areas of function. However, it was her opinion that the applicant's ongoing difficulties with bodily pain, headaches, poor sleep/ fatigue, and/or psychological distress were likely serving to exacerbate his cognitive difficulties as those factors have been shown to both independently, and collectively, give rise to cognitive impairment. She had stated earlier in her report that the applicant's results on dedicated measures of performance validity were variable and as such, the neurocognitive test results must be interpreted with caution. Dr. Kurzman testified that the validity of the test results is important in forming an opinion. Contrary to Dr. Kurzman's critique of Dr. West, I find that once there was a determination of variable performance measures, it was incumbent on Dr. Kurzman and Dr. Lubinsky to either give an opinion on the extent of the cognitive impairment in light of the validity testing just as Dr. West did or, if that could not be done, explain why the validity measures were being ignored. Dr. Kurzman and Dr. Lubinsky did neither. For this reason, I do not find Dr. Kurzman's critique of Dr. West persuasive.

[48] Dr. Kurzman testified that there were a couple of errors in his executive summary report. The first was that Dr. Lubinsky issued a report dated August 16, 2017 instead of November 5, 2018. The second error was that the most important factor in the applicant's outcome under the GOS-E was the effect of illness or injury to another part of the body. This was set out in the GOS-E interview questionnaire answers prepared by Ms. D'Souza, that were reviewed by Dr. Kurzman and endorsed by him, Dr. Lubinsky and Ms. D'Souza in an executive summary report. Dr. Kurzman testified that the most important factor in the applicant's outcome should have been a combination of both the TBI and the effects of the illness or

[22] Exhibit 27: IE report of Dr Mohammad Nikkhou, psychologist, of July 17, 2018, p.21 of 41.

injury to another part of the body. However, to him, Ms. D'Souza clearly erred because, otherwise, Dr. Kurzman would not have filled out an application for catastrophic impairment for the applicant. His answer does not make sense given his testimony that Ms. D'Souza was the most qualified person to conduct the GOS-E interview. It does not make sense in light of his and Dr. Lubinsky's report that the applicant's ongoing difficulties with bodily pain, headaches, poor sleep/fatigue, and/or psychological distress were likely serving to exacerbate his cognitive difficulties. Nor does it make sense in light of his testimony that lack of restorative sleep would affect the applicant's neurocognitive test results and that a lack of sleep and overmedication could cause headaches.

[49] Another error was that Dr. Lubinsky gave a birth date for the applicant that made him 37 years old instead of 24 years old. Yet, Dr. Kurzman testified that he reviewed the report before it was signed. In his rebuttal report dated September 13, 2019, Dr. Kurzman stated that the applicant sustained a GOS-E of 4, Low Severe Disability.[23] He testified that this also was an error because it was his opinion that the applicant sustained a GOS-E of 3, Low Severe Disability.

[50] Dr. Kurzman testified that in addition to the validity of the test results, the accuracy of a person's medical history is very important in formulating an opinion. The applicant told Dr. Lubinsky that he never failed a course in school. Dr. Kurzman took that to mean in high school. Dr. Lubinsky did not ask the applicant about university and did not review the applicant's university transcripts, which disclosed the applicant failed a course twice. He eventually got a D+ on his third try in the course and achieved six other Ds and an E in his 4 years at university before the accident occurred.

[51] Dr. Kurzman did not know that the applicant spent time playing video games. He had no information on the type of video games or how much time the applicant spent on them. He admitted that the applicant's refusal to act due to lack of sleep, fatigue or pain is not the same as a cognitive defect. However, Dr. Kurzman also testified that fatigue could be an effect of the TBI. In fact, the applicant had reported to Dr. Jeremy Frank, a psychologist who conducted an assessment at the applicant's request on April 23, 2018, that he has difficulty falling asleep, which he attributes to pains from his headaches, anxious thoughts or for no reason at all. The applicant reported that it will take between two and three hours for him to fall asleep each night on average, stating that he must achieve "sheer exhaustion." The applicant remarked on waking after two or three hours of sleep, owing

[23] Exhibit 6: Rebuttal report of Dr. Kurzman dated September 13, 2019. The GOS-E for level 4 is an Upper Severe Disability.

occasionally to nightmares, pains, or noises.[24] He told Dr. Nikkhou it was also because of his pain.

[52] Dr. Kurzman relied on the GOS-E interview by Ms. D'Souza rather than preparing his own GOS-E interview. I find this is problematic as it is clear form Ms. D'Souza's testimony that she did not differentiate the physical and psychological injuries from the TBI injuries that limit the applicant in a number of the activities set out in the GOS-E.

[53] The applicant reported that he was tired about 2.5 hours into the interview with Ms. D'Souza. She was aware that the applicant had difficulty sleeping at night, that pain was a factor, but did not know how much sleep he had the night before and did not ask him. Ms. D'Souza testified that she was looking for consistency of performance on formal and informal observation and the file. Her type of assessment does not address other motivations. Ms. D'Souza agreed that a reduced motivation to travel and a reluctance to engage in social outings and his physical restrictions would impact on the applicant's ability to initiate on a consistent basis. She was aware that the applicant did not socialise because he felt like his friends looked at him as half a man and as a burden. Ms. D'Souza did not assess his ability to attend school because she conducted a 6-month GOS-E assessment, even though her assessment was done one year and four months after the accident. Therefore, the answers on the GOS-E interview are incomplete.

[54] Ms. D'Souza reported that the applicant was incapable of travelling locally without assistance. However, she reported and testified that the applicant is able to use a taxi. He advised Ms. D'Souza that he avoids taking transit because he was hit by a bus and, therefore, accesses the community through his PSW and mother. The applicant also advised Mr. Le that he uses taxis. Mr. Le determined in May 2018 that the applicant required supervision ambulating outdoors due to balance issues from his pelvic fractures and his reports of dizziness. I find that the applicant no longer had dizziness issues when he was assessed by Ms. D'Souza as it was not reported as one of his complaints. Given the lack of analysis by Dr. Kurzman or Ms. D'Souza on whether the applicant's balance/physical issues are the reason he required supervision to travel locally as of October 2018, I prefer Dr. West's opinion that the applicant was capable of travelling without assistance.

[55] Ms. D'Souza had determined that the applicant was unable to do a budgeting task because his answer was off by a few cents and she believed that because of his level of university, the applicant's answer should have been perfect. However, she never reviewed the applicant's transcript nor asked him how he did at university.

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[24] Exhibit 18: report of Dr. Frank, psychologist, dated May 31, 2018

Dr. Kurzman testified that the applicant was able to do simple math problems in a timely fashion, which contradicts Ms. D'Souza's determination.

[56] Ms. D'Souza determined on the GOS-E interview that the applicant needed frequent help or someone to be around at home most of the time. I find her determination problematic for the following reasons. Ms. D'Souza determined that the applicant exercised deficits in judgment and problem solving in an emergency situation because he verbalized his steps rather than demonstrated his steps, which required him to go up and down stairs despite having to use a cane and despite telling her that he was told not to weight bear. Ms. D'Souza testified that the applicant demonstrated that he could weight bear by going up and down the stairs. The applicant further declined to demonstrate leaving the house because he did not want to go outside without his shoes. In a role-playing task where the applicant received a phone call from someone purporting to be from the Canada Revenue Agency who asked for information, he declined to give his SIN, his earnings for the past year and advised that he is never home alone. Ms. D'Souza determined that the applicant exercised poor judgement because he gave the person his address, advised there were 9 people living there and said he was never home alone. Ms. D'Souza was unable to give a coherent answer when asked how advising he was never home alone was an exercise in poor judgement.

[57] Ms. D'Souza spoke with the applicant's treating occupational therapist and his mother. Despite having reviewed two reports prepared by Tony Le, the applicant's treating occupational therapist, and despite having talked to Mr. Le, Ms. D'Souza was unaware that Mr. Le had determined five months earlier that the applicant was cognitively capable of dealing with an emergency.[25]

[58] In looking at the applicant's interpersonal relationships, Ms. D' Sousa determined that the applicant has psychological problems that has resulted in ongoing family disruption or disruption to friendships. The applicant reports to numerous assessors and testified that he feels shame and embarrassment for needing a cane, which causes him to be depressed and like a burden to his friends. He has a fear of leaving the house because he does not want people to see him. The client's mother disclosed that she continues to maintain a close relationship with her son. However, the nature of their relationship has changed. She highlighted that "he used to do things by himself, but he doesn't do anything but sit in the house, so we keep him company, sit and talk to him." However, his mother did not

[25] Exhibit 21: report of Tony Le dated May 28, 2018, p.9. See also Exhibit 25: IE report of Rodney Pritchett, occupational therapist, dated October 26, 2017 at p.11 stating the applicant "...presented with intact problem-solving abilities of potential domestic crises. That is, he provided appropriate answers to safety/crisis scenario questions. Basic Supervisory Care is not recommended in this regard."

disclose that his personality has changed or that his psychological problems have disrupted the family.

[59] Neither Ms. D'Souza nor Dr. Kurzman parsed out the effect the applicant's lack of sleep had on his reported deficits in attention or ability to recall task instructions. However, Ms. D'Souza did note on her GOS-E interview that the most important factor in the applicant's outcome was the effect of injury to another part of the body. She could have answered that it was a mixture of the effects of the TBI and injury to another part of the body or the effect of the applicant's TBI, but did not. Therefore, I find that the reasons Ms. D'Souza found the applicant is unable to work, unable to travel unsupervised, shop without assistance or be home unsupervised has little or nothing to do with the applicant's mild TBI.

[60] My determination is supported by the applicant's testimony and his reports to various medical professionals. In fact, Dr. Kurzman testified that the applicant's emotional distress was partly responsible for his inability to return to his pre-accident functional ability. He disagreed that it was a substantial part, although Dr. Lubinsky reported that the applicant's psychological impairment was substantial. She reported the applicant suffers from multiple somatic symptoms that are extremely distressing to him and that have resulted in significant disruption of, and avoidance of, his daily life routine.[26]

[61] The applicant submitted that Dr. West's opinion should be given little weight for the following reasons:

i. He testified as an advocate with bias;

ii. There was no way to know what documents he reviewed because he did not include a list of documents that he reviewed within his report;

iii. He did not obtain collateral evidence and mistakenly thought that Ms. Youm, the occupational therapist who conducted a CAT IE, did;

iv. The applicant did not report a number of the same complaints to him as he reported to other assessors;

v. His opinion was that the applicant may have lost consciousness at the accident scene when numerous hospital records and reports stated he actually lost consciousness; and

[26] Exhibit 2: Dr. Lubinsky's report of November 5, 2018

vi. He ought to have known that he was missing a neuropsychological report when he reviewed Dr. Kurzman's report, and he ought to have requested it from Dr. Lubinsky.

[62] The applicant submits that Dr. West was biased and acted as an advocate because he ignored the opinions of other practitioners, he concluded they were wrong, or he found that the applicant was liar.

[63] I do not find that Dr. West testified as an advocate. Dr. West did not find that the applicant was a liar, but that the validity testing showed the applicant's subjective complaints were not reliable and that his level of effort meant one could not rely on his test results. This is not completely at odds with the validity tests administered by Dr. Lubinsky or the other psychologists.

[64] For example, Dr. Frank reported that the applicant's memory of the accident was patchy. The applicant reported seeing the TTC bus approaching his vehicle, then he blacked out and was in and out of consciousness. He reported experiencing difficulty with his memory since the subject accident. Notably, the applicant stated that he experiences difficulty recalling dates, appointments, birthdays, and things that he is supposed to do. He also stated that his memory of the accident and the month after the accident is a "blur." He indicated that his concentration is poor, noting that he finds it difficult to follow conversations or television plots. Dr. Frank reported that the applicant produced a valid profile on the Pain Patient Profile (P3). He occasionally responded inappropriately on the Personality Assessment Inventory ("PAI"). There was some indication of a mild degree of overreporting of symptoms, but not to the extent that would render the profile invalid or uninterpretable. Overall, the profile was valid but was interpreted with some degree of caution.[27]

[65] As mentioned earlier, Dr. Nikkhou also reported that the applicant had a significant tendency to report the symptoms in an exaggerated and inconsistent manner. Dr. Lubinsky reported that the applicant's results on validity measures were variable. All of these assessors' findings on the validity measures were similar to Dr. West's.

[66] I am not persuaded by the applicant's submission that Dr. West's opinion be given little weight because he did not accept that the applicant sustained a loss of consciousness. Although there are numerous references in the records to the applicant having lost consciousness at the scene of the accident,[28] I find that the

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[27] Exhibit 18: report of Dr. Frank dated May 31, 2018

[28] Exhibit 10: clinical notes and records from Sunnybrook, p.746 dated June 29, 2017 at 19:13 and p.747; p.727 CT of head taken at 19:53; p.704 report of Dr. Paskar of June 29, 2017 from 19:15 to 20:30 describing transient loss of consciousness and some amnesia with a diagnosis of possible concussion;

most reliable record is that of the ambulance call report. It is the record most contemporaneous to the accident. The notations relied upon by the applicant do not indicate where the information came from. If it was from discussions with one or more of the passengers, then it might be more persuasive. If it is from the applicant, it is not clear how he would know whether he lost consciousness as he claims he was amnesic for the event. However, if the various practitioners were relying on the ambulance call report, then they were not accurate. It states that the applicant was conscious at the scene but "may have" lost consciousness. The applicant was alert to person and place, but not to time. His GCS was 15/15 at the scene of the accident[29] and remained at 15/15 up until three hours after his arrival at the hospital. Upon admission to the hospital, the applicant had some event amnesia. While in the hospital, the applicant recited seeing the bus coming towards him and having flashbacks of the accident. He still recalled seeing the bus coming towards him a year after the accident but did not recall the accident occurring or being at the accident scene. The hospital records also state that the applicant was not unconscious at the scene.[30] Without evidence from someone else who was at the accident scene to corroborate that the applicant did, indeed, lose consciousness, I find that Dr. West's reluctance to carte blanche accept the hearsay as reliable evidence of a loss of consciousness has the opposite affect on the weight that should be given to his report than what the applicant intended. Accordingly, I find that Dr. West was properly cautious about whether the applicant lost consciousness. Whether or not the applicant lost consciousness, other than Dr. Kurzman and Dr. Lubinsksy, the consensus was that the applicant's TBI was mild.

[67] With respect to the documents, Dr. West's report was part of a 62-page multidisciplinary report prepared by a team consisting of Dr. Oshidari, Dr. West and Ms. Youm. The report contained an appendix listing all of the documents that the multidisciplinary team were provided with. The appendix was listed in a table of contents that listed the contents of the entire multidisciplinary report. Dr. West testified that he reviewed all of the documents listed in the appendix and I have no reason to not believe him. If there was any doubt, Dr. West prepared two addendum reports, each of which listed all of the documents he reviewed and when he received them. The applicant's counsel took him through a number of documents asking him if he reviewed them, to which Dr. West referred back to his report. Dr. West's testimony that he reviewed all the documents listed in the appendix and the documents listed in his addendum reports satisfies me that he

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p.686 occupational therapy report of July 4, 2017; p. 675 discharge summary of Dr. Tremblay of July 7, 2017; and some records from Westpark and from Dr. Weistrich.

[29] Exhibit 8: ambulance call report dated June 29, 2017

[30] Exhibit 10: p.759 trauma assessment record of June 29, 2017 of Dr. Steinberg

did review all of the documents. In fact, he reviewed more documents than Dr. Kurzman.

[68] Dr. Kurzman did not provide a comprehensive list of the documents he and /or Dr. Lubinsky reviewed. They provided a summary of a number of documents and noted that there were a variety of other forms and documents that may have also been reviewed but were not detailed. Dr. West testified that he reviewed all of the occupational therapists' reports. The reports of both Tony Le, the applicant's treating occupational therapist, and Rodney Pritchard, an occupational therapist who conducted a couple of the IEs, were listed in the appendix of documents reviewed by Dr. West. Dr. Kurzman, who testified that it was very important to have the input of an occupational therapist in formulating his opinion, only listed Tony Le's report dated August 25, 2017. No mention was made of Mr. Le's reports dated May 28, 2018 or any of Mr. Pritchart's reports. Accordingly, the evidence does not support the applicant's submission that I should give little weight to Dr. West's opinion because I cannot know what documents he reviewed.

[69] Given the errors in Dr. Kurzman's report and the little weight I place on his and Ms. D'Souza's opinions, I find that the applicant has failed to prove on a balance of probabilities that his traumatic brain injury, when assessed with the *GOS-E Guides*, results in either a Severe Disability (either Upper or Lower) six months or more after the accident or a Lower Moderate Disability one year or more after the accident. However, if I am incorrect in my determination that non-TBI physical injuries and non-TBI psychological impairments are not to be considered in the GOS-E, then I would have found that the applicant sustained a Lower Moderate Disability because of his inability to resume regular social and leisure activities outside his home. This is because I accept that because of a combination of his psychological problems and his orthopaedic injuries, he no longer socialises with his friends or engages in his active pre-accident leisure sporting activities. However, based on my earlier determination that the GOS-E must be based on TBI injuries alone, I am unable to find that the applicant meets the test for catastrophic impairment under 3.1(1)4 of the *Schedule.*

## CONCLUSION

[70] The applicant's claim for catastrophic impairment determination under the GOS and the GOS-E criterion of s.3.1(1) 4(ii) of the *Schedule* is dismissed.

**Released: December 6, 2021**

**Deborah Neilson, Adjudicator**

[i] Praxis is the ability to execute movement.