WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 2738/17

BEFORE:	A.G. Baker: Vice-Chair
HEARING:	July 31, 2018, at Toronto Written
DATE OF DECISION:	March 8, 2019
NEUTRAL CITATION:	2019 ONWSIAT 623
DECISION UNDER APPEAL:	WSIB Appeals Resolution Officer (ARO) decision dated March 27, 2013

APPEARANCES:

For the worker:	R. Fink, Lawyer N. Daley, Lawyer
For the employer:	Not Participating
Interpreter:	n/a

REASONS

(i) Introduction and background

[1] The worker's estate appeals the decision of Appeals Resolution Officer (ARO) A. Rivet, dated March 27, 2013. From that decision, the estate appeals a single issue, entitlement to section 147(4) benefits. I also noted the background to this matter was outlined generally by the ARO as follows:

> On January 9, 1986 this worker was employed as a labourer earning $13.54 per hour when he fell at work and sustained a right neck and shoulder injury. The worker had been with the employer since May 23, 1986. The worker was granted a 15% Permanent Disability (PD) award in January of 1990. Entitlement to cervical disability and cervical torticollis as well as a pension reassessment was granted per the November 22, 2002 Appeal Officer decision. Entitlement to generalized Dystonia was denied in this same decision. The worker underwent a pension reassessment in March of 2003 and was found to still be at a 15% PD level. The June 4, 2009 decision from the Workplace Safety and Insurance Appeals Tribunal (WSIAT) [Decision No. 2254/03] confirmed the worker's entitlement to Cervical Dystonia and that the tremors in the worker's upper extremities were to be included in the worker's permanent disability pension. The decision also determined the worker was not entitled to Generalized Dystonia or Oramandibular [sic] Dystonia. WSIAT also ruled the worker's pension assessments were properly carried out.
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> The worker's entitlement to 147(4) benefits ceased as of June 1, 1992. The worker appealed and the decision was upheld by the Decision Review Specialist Decision of February 9, 1993 on the basis the worker declined modified work offered by the employer. The worker objected to this decision in his letter of December 17, 1993.
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> The DRB decision of April 22, 1993 determined the worker was not entitled to a pension reassessment and was not totally disabled.
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> On September 13, 2011 the worker's representative requested the worker be granted chronic pain and/or psychiatric entitlement as well as entitlement to 147(4) benefits. In response, on October 24, 2011 the Case Manager sent the representative a copy of the February 9, 1993 DRB decision and requested additional medical information be submitted regarding the issues of CPD and Psychotraumatic Disability.
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> On December 8, 2011 the representative objected to the February 9, 1993 decision and on December 11, 2012 the Case Manager denied entitlement to psychotraumatic disability. The representative objected to the prior October 24, 2011 decision letter. He requested that the worker be granted CPD and or Psychotraumatic Disability entitlement as well as entitlement to 147(4) benefits…

[2] The ARO found that the worker was entitled to Psychotraumatic Disability benefits, but not CPD benefits, and a further PD assessment was ordered in regard to the worker's non-organic condition. However, section 147(4) benefits remained denied, and the worker's estate has appealed that issue to the Tribunal.

(ii) Law and policy

[3] On January 1, 1998, the *Workplace Safety and Insurance Act, 1997* ("WSIA") took effect. However, pursuant to section 102 of the WSIA, the Workers' Compensation Act continues to apply to pre-1998 injuries. Since the worker's original injury occurred in January of 1986, the pre-1989 Act continues to apply, as amended by the WSIA. The section 147 supplement provisions in the pre-1997 Workers' Compensation Act also continue to apply. Subsection 147(2) and 147(4) of the pre-1997 Workers' Compensation Act provide:

> **147(2)** Subject to subsections (9) and (10), the Board shall give a supplement to a worker who, in the opinion of the Board, is likely to benefit from a vocational rehabilitation program which could help to increase the worker's earning capacity to such an extent that the sum of the worker's earning capacity after vocational rehabilitation and the amount awarded for permanent partial disability approximates the worker's average or net average earnings, as the case may be, before the worker's injury.
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> **(4)** Subject to subsections (8), (9) and (10), the Board shall give a supplement to a worker, (a) who, in the opinion of the Board, is not likely to benefit from a vocational rehabilitation program in the manner described in subsection (2); or (b) whose earning capacity after a vocational rehabilitation program is not increased to the extent described in subsection (2) in the opinion of the Board.

[4] I also note Board *Operational Policy Manual* Document No. 18-07-10, which provides in part as follows:

> A worker with a pre-1990 injury is entitled to a full supplement under s.147 (2) if that worker would benefit from a Labour Market Re-entry (LMR) plan, and co-operates in one. If a worker is unable to benefit from an LMR plan or following completion of an LMR plan, did not increase his her earning capacity to the extent expected, that worker may be entitled to a supplement under s.147(4).

[5] I also note the following regarding the appropriate test for section 147(4) benefits from Tribunal *Decision No. 579/02*:

> ... the appropriate test in relation to entitlement to benefits pursuant to section 147(4) is whether the work injury was a factor contributing to the wage loss, or was "at least partially related to the work injury", but not necessarily a significant contributing factor.

(iii) Decision

[6] It is also important to note in this case that the worker was granted benefits for Psychotraumatic Disability. The worker was assessed for a PD award, and granted 15%. The worker also appealed the arrears date of his PD award. An ARO decision dated January 9, 2014, ruled that an arrears date for the PD award of June 13, 2011, three months prior to the date of the request for recognition of Psychotraumatic entitlement. A WSIAT *Decision No. 2738/17E* denied a time extension to appeal the arrears date.

[7] That said, in awarding the worker psychiatric benefits, the ARO conducted a medical review of the record in 2013 that was not largely in dispute and stated as follows:

> On June 9, 1986 the worker tripped and fell hitting the right side of his neck and shoulder (trapezius) area. The worker complained of pain and an inability to hold his head up. The worker was admitted to the Toronto Western Hospital on September 2, 1986. A myelogram and CT of the neck were reviewed and showed no sign of pathology. Consultation with psychiatry resulted in an impression of a soft tissue injury with symptoms of post-traumatic reaction. The worker was transferred to psychiatry but then became quite agitated. He complained of pain but denied parameters of depression, anxiety, suicide or vegetative symptoms. The March 6, 1987 progress report is the first to mention spastic cervical muscles and torticollis.
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> On May 11, 1987 the worker was assessed by Orthopaedic specialist Dr. Peddle who noted that on examination the worker had spastic torticollis. Dr. Peddle had a long conversation with the worker at the time and suggested a psychiatric consultation. In November 27, 1987 the worker was seen by Dr. Parsons who noted a marked torticollis. He recommended admitting the worker for manipulation of the cervical spine under general anaesthesia to see what his range of motion was and whether the torticollis would correct spontaneously. The procedure was done on December 10, 1987 and under

anaesthesia the cervical spine could be manipulated in all directions quite freely. When the worker awakened after the procedure he claimed his neck was still as bad as ever. The January 8, 1988 opinion from Dr. Peddle was the worker's condition was more tenorial than physical and he planned to see the worker weekly to see if the problem could be overcome. The worker was seen frequently by Dr. Peddle for cervical manipulation. His progress report of April 18, 1988 indicated the worker's condition was improving. It also stated that passively full range of motion could be attained. Actively with some encouragement it also could be attained; however, immediately following the situation the worker would go into his torticollis position.

On July 15, 1988 the worker was seen by Dr. Farrell for an assessment. He noted the worker reported a persistent aching pain-in the neck and nuchal area which varied in intensity based on activity. The worker reported some improvement. Dr. Farrell noted the worker had developed spastic torticollis following his injury. He also noted the worker was in no obvious distress throughout the assessment but complained that passive manipulation aggravated his neck discomfort.

The worker was assessed by Dr. Pryse-Phillipson on July 27, 1989. He noted the worker presented in an almost constant state of torticollis with the head rotated to the right side, the chin up, the left shoulder also elevated and the ear side depressed. Sitting, even for a short period of time lead to marked relaxation. The physician diagnosed generalized dystonia. In his follow up report of February 13, 1989 he stated the patient had segmental dystonia in the form of torticollis. The worker was somewhat improved but by no means able to return to work although in a previous statement Dr. Pryse-Phillipson gave to the WCB he noted if given a suitable work environment the worker may be able to do so. Dr. Pryse-Phillipson questioned the worker's intellectual ability, sociological factors and the availability of suitable work as reasons the worker was unable to work.

In February 1989 the worker was admitted to the Downsview Rehabilitation Centre (DRC). During the initial assessment the worker's principle complaint was stiffness and tightness in the neck. The worker indicated at the time that despite multiple and prolonged treatment there was no improvement in his condition. He denied memory, emotional or sleeping problems. He reported that after walking his head "goes numb". During the examination the worker was holding his head turned to the right side and rotated upward. This deformity varied throughout the examination but complete straightening was not observed. There was no obvious muscle spasm in the cervical spine and minimal tightness of the left tapezius. The left shoulder was slightly elevated and a mild kyphus scoliosis to the left was noted in the dorsal spine. There was some tremor of the hand.

During the DRC Neurosurgical Consultation of March 2, 1989 the worker's principle complaint was that he was unable to maintain his head in an upright position. The worker had difficulty looking straight forward. From time to time he had uncontrollable writhing movements of the neck as the left ear is pulled downward toward the shoulder and his chin turned to .the right. Muscular aching and stiffness was reported and the worker indicated the pain goes as far down as the mid portion of his back to the sacrum. On examination the worker did not appear to be in distress. The specialist also noted that when the worker's attention was drawn to the neck, the posturing was exaggerated. When the worker lay in a supine position, the head occupied an almost normal position and could be moved with much less resistance than encountered with the worker upright.

From March 2-7, 1989 the worker underwent a General Clinic Psychological Assessment at the DRC. The worker reported at the time his major problem was the back and forth movement of his neck on a constant basis. When he walked the movement was more pronounced but it was still steady when he was seated. The worker reported no difficulties with headaches, dizziness, or other somatic complaints. Attention/concentration and memory function were stated by the worker to be adequate. The worker reported sleeping well and had no accidents or other nightmares. He reported

no other psychological symptoms. The worker did report being a little bit more anxious since his accident because people stare at him which makes him uncomfortable. He did not feel irritable or depressed. He also continued to interact on a social basis. The assessment was inconclusive for any diagnosis.

On March 8, 1989 the worker had a Social Work Assessment. During the assessment the worker reported pain and stiffness in his neck and shoulder area. The worker did report having difficulty falling asleep at times since it is necessary for him to locate a comfortable position before this is possible. When in public the worker did have anxiety since he felt people looked at him because he was unable to move his neck. His predominant mood remained largely unchanged. The worker denied any deficits in memory or concentration. The worker claimed to be physically unable to work. The worker reported a sedentary lifestyle and that this did not appear to be a concern to the worker.

On March 13, 1989 the worker complained to Dr. Horsey at that his benefits had been reduced because Dr. Pryse- Phillips had indicated he was not totally disabled. The worker stated that he considered himself totally disabled. Dr. Horsey disagreed and advised he considered the worker to be partially disabled, but with effort and patience the worker could be employed in a very light job. The worker indicated the DRC program had made him sore all over. If he walks, the top of his head goes dead and that precludes any form of gainful activity.

On March 14, 1989 the worker was assessed by Dr. Lang a neurologist. The worker reported pain was present for more than 75% of the time and is a major contributor to his disability. The worker reported parasthesia in the occipital region when he walked. He also noted a tremor of his hands since age 18 or 19 when he began to drink alcohol. The specialist reported a complex abnormality of the worker's head and neck posture. Dr. Lang stated the worker's clinical features were typical of an organic neurologic dystonic disorder, namely spasmodic torticollis. In addition to the torticollis there was a mild essential tremor and indefinite findings such as minor abnormal posturing of the hands and. clenching of the jaw which was suggestive of segmental and cranial dystonic involvement It was unclear whether these features might be indicative of a predisposition to dystonic sequelae of peripheral trauma. Dr. Lang recommended treating the worker with botulinum toxin injections.

The March 21, 1989 DRC Psychiatric consultation report indicated that there was significant evidence from personality testing to suggest the worker's condition is psychogenic and the psychogenic factors are the worker's personality characteristics. "This is the kind of person who is ready at the least excuse, such as a minor accident, to claim total disability and maximum financial gain in order to continue his basic dependant personal lifestyle".

The March 31, 1989 DRC discharge report stated the worker could return to modified employment, avoiding lifting about 10kgs and overhead level work. The discharge report noted a soft tissue injury to the neck, spasmodic torticollis, alcohol abuse and features of dependent and histrionic personality.

The April 11, 1989 follow up report from Dr. Pryse Phillips noted the worker showed very substantially less torticollis. The doctor would not comment on the worker's fitness to return to work noting the worker had already been assessed at DRC. He did state that further exercise to the worker's body musculature would not be harmful to the focal dystonia.

On June 16, 1989 Dr. Peddle commented that he agreed the assessment in Toronto and felt the worker could return to light work.

On July 9, 1989 the worker had a Pension Assessment. The report noted the worker's head was inclined to the left at about 30 degrees and constantly rotated to the right at about 45 degrees. The tremor was sometimes vertical and sometimes horizontal and

sometimes a mixture of both. The physician noted in his report the tremor, restriction of motion and deviation of the cervical region, if psychological, appeared to be at an unconscious level The worker did not appear to be employable as a result of organic and non organic factors.

On April 18, 1991 Dr. Pryse-Phillips report indicated the worker was adamant that he could and would not work and it was unfair for the doctor to say he could perform light work. Dr. Pryse-Phillips stated the worker was unmotivated to work although he accepted the worker had a good deal of muscle pain which was worsened by activity. He recommended the worker be assessed by Dr. Curran a specialist in involuntary movement disorder.

The January 13, 1992 report from Dr. Curran noted the worker reported no significant improvement and complained of an incredible amount of pain as well as torticollis. Dr. Curran disagreed as he saw significant improvement in the worker's condition. During the April 28, 1993 follow up [the doctor] again was of the opinion there was more improvement than the worker perceived. [The doctor] indicated the worker was totally incapacitated from working because of post traumatic dystonia

The April 28, 1993 report from Dr. Curran stated that he believed there was more improvement in the worker's torticollis than the worker but that was a matter of debate. In his June 10, 1993 report Dr. Curran believed the worker was gaining some visible benefits from Botox injections in that his head was straighter than the first time he saw the worker. He also stated the worker was certainly experiencing significantly more pain with the injections which he presumed was due to degenerative disc disease.

The worker received psychiatric treatment from Dr. Hanley. The July 29, 1996 report from Dr. Hanley noted the worker was initially seen in 1969. The worker was concerned about the side effects of torticollis on his personal life as it impacted on his ability to work and participate in social interaction. The worker was frustrated by the pain and the embarrassment of his continuous spasm. At the time Dr. Hanley felt the worker's depressive symptomology was secondary to the torticollis, the embarrassment he was suffering and the result was curtailment of life, work and social activities.

In December 1995 the worker was re-referred to Dr. Hanley for symptoms of severe depression. There had been no change in the worker's torticollis however there was a marked change in his affective state. The effects of the injury had acted devastatingly on the worker's emotional and social life. Dr. Hanley stated the worker had been afflicted with a total arid pervasive anhedonia to the point where he had actively contemplated suicide. He felt his life was futile, he was unable to work and he continued to be disfigured and troubled by the loss of movement in his neck and upper torso. The loss of social and personal capacity had been severe, productive of a man who was isolative, withdrawn. Dr. Hanley diagnosed the worker with a Major depressive disorder with symptoms of generalized anxiety.

The June 2001 radiology report indicated there is marked decrease in the C3 - C4 disc spacing with osteophytic formation, minor degenerative osteoarthritic changes posteriorly.

There is a report dated July 4, 2001 from Dr. Earle a chiropractor who treated the worker for torticollis and associated cervical joint dysfunction and tremors for three years. He indicated the worker gazed at the floor and avoided direct eye contact which was taken as a sign of embarrassment and anxiety concerning his condition. The worker reported continuous and often excruciating pain. Physical examination revealed a significant tremor of the head and neck.

There was a left cervical tilt with right rotation of the head and protrusion of the chin. Palpation revealed spasm and tenderness of the posterior and lateral cervical musculature extending down into the upper posterior thoracic region. Dr. Earl noted the June 2001 radiology report and had reviewed an archived cervical x-ray on file for the worker dated

August 22, 1986 which was normal with no evidence of degenerative changes. Dr. Earle stated the changes in the cervical joint structure were indicative of post traumatic joint degeneration.

On March 4, 2003 the worker had a pension reassessment examination. The report noted the worker was capable of doing lighter chores at home if he paced himself. He was unable to do any lifting or carrying of heavy objects. He was able to manage with activities of daily living and was able to sit for approximately 23-30 and could walk for 15-20 minutes. While sitting the worker displayed a constant tremor of the head, and externally rotated his shoulders. This movement seemed to settle his torticollis to a small extent. The report commented on the worker's movement, range of motion and motor testing.

The May 31, 2007 report by Dr. Consky indicated the worker continued to have marked symptoms of cervical dystonia. The worker reported constant pain in the region of the left posterior triangle which he rated at a severity of 10/10. The worker's fingers curled involuntarily, more so, on the right. He occasionally had clenching of the jaw. At times, he had severe tremor of the head, hands, and whole trunk. He had difficulty shaving, doing up buttons. His shoe laces were pre-tied. He avoided social activities. He had periods of severe depression but had not been on anti-depressants for several years Cervical spine x-rays obtained June 11, 2001 showed marked degenerative disc disease of the cervical spine most significant at C3-4. Dr. Consky stated that patients with cervical dystonia were also at risk for developing premature cervical degenerative joint disease secondary to abnormal neck movements and asymmetric postures. This may be a contributing factor to the worker's severe neck pain. Dr. Consky also stated that Dystonia was a chronic neurological disorder for which there is no cure and the worker had marked disability secondary to his post-traumatic dystonia and the associated upper tremor.

The June 28, 2012 report from Dr. Parsons indicated the worker complained of longstanding social embarrassment and feelings of shame with negative self-esteem stemming from the perceived social stigma and the ridicule he experienced because of his physical disabilities. Significant poor mood and frequent agitation was described because of the reactions he received in a public setting. There were indications of psychomotor agitation and significant anger and frustration stemming from these encounters. The worker reported significantly reduced social activities to the point that he described himself as being socially isolated. Dr. Parson's clinical impression was depressive disorder of a chronic nature and despite significant social dysfunction stemming from the worker's mood and anxiety symptoms the worker resisted medical intervention or further specialist psychiatric assessment. Dr. Parsons stated he had no reason to disagree with the comments of the previous psychiatrist. The worker continued to display significant symptoms of depressed mood and marked social isolation and anxiety. This was the last medical report on record.

In addition to reviewing the above documentation I requested an opinion from a Physician Consultant. I specifically asked for an opinion on the following;

1) Based on the medical reporting on file, are the worker's pain level and complaints consistent with the compensable organic condition of cervical dystonia?

2) Does the worker meet the medical criteria for Chronic Pain Disorder?

Dr. Mula a physician consultant spoke to the worker's treating physician Dr. Parsons to obtain additional details regarding the worker's condition. Dr. Parsons stated that the worker does suffer continuous consistent and genuine pain. Also, the worker's pain was not inconsistent with the objective findings. Dr. Parsons had not specifically assessed the worker for chronic pain. He reported the worker has been seeing a pain specialist and that he has seen the worker for mechanical lower back pain as well in the last year. Dr. Mula having reviewed the medical documentation on file and discussed the worker's condition with the family physician concluded that the worker did not meet all the criteria for

> chronic pain. He stated that there is no certainty that chronic pain was impairing he worker's earning capacity and the worker's pain is not inconsistent with objective findings. The worker's complaints are consistent with the compensable organic condition of cervical dystonia.

[8] The worker's counsel in this case also provided a written submission in March of 2017 addressing the worker's further claim for supplemental benefits. It was noted that the worker was a labourer when he was originally injured. The worker's sister also provided an affidavit on file that listed a range of labouring jobs for the worker's history. The worker was also offered a light job in 1989, after claiming he could not do his regular job. He was evidently offered a job as an assistant mechanic, washing vehicles and cleaning small parts, which involved some bending. The worker refused the job as he felt himself to be totally disabled.

[9] It was also noted that the worker was in receipt of a 15% permanent disability award for his neck condition as of January 29, 1990, with full arrears. The quantum of the worker's PD award was confirmed by the WSIAT in *Decision No. 2254/03*. It was further noted that supplemental benefits were awarded at the time on the basis that, even if the worker had returned to the light duty work offered by the accident employer, he would have suffered a wage loss and qualified for a supplement. The worker started receiving section 147(4) supplemental benefits on April 30, 1990.

[10] The supplement however was terminated by the Board on June 1, 1992. It was noted in a letter to the worker that his employer had suitable modified work for him, but that he had moved and was no longer available for modified work in Ontario. Therefore, his supplemental benefits were discontinued.

[11] I note however that section 147(4) supplements are ongoing from the date that they are awarded, continuing until the worker becomes eligible for old age security benefits; see sections 147(7) and (8) and *Decision No. 1858/08*. As stated below it does not look like these benefits were terminated following a review under section 147(13) or (14). That said, Tribunal decisions have held that a section 147(13) review is only intended for recalculation purposes, and that initial entitlement to the supplement should not generally be addressed on a section 147(13) review; see *Decisions No. 806/94*, *941/94* and *775/14*. In light of the above therefore, there is no apparent basis for terminating the 147(4) supplement in June 1992 in the case before me, which the worker was granted as of April 1990.

[12] In any event, for the reasons below, I find that the worker would still have been entitled to the section 147(4) supplement as of June 1992. In this regard, I make no ruling in this decision with respect to statutory reviews provided under section 147(13) or (14).

[13] I also noted that the Decision Review Branch (DRB) ruled in February of 1993 that the worker did not return to work after his neck injury and had also established residency in another province. He was also evidently in receipt of CPP Disability benefits. The previous ruling that the worker was not available for suitable modified work was also noted. The DRB also noted a VR rehabilitation report in June of 1990 in which the worker claimed an inability to return to the work force. However, the worker's objection was denied on a similar basis due to the worker's inability to return to suitable modified work after his move out of the province.

[14] The 2013 decision of the ARO was also noted as refusing the renewal of the supplement. The submission focused on the fact that the worker was found to have failed to accept an offer of employment from the accident employer, and failed to mitigate his earnings loss. The worker's

counsel submitted that such reasons are not relevant to the issue at hand. I note again however that the only issue before me is the worker's entitlement to section 147(4) supplemental benefits. In that regard, it was submitted that the reporting from Dr. Hanley in 1996 indicated the worker had not worked since 1989. There was also evidently an affidavit from the worker's spouse that indicated the worker did not work during the years from 1990 to 1996. It was further noted by Dr. Hanley that by December of 1995 the worker was suffering from severe depression, which further compounded his disability, and an inability to restore his pre-accident earnings as a labourer.

[15] I have considered the submission on behalf of the worker regarding section 147(4) benefits and also noted the ARO's findings regarding the diagnosis of the worker with depression and anxiety from Dr. Hanley. It was evident that the worker's injury impacted his ability to work, along with the impact on his social and personal life. Dr. Parson's also evidently confirmed his ongoing chronic depressive problems in 2012.

[16] While psychiatric benefits for the worker were allowed, the ARO found similar to the prior decisions that the worker had been offered suitable modified work, but declined the worker after moving out of the province. It was further noted that the medical information on file indicated that the worker was partially disabled at the time with restrictions of avoiding overhead work and lifting over 10 kgs as per the DRC discharge memorandum of March 31, 1989. It was also confirmed that the worker was offered a job as an assistant mechanic, which I again note was at a wage loss and was the basis initially for the worker being granted supplemental benefits.

[17] It was further noted that VR services were stopped when the worker declined to consider modified work. It was found that the medical information on file indicated that the worker was partially disabled, but employable, and that suitable modified work remained available. The ARO went on to find that, despite the award of psychiatric benefits, the worker was not totally disabled. It was also found that the worker's past actions were a contributing factor to his current situation, in that he did not accept the employer's offer of modified work, or accept the assistance of the case worker, in order to mitigate his wage loss. Given the worker declined to participate with vocational rehabilitation services, it was found that he was not eligible for section 147(4) benefits.

[18] I note again however the test for qualifying for such benefits cited above. The work injury need only have been partially related to the worker's wage loss, and need not have been the only or even a significant factor. In this case, the worker continued at the relevant time to have significant physical restrictions, including for example ongoing pain that was worsened by activity according to Dr. Pryse-Phillips in April of 1991. The doctor also stated that the "stresses of even a light or moderate occupation may lead to increasing discomfort and I suspect that would disable him entirely." Such concerns regarding the worker's marked disability were also echoed by other treating physicians in the reporting noted above.

[19] It was therefore evident that there were barriers to the worker returning to even light/modified duties. A number of doctors expressed concern over the impact of the worker's neck condition and his ability to return to the workforce. For further example, in 1992 and 1993 Dr. Curran questioned the worker's ability to return to work. The reporting from Dr. Hanley also clearly painted a picture of a significantly disabled worker due to his work injury, and that it had impacted his ability to return to gainful employment.

[20] I also noted the reporting from Dr. Consky, neurology, in 2007, and that the worker continued to suffer marked life disruption due to "post-traumatic dystonia". As the WSIAT has previously concluded in *Decision No. 2254/03*, cervical dystonia was recognized as compensable, and "With respect to the tremors in the worker's upper extremities, we find that this is a condition which was either caused or exacerbated by the worker's compensable accident and is to be included in rating the worker's permanent disability pension."

[21] After considering the balance of the medical and file evidence, it is my view that the worker's longstanding neck injury was at least partially related to the impairment of the worker's earning capacity. The worker was therefore entitled to section 147(4) benefits beyond June 1, 1992.

[22] I also finally note that it was submitted that the worker should be awarded a full supplemental award after the supplement was terminated. It was further submitted that the Board should be directed to consider a supplement review under section 147(13) (14). However, benefits under either of those sections were never considered in the ARO decision under appeal or in either the Board or Decision Review Specialist decisions in 1992 and 1993. I do not therefore make any order in regard to those sections of the pre-1997 Workers' Compensation Act.

DISPOSITION

[23] The appeal is allowed.

[24] The worker is entitled to section 147(4) benefits beyond June 1, 1992.

[25] This decision makes no ruling with respect to statutory reviews provided under section 147(13) or (14).

DATED: March 8, 2019

SIGNED: A.G. Baker