Automobile Injury Appeal Commission

Province of Saskatchewan

Citation: *R.U. v. Saskatchewan Government Insurance* 2008 SKAIA 048
Date: 20081106
File: 120 of 2006

BETWEEN:

R.U., Appellant

and

Saskatchewan Government Insurance, Respondent

Appearances*:*
Terry Zakreski, for the Appellant
Dale Brown, for the Respondent

Before: **Jane Lancaster, Q.C., Chair**
Carol Olson, Commission Member
Barbara Tomkins, Commission Member

THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Heard at Saskatoon, Saskatchewan
September 25, October 15 & November 21, 2007 and
January 28, March 18, May 22 & September 8, 2008

DECISION

[1] The Appellant was seriously injured in a vehicle accident on February 10, 2001. Her injuries included multiple bruises and lacerations, ruptured bladder, pelvic fracture, and abdominal trauma. Her most serious injury, however, was a closed head injury that has resulted in permanent cognitive impairment.

[2] The Appellant applied for and receives benefits under Part VIII – the no-fault provisions – of *The Automobile Accident Insurance Act* ("the *Act*"). Eventually, it became necessary to determine whether the Appellant's injuries were catastrophic, as that term is defined in the *Act*. SGI determined that they were not and provided a decision letter to this effect. The Appellant has appealed that decision.

THE ISSUE

[3] The *Act* sets out that when a person is catastrophically injured in an accident, certain benefits are calculated differently. For example, the one-week waiting period required in non-catastrophic circumstances is not applied and the amount payable for income replacement benefits can be increased. There are other benefits affected but these are the two that most directly affect this Appellant. This appeal requires the Commission to consider and determine only whether the Appellant suffered catastrophic injuries in her accident.

[4] The relevant portion of *The Personal Injury Benefits Regulations*[1] defines "catastrophic injury" as follows:

> 2(1) In these regulations:
>
> (c) **"catastrophic injury"** means:
>
> (iv) a functional alteration of the brain within the meaning of Division 2, Subdivision 1, Parts 4.6, 4.7 and 4.8 of the Schedule

[1] Although the Appellant's accident occurred prior to August 1, 2002 and therefore is generally administered within the provisions of the Act as it existed at the time of her accident (commonly referred to as "the old Act"), it has been decided and the parties have agreed that the issue in this appeal is governed under the relevant provisions of the post-August 2002 Act.

> of Permanent Impairments resulting in a determined impairment of 50% or more;
>
> (v) the total impairment of 80% or more calculated using the table of successive remainders based on a combination of one or more of the following:
>
> > (A) those impairments identified in subclauses (i) to (iv);
> >
> > (B) a Division 1, Subdivision 2, Part 2.1 or 3.1(a) impairment;
> >
> > (C) a Division 1, Subdivision 2, Part 3.1 impairment;
> >
> > (D) a Division 2, Subdivision 2, Part 3 impairment;
> >
> > (E) an impairment identified in clause (a) of Division 4;
> >
> > (F) an impairment of 50% or more from Division 4;
> >
> > (G) an impairment of 30% or more from Division 2, Subdivision 1, Parts 4.6, 4.7 and 4.8[.]

[5] The Appellant has submitted that she has suffered cognitive injuries that are catastrophic pursuant to the definition set out in subclause (iv) above. She further submitted that her injuries might constitute catastrophic injuries pursuant to the definition set out in subclause (v) but she argued that the Commission ought not to consider this section. Instead, counsel asked for the Commission's decision regarding subclause (iv) only and says that if we conclude that her injuries are not catastrophic for purposes of that subclause, it will then fall to SGI to consider and provide its decision specifically with regard to subclause (v).

[6] We agree with this submission. The decision letter appealed specifically considers whether the Appellant's injuries are catastrophic for purposes of subclause (iv). SGI wrote:

> Part 1-2(c)(iv) of the Automobile Accident Insurance Act defines "catastrophic injury" as a functional alteration of the brain within the meaning of Division 2, Subdivision 1, Parts 4.6, 4.7 and 4.8 of the Schedule of Permanent Impairments resulting in a determined impairment of 50% or more.
>
> Upon review, our consultant has determined that your injuries do not meet the definition for catastrophic injury as per the Automobile Accident Insurance Act, Part 1.

[7] It appears inherent in this that SGI did not think subclause (v) could apply, just as it did not provide a decision regarding subclauses (i) to (iii), which obviously do not apply to the Appellant's circumstances.

[8] There having been no decision provided regarding subclause (v), there is no such decision to appeal and the Commission cannot, therefore, decide whether that clause might apply or not.

[9] We note, however, that our decision regarding subclause (iv) will necessarily involve the consideration of Parts 4.6, 4.7 and 4.8 as these are specifically relevant to subclause (iv). As they are also specifically relevant in subclause (G) of subclause (v), these findings may be relevant to any subsequent decision and possible appeal respecting a determination pursuant to subclause (v).

[10] Further, it appears to us that subclause (v) involves conditions, in addition to those we will consider in this decision, such as paraplegia, quadriplegia, blindness and amputations that we understand the Appellant did not suffer. If so, this narrow issue may be academic.

JURISDICTION

[11] The Commission derives its jurisdiction from section 191(1) of the *Act* which provides as follows:

> 191(1) A claimant may appeal a decision of the insurer pursuant to this Part to either the Court of Queen's Bench or the appeal commission within the later of:
>
> > (a) 90 days after the date of insurer's written decision; and
> >
> > (b) if a claimant has requested mediation pursuant to section 190, 60 days after the date [of] the mediator's written statement pursuant to subsection 190(8) declaring that the mediation is completed.

[12] SGI's decision letter in this matter is dated January 27, 2006. The Appellant requested that the matter be referred for mediation and the mediation was concluded on October 20, 2006. The appeal was filed on December 8, 2006.

[13] Thus, her appeal was filed within 60 days of the mediator's letter and in accordance with section 191(b). The appeal is properly before us.

FACTS AND FINDINGS

[14] Given the specific issue before us, it is not necessary that we recite detailed facts or reach conclusions regarding the Appellant's physical injuries or the progression of her cognitive injury. Instead, our findings of fact will be limited to those regarding her permanent cognitive impairment. Additional information will be provided, however, to give context to the facts necessary to our decision.

[15] The Appellant was hospitalized for about a month following the accident and then was transferred to a rehabilitation facility. Upon discharge from the facility, she was noted to have significant cognitive deficits including inconsistent memory, distraction and irritation. She was then still in a state of post-traumatic amnesia. She could participate in conversation and follow two-step instructions. It was noted that she appeared to comprehend hospital signs and schedules. She was unable to initiate any tasks other than those relating to basic self-care. Her memory was not consistent for daily information and she was considered a risk due to impaired judgment.

[16] A neuropsychological examination conducted by Dr. Terry Levitt on January 31, 2002 showed that, in the time following the accident, the Appellant's cognitive function had improved, although she continued to experience significant impairment.

[17] Dr. Levitt concluded that the Appellant had suffered a brain injury that fell within the severe range. He said, however, that the Appellant's pre-accident level of cognitive functioning was not optimal, partially for environmental reasons and partially due to significant alcohol abuse prior to the accident. In considering the impact that pre-existing factors might play on the Appellant's post-accident cognitive state, he wrote:

> The level of her injury certainly places her at risk for multiple neuropsychological weaknesses. Level of impairment on tests of processing speed, attention, memory, signs of executive behavior, and speeded motor tasks is definitely beyond what would be expected based on demographic and alcohol history alone. That is to say, there is a definite basis given what is known about individuals with similar injuries for her to have neuropsychological weaknesses beyond expectations of other influences. Quantifying the

> extent of attribution is really imprecise. In these areas, the contribution of the accident is likely to be quite high.

[18] He concluded that there was a "high likelihood of persisting neuropsychological sequelae secondary to her injury" and "It is too early to tell but the chances that there are permanent sequelae are high given the severity of her injury." Describing her condition at the time of the report (January 2002) he wrote:

> At this point, her cognitive impairment places her at risk for difficulty with even basic activities of daily living (i.e. shopping, money management, cooking) and more certain risk with novel activities, such as independent childcare; ideally, she would receive supports with this. Given her educational and vocational (nil) background and level of neuropsychological difficulty, risk for difficulty with future competitive employment is clearly high.

[19] However, Dr. Levitt thought the Appellant had potential for further recovery until as long as five years after the accident. It was too early, therefore, to determine the degree and impact of her *permanent* cognitive injury.

[20] Shortly following this assessment, the Appellant commenced a tertiary treatment program at FIT for Active Living ("FIT) on April 30, 2002. While a period of 14 to 16 weeks of full-time participation had been recommended upon assessment, her commitment and progress was excellent and she was able to be discharged on May 31, 2002 after only five weeks of treatment.

[21] In its discharge report, FIT reported excellent improvement in the strength and function of the Appellant's left ankle, her tolerance for walking, and her level of safety doing household tasks and in her readiness to adopt strategies for dealing with the consequences of her brain injury. As to the brain injury itself, FIT reported that she still suffered ongoing memory concerns, though there had been some improvement.

[22] Although the FIT program was focused on the Appellant's physical rehabilitation, the report provided the following observations regarding her cognitive deficiencies at May 2002:

> With respect to her memory, [the Appellant] had some difficulty remembering the names of her therapists, and on one occasion repeated a story within an hour session, as if she was telling it to this writer for the first time. There were also times when she lost her train of thought if interrupted and could not retrieve her thoughts in spite of cognitive

> effort and cueing. On the other hand, she was able to remember conversations from one session to the next, had committed several important phone numbers to memory and surprised herself with her ability to spontaneously remember the phone number for a taxi company. Ms. Meger [Occupational Therapist] also reported that the client was able to demonstrate the ability to multitask and remain focused during a household assessment in the kitchen.

[23] A second neuropsychological assessment was conducted by Dr. Levitt on January 19, 2004. He reiterated that the Appellant had suffered a severe brain injury and that:

> The accident is a major contributor to difficulties with memory, conceptual thinking and problem solving, and slowed motor functioning. Milder suppression of visual intellectual skills and aspects of visual constructional skills is also possible. Although there are some validity concerns with memory on this assessment, the level of difficulty apparent at almost one year post injury was pronounced and, although some ensuring recovery is possible, quantum resolution is not likely.

[24] Later in the report, he concluded that "[f]urther significant neuropsychological recovery at this point in time is unlikely although accommodation for functional difficulties can occur indefinitely."

[25] With respect to the Appellant's ability to undertake specific kinds of employment, Dr. Levitt wrote:

> Regarding specific duties, although at face [the Appellant's] profile would not suggest the inability to perform the aforementioned jobs, based on the available information there are still concerns. For example, regarding [the Appellant] being able to manage a position that involves a cash float, difficulties with memory could impede her ability to give a good account of events should problems arise (e.g. if she ends up "short" with her float) and collateral report notes poor ability to account for change and risk of inaccuracies and being taken advantage of. She also appears to be a very poor problem solver when under stress and she should not be expected to effectively trouble shoot non-routine situations that can emerge (e.g. dealing with a complaining, angry customer). This could render her non-competitive. Although mostly routine, working as an usher can involve some on the spot problem solving which could again be problematic. I can not identify any barriers to a "ticket taker" position with regard to the specific task requirement although, again, the concern is if she had to manage an out of the ordinary situations, something that can probably not be ruled out.

[26] In July 2005, SGI's medical consultant, Dr. Howlett, provided his opinion that the Appellant's injuries did not meet the definition of catastrophic injury" as defined in the legislation. Despite the complexities of this case, he did not provide any facts or analysis in support of his conclusion.

[27] In anticipation of this appeal, SGI requested a further opinion from its consultant. By letter dated March 8, 2007, Dr. Howlett again concluded that the traumatic brain injury the Appellant suffered did not amount to a catastrophic impairment within the definition in the Act.

[28] He concluded that the total permanent impairment for the combined effects of the traumatic brain injury would be assessed at 21%. Of that 21%, he said, only 15% fell within Parts 4.6, 4.7 or 4.8 – the sections necessary to find catastrophic injury for purposes of subclause (iv) of the definition in the Regulations quoted above. He gave the following explanation for his assessment:

> **4.6 Communication Disorders**
>
> - *In his Neuropsychological Evaluation of January 19, 2004 Dr. Levitt states "A good proportion of verbal acquired knowledge and language and reading deficits in general should be attributed to non injury factors".*
> - *No specific permanent communication disorders have been identified in this case.*
>
> **4.7 Alteration of Consciousness**
>
> - *There is no documentation of any posttraumatic epilepsy, syncope, cataplexy, narcolepsy, or other neurological disorders causing disturbances of consciousness.*
>
> **[4.8] Cognitive Function**
>
> - *Dr. Levitt (January 19, 2004) – "A mild-moderate level of reduced functional efficiency in cognitively demanding settings is likely based on the nature of her injury and general indications regarding her outcomes."*
> - *Acquired Brain Injury Outreach Team progress report (June 3, 2003) – ". . . family has noticed significant short-term memory loss, changes in behaviour (ie: irritability), and organization. However, [Appellant's brother] did state that [the Appellant] compensates well while depending on her family supports."*
> - *Acquired Brain Injury Outreach Team progress and inactivation report (September 2, 2003) – ". . . [the Appellant] has a total of seven children that she regained custody of after her injury. Her younger children live with her and are attending school a few blocks away in [her town of residence] . . . writer was informed that [the Appellant's] family was assisting her by advocating on her behalf . . . She told this writer that she was having her cousin [name deleted] and her brother [name deleted] assist her with her finances. . ."*
>
> *Based on the above and other information from the file it appears that [the Appellant] has made a reasonable cognitive recovery as it related to tasks necessary for every day life. She maintains a home, cares for herself and cares for her children without supervision. There is indication that some assistance is required when it comes to financial matters and when dealing with institutions like SGI or Health Canada. This assistance does not seem extraordinary and many individuals seek the counsel of family*

> *members in their financial dealings. Therefore, it is my opinion that permanent impairment for alteration of cognitive function should be abased on the following description:*
>
> (d) Alteration of the higher cognitive or integrative mental functions which slightly impair the performance of the tasks necessary for every day life, include any side effects of medication:………………………………………………..…...…….15%

[29] In the course of the hearing, it became apparent that Dr. Levitt had not specifically addressed the conditions set out in Parts 4.6 and 4.7 in his neuropsychological assessment report. The parties agreed to adjourn the hearing and seek expert opinion as to whether the Appellant suffered any of the conditions set out or included in those parts. In particular, therefore, they sought Dr. Levitt's opinion regarding Communication Disorders and Alterations of Consciousness.

[30] Dr. Levitt provided a letter dated November 9, 2007 in which he wrote:

> . . . I refer you to page six of my report where I discuss her objective performance on tasks of language function in detail. Significant language disturbance is not common after moderate or severe traumatic brain injury (TBI) although certain types of language disturbances can be seen more frequently. In her instance, regarding the disturbances listed under question number one (i.e., dysphasia, aphasia, alexia, agraphia, and acalculla), the combination of my behavioural observations and objective test results from my March 2002 and February 2004 evaluations do not indicate clinical deficits in any of these areas.

[31] With regard to Part 4.7, Dr. Levitt indicated that diagnosis in those areas was beyond his area of expertise and suggested that those diagnoses lay in purview of a neurologist.

[32] Therefore, Dr. Voll, the Appellant's consulting neurologist, was consulted with regard to Part 4.7. He advised by letter dated April 22, 2008:

> I am unable to identify any objective neurological findings to account for this patient's subjective complaints of dizziness. You inquire specifically regarding a diagnosis of post-traumatic epilepsy, syncope, cataplexy or narcolepsy or other neurological disorders associated with disturbances of consciousness. As noted above, I am unable to find any objective evidence for any of these disorders.

[33] The documentary evidence recounted above was supplemented by oral evidence.

[34] The Appellant's brother testified to visiting the Appellant within hours of the accident and occasionally thereafter. He said that she is noticeably different now than she was before the accident. For example, he said that before the accident she was strong

and fun-loving but is now "blank". Before the accident, he said, her brain was like a vice, whereas now she doesn't remember things unless she writes them down. Simply put, he said she is not the person he knew. He thinks she cannot now live on her own and he doubts she will ever be able to do so.

[35] The Appellant's daughter also testified. She was 13 years old at the time of the accident and was not then living with her mother. She came back to live with her mother three years later, when she was 16 years old. She also said her mother is different than she was before. She said she sometimes forgot who her children were or forgot their names and still mixes them up occasionally. She said her mother needed help with cooking, cleaning and bathing, and that she still helps with these activities. She said she didn't think her mother could walk to a friend's house alone as she would forget where she was going. In addition, she helps with groceries and her uncle helps with financial matters and banking.

[36] The Appellant testified. She said she is unable to sweep, walk stairs or get out of the bathtub without help because she has occasional bouts of dizziness and fears she will fall. She said her daughters do most of the cooking. The Appellant said she will make simple foods like soup or hamburgers but said someone has to watch her or she will forget about it. She said she might doze off. She said she has problems with her short-term memory and at times can't remember where she's going. On the other hand, she had little difficulty listing the medications that she takes, including the pharmaceutical name of one of them.

[37] Dr. Howlett testified for SGI. He said that in completing his review and assessment of permanent impairment, he relied particularly on Dr. Levitt's January 2004 opinion because it involved an examination and conclusions later in the Appellant's recovery and when she had likely reached maximum medical improvement.

[38] He said that with regard to Parts 4.6 and 4.7, no diagnosis of the listed conditions had been given. He therefore concluded that the Appellant was not impaired in regard to those conditions.

[39] For purposes of assessing Cognitive Function for Part 4.8, Dr. Howlett explained, he thought that the following fairly described the condition necessary to meet the criteria:

[40] For (a) – marked impairment of the performance of the tasks necessary for everyday life or that require continuous supervision – Dr. Howlett identified a person who was confined to bed or a wheelchair and who would die without constant care.

[41] For (b) – significant impairment of the performance of the tasks necessary for everyday life and that require nearly continuous supervision – Dr. Howlett identified a person who may be mobile with assistance but would not be alone to navigate. This person would have very low language skills and might communicate, for example, with grunts.

[42] For (c) – Moderate impairment of the performance of the tasks necessary for everyday life and that require occasional supervision – Dr. Howlett identified a person who would require reminders and assistance with complex tasks and who would not be expected to make decisions by themselves.

[43] For (d) – slight impairment of the performance of the tasks necessary for everyday life – Dr. Howlett identified a person who would be seen by others as forgetful and may be competitively employable. This person would require reminders and assistance with complex tasks but would be independent in most areas.

[44] For (e) – very light impairment of the performance of the tasks necessary for everyday life – Dr. Howlett identified a person who may see herself as forgetful and confused but who can live alone and function independently This person would need a day-timer.

[45] In assessing these categories, Dr. Howlett said he drew a distinction between a person who required supervision and a person who required assistance. Supervision, he said, is required to ensure safety and requires the injured party to rely on someone else's discretion. Assistance, as we understood his use of the term, would be closer to guidance

or advice. He concluded that the Appellant required occasional assistance but not supervision.

[46] After considering the medical evidence, and especially Dr. Levitt's reports, Dr. Howlett concluded that the Appellant best fit into category (d) and was therefore entitled to an assessment of 15% for cognitive impairment.

LAW AND ANALYSIS

[47] In reaching our conclusions as whether the Appellant has suffered a catastrophic injury in accordance with section 2(1)(c)(iv) of the *Regulations*, we gave greater weight to the medical opinions than to subjective evidence reported in medical documents or to the oral evidence provided by the Appellant and her family members. While we do not doubt the credibility of those witnesses and the genuine concern they have expressed, we note that in some instances their evidence was second-hand and, more commonly, founded in their fears and expectations for the Appellant. Whereas, for example, medical reports throughout her rehabilitation identify activities that the Appellant was considered able to manage, family members have said that she cannot manage those activities at all or, at least, not without supervision. We are concerned that these observations are founded in concern and a desire to help, rather than on the Appellant's real capabilities.

[48] On the other hand, we are not impressed by single incident observations. For example, the Occupational Therapist observed the Appellant peeling and frying potatoes; this does not translate to an ability to make reasonable meals unassisted. Similarly, the fact that on one occasion, the Appellant neglected a pot on the stove does not indicate that she cannot safely cook unassisted.

[49] Finally, we are aware that some of the Appellant's disability is physical and likely permanent. However, the issue before us relates only to disability that arises from functional alteration of the brain and we are mindful that limitations arising from her physical disability are not relevant to this decision.

[50] For ease of reference, we have divided our discussion and conclusions by reference to Parts 4.6, 4.7 and 4.8 which are under consideration in these reasons. Those provisions read as follows:

> 4.6 Communication Disorders
>
> Dysphasia, aphasia, alexia, agraphia, acalculia and other communication disturbances:
>
> (a) Disturbances leading to a complete inability to understand and use language 95%
>
> (b) Disturbances not affecting the ability to understand linguistic symbols, but severely interfering with the ability to use sufficient or appropriate language 70%
>
> (c) Disturbances not affecting the ability to understand linguistic symbols, but moderately interfering with the ability to use sufficient or appropriate language 40%
>
> (d) Disturbances entailing minor communication difficulties 10%
>
> 4.7 Alterations of Consciousness
>
> Posttraumatic epilepsy, syncope, cataplexy, narcolepsy, and other neurological disorders and disturbances of consciousness:
>
> (a) Stupor, coma, or other disorder or disturbance that prevents the performance of the activities of daily living or require constant supervision for the performance of such activities or confinement, including side effects of medication 100%
>
> (b) Disorder or disturbance that severely disrupts the performance of the activities of daily living and requires an almost constant supervision for the performance of such activities, including side effects of medication 70%
>
> (c) Disorder or disturbance that moderately disrupts the performance of the activities of daily living and requires occasional supervision for the performance of such activities, including side effects of medication 40%
>
> (d) Disorder or disturbance that hinders the performance of the activities of daily living, including side effects of medication 10%
>
> 4.8 Cognitive Function

Organic cerebral syndrome, dementia and neurologic deficiencies:

> (a) Alteration of the higher cognitive or integrative mental functions which markedly impairs the performance of the tasks necessary for everyday life or that require continuous supervision for performing such activities or confinement, including any side effects of medication 100%
>
> (b) Alteration of the higher cognitive or integrative mental functions which significantly impairs the performance of the tasks necessary for everyday life and that require nearly continuous supervision for performing such activities, including any side effects of medication. 80%
>
> (c) Alteration of the higher cognitive or integrative mental functions which moderately impairs the performance of the tasks necessary for everyday life and that require occasional supervision for performing such activities, including any side effects of medication..45%
>
> (d) Alteration of the higher cognitive or integrative mental functions which slightly impairs the performance of the tasks necessary for everyday life, including any side effects of medication 15%
>
> (e) Alteration of the higher cognitive or integrative mental functions which very slightly impairs the performance of the tasks necessary for everyday life, including any side effects of medication 5%

REGARDING PART 4.8

[51] Turning first to the Appellant's disability under Part 4.8, we do not accept Dr. Howlett's broad categorization as to the circumstances of persons that he ascribed to each of the subclauses. The circumstances he describes are unnecessarily narrow and, in some cases, are inconsistent with the wording of the sections. For example, in subsection (a), the regulations state ". . . markedly impairs the performance of the tasks necessary for everyday life *or* that require continuous supervision for performing such activities *or* confinement". Whereas Dr. Howlett has concluded that a person fitting this category would necessarily be confined to bed or a wheelchair and would die without supervision, we note the disjunctive "or" in the definition. That is, the section contemplates that the person may be confined or he or she may not be confined. The person may require continuous supervision or he may not. Dr. Howlett's categorization appears to incorporate a conjunctive "and".

[52] With respect to subclause (b), Dr. Howlett provided no explanation for his conclusion that a person fitting this category would require assistance to navigate or that his or her speech would be rudimentary. We certainly cannot find support for his conclusion in the wording of the subsection.

[53] Instead, we will look to the medical information and the specific wording of the clauses.

[54] Dr. Levitt wrote in his first report in January 2002 that:

> At this point, her cognitive impairment places her at risk for difficulty with even basic activities of daily living (i.e. shopping, money management, cooking) and more certain risk with novel activities, such as independent childcare; ideally, she would receive supports with this. Given her educational and vocational (nil) background and level of neuropsychological difficulty, risk for difficulty with future competitive employment is clearly high.

[55] In his January 2004 report, in response to the same question that elicited the response above, Dr. Levitt wrote:

> PTA durations of greater than one month are associated with high risk of difficulty of returning to higher level, demanding (e.g. work, school) situations. Most persons with PTA of that duration do not achieve good recovery defined as the ability to return to non-sheltered work, perhaps in a decreased capacity and resume social roles, although some neurological or psychological impairments may remain. There is no indication of major day-to-day difficulty managing her home although subtle problems are apparent. Some informal assistance (serving as a buffer) from older children and her cousin is likely.

[56] It is difficult to compare the reports because Dr. Levitt's conclusions in the second were directed more at the Appellant's capability to hold employment, than at her general cognitive capabilities. Notwithstanding this, we did not note anything in the second report that would lead to conclusions significantly different in respect of the matters in the portion of the first report quoted above.

[57] In that second report, Dr. Levitt recounts, and appears to accept as consistent with his testing, observations and conclusions, information from the Appellant's brother and from the Appellant and says:

> The general impression from collateral report is that [the Appellant] carries out simpler daily tasks independently but that she requires some assistance with more complex aspects of shopping and some daily living activities. Examples of functional memory in

> the file include being unable to remember the nature of her June, 2002 bowel surgery or the nature of her neurology assessment. [*References omitted.*]

[58] It appears, therefore, that the Appellant can manage certain of the tasks necessary for everyday life independently but requires help from others with some activities and more complicated tasks. This would constitute a need for occasional supervision. Given this, we are satisfied that the Appellant's post-injury cognitive impairment is better fitted to subsection (c), rather than subsection (d) as SGI has concluded. We therefore assess her permanent impairment for Cognitive Function pursuant to Part 4.8 at 45%.

[59] We note that this conclusion is also in keeping with some of Dr. Howlett's evidence differentiating between a person who would meet the criteria for subclause (c) and subclause (d). He suggested that a person who fit subclause (c) "may be employable in a sheltered environment" while a person who fit subclause (d) may be competitively employable. Dr. Levitt concluded in his second report that "[m]ost persons with PTA of that duration do not achieve good recovery defined as the ability to return to non-sheltered work . . ." and that her limitations could render her "non-competitve" for employment. These conclusions suggest that, using Dr. Howlett's criteria, the Appellant's cognitive disability better suits subclause (c) than (d).

[60] In so concluding, we are not persuaded by Dr. Howlett's differentiation between "assistance" and "supervision" tendered in his oral evidence. In his written opinion, he used the word "advice" apparently as something different than supervision and suggested that many people – whatever their cognitive abilities – solicit financial advice from others from time to time. We think we should focus our analysis instead on the word "supervision" that is used in the regulations.

[61] In this case, it has been suggested that the Appellant seeks something more than advice in financial matters or, in Dr. Howlett's words, "when dealing with institutions like SGI or Health Canada". We agree that many of us seek advice to assist in making decisions and acting in our best interests. However, the nature of "advice" the Appellant requires is necessary because she is unable to independently make reasoned decisions that are in her best interests; one cannot be confident that she understands the factors in those

decisions and their consequences. In essence, she requires someone to make these decisions for her or, at least, to supervise closely when she makes them herself. This, we believe, is “supervision”; it is something greater than advice or assistance. We have concluded, therefore, that the Appellant requires occasional assistance to perform some of her activities of daily life.

[62] We are also mindful and accept evidence that the Appellant was not enthusiastic about rehabilitation to provide coping strategies; she apparently preferred to accept the generous help offered by her family to managing some tasks on her own. However, there is no suggestion that her level of cognitive capability and coping would be significantly improved if she accepted and used all available coping strategies. Indeed, Dr. Levitt reported her apparent lack of interest in this type of assistance but did not suggest that her reported disability was significantly affected.

[63] Finally, Counsel for the Appellant has argued that the percentages set out in Part 4.8 are not definitive and instead, that they define ranges. That is, he suggests that whereas each of subclauses (a) to (e) set out a specific percentage of permanent impairment for a person who meets the criteria of that subclause, we are able to find a degree of disability between those set out and determine an appropriate percentage between those prescribed. In effect, he says that Part 4.8 sets out a range of percentages and identifies “milestones” within the range.

[64] We do not agree. There are many permanent impairments for which a range of percentages are provided. These involve disabilities that are not precise in nature or impact and the range allows for a greater assessment when a greater disability is found. Part 4.8, however, specifically defines degrees of disability and, in our view, ascribes specific percentages that are awarded for those defined degrees.

[65] We are satisfied that the regulations do not contemplate an award for cognitive function disability other than those specifically set out in Part 4.8. We are supported in this conclusion by the fact that a prior version of these regulations did provide a range of percentages; there appears no reason for the amendment to include specified percentages

unless it was intended that the discretion among percentages that was previously available would be removed.

[66] Further, the matter is academic in this case as we are not satisfied that the Appellant's degree of cognitive impairment under Part 4.8 exceeds that described in subclause (c).

PART 4.6

[67] There is no evidence that the Appellant has suffered a permanent impairment within the purview of either Part 4.6 or 4.7.

[68] Counsel for the Appellant suggested that Dr. Levitt's reports included information that might lead one to conclude that she suffered a communication disorder under Part 4.6. He particularly drew our attention to the portion of Dr. Levitt's January 2004 report titled "Language Functioning" and his conclusion that the Appellant's language functioning was mildly impaired. The portion titled "Language Functioning", he says, therefore supports a conclusion that the Appellant has suffered a minor communication disturbance or acalculia (or both), yet Dr. Levitt later concluded she did not suffer even a minor communication disturbance. Counsel says that without explaining the discrepancy between this finding and his later conclusion, we cannot rely on Dr. Levitt's final opinion. It follows, he argued, that we must find the Appellant suffers a "disturbance entailing minor communication difficulties" as set out in subclause (d) of Part 4.6.

[69] We reject this argument for two reasons. First, it is apparent that Dr. Levitt was aware of his own prior findings and conclusions when he gave his opinion specifically regarding Part 4.6 as he expressly referred to that part of his prior opinion. In particular and in regard to this issue, he was asked:

> 1. Whether, in [Dr. Levitt's] view, [the Appellant] has sustained either dysphasia, aphasia, alexia, agraphia, acalculia, or other communication disturbances.

He replied:

> With respect to Mr. Zakreski's first question, *I refer you to page six of my report where I discuss her objective performance on tasks of language function in detail.* Significant

> language disturbance is not common after moderate or severe traumatic brain injury (TBI) although certain types of language disturbances can be seen more frequently. In her instance, regarding the disturbances listed under question number one (i.e., dysphasia, aphasia, alexia, agraphia, and acalculia), the combination of my behavioural observations and objective test results from my March 2002 and February 2004 evaluations do not indicate clinical deficits in any of these areas. *(Italics ours.)*

[70] Dr. Levitt clearly did not overlook the referenced findings and, in fact, referred to that very section in support of his conclusion. It is clear that he did not see the conclusions to conflict and it is clear that he did not inadvertently overlook information that might conflict.

[71] Second and perhaps more important, we note that there is no evidence that a mild impairment in language functioning necessarily involves a diagnosis of communication disorder.

PART 4.7

[72] There is no evidence that the Appellant suffers any neurological disorder or disturbance within the provisions of Part 4.7. Indeed, Dr. Voll has provided a clear and direct opinion stating that she does not.

[73] We therefore are satisfied that the Appellant is not eligible for any award for permanent impairment pursuant to Part 4.7.

CONCLUSION

[74] We are satisfied that the Appellant, as a result of cognitive injury, suffers a permanent impairment of her cognitive function within the provisions of Part 4.8 subclause (c) and should be assessed 45% impairment in this regard. We are not satisfied that she has suffered any additional permanent impairment pursuant to Part 4.6 or 4.7. Therefore, the total permanent impairment pursuant to all of Parts 4.6, 4.7 and 4.8 for purposes of subclause (iv) of clause 2(1)(c) of the regulations is 45% and she has not suffered a catastrophic injury within the definition in that subclause.

COSTS

[75] As the Appellant has not been substantively successful in her appeal, there shall be no order for reimbursement of her costs and her appeal fee shall be forfeited.

Dated at Saskatoon, Saskatchewan, on October 31, 2008.

Jane Lancaster, Q.C., Chair

Carol Olson, Commission Member

Barbara Tomkins, Commission Member