Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A04–002601

BETWEEN:

KYLE MILSON

Applicant

and

AVIVA CANADA INC.

Insurer

REASONS FOR DECISION

Before: Jeffrey Rogers

Heard: April 3 and 4, 2006, in Kitchener, Ontario.
Written submissions were completed on April 21, 2006.

Appearances: Robert Deutschmann, solicitor for Mr. Milson
James Brown, solicitor for Aviva Canada Inc.

Issues:

The Applicant, Kyle Milson, was injured in a motor vehicle accident on June 27, 2000. He applied for and received statutory accident benefits from Aviva Canada Inc. ("Aviva"), payable under the *Schedule*.[1] The parties disagree on whether Mr. Milson suffered a "catastrophic impairment". They were unable to resolve their dispute through mediation, and Mr. Milson applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

[1]The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

The issue in this hearing is:

1. Did Mr. Milson suffer a "catastrophic impairment" within the meaning of section 2(1.1)(e)(i) of the *Schedule*?

Result:

1. Mr. Milson suffered a "catastrophic impairment" within the meaning of section 2(1.1)(e)(i) of the *Schedule.*

INTRODUCTION:

The only issue in this arbitration is whether Mr. Milson suffered a "catastrophic impairment" within the meaning of section 2(1.1)(e)(i) of the *Schedule*. That section defines "catastrophic impairment" as follows:

> brain impairment that... results in,
>
> (i) a score of 9 or less on the Glasgow Coma Scale... according to a test administered within a reasonable period of time after the accident by a person trained for that purpose...

If Mr. Milson suffered a "catastrophic impairment", he has access to enhanced benefits under the *Schedule*.

EVIDENCE:

I heard evidence from Mr. John Kirkconnell, Ms Kim Crawford, Dr. Jim Squires, Mr. Mark Hunter and Dr. Susan Goodwin. Mr. Kirkconnell is the paramedic who transported Mr. Milson from the scene of the accident to the hospital. Ms Crawford is the emergency room nurse who noted the GCS score in the emergency room. Dr. Squires is the emergency room doctor who treated Mr. Milson. Dr. Goodwin is a neurologist who was responsible for review of the GCS scores as a member of the DAC team. Mr. Hunter is professor and academic coordinator of the paramedic program at Fanshawe College, in London, Ontario. Mr. Hunter's evidence was limited to general information on the purpose of the GCS and how a score is acquired. His evidence was not challenged.

It is not disputed that Mr. Milson suffered a brain impairment when he was injured in a head-on collision as the driver of a Honda Civic. It is not disputed that Mr. Milson's Glasgow Coma Scale (GCS) was assessed three times within a reasonable period after the accident. His scores were 7, 7 and 6. The first two scores were given by Mr. Kirkconnell. It is not disputed that Mr. Kirkconnell is trained in assessing the GCS. The third score was given by a nurse in the emergency room.

Ms Crawford testified that she was not sure whether she conducted the test herself. More likely, she just noted scores given to her by another trained and experienced nurse. Her evidence was that the practice at the hospital is that the person keeping the record would not normally be the person administering the test. Aviva conceded at the hearing that all three tests were administered by persons trained for that purpose. In its written submissions, Aviva for the first time questioned the training of the emergency room nurse, because she had not been identified by name. I find it procedurally unfair to allow Aviva to raise this issue for the first time in submissions. In any event, the only evidence is that the nurse, although not identified, was trained for the purpose of administering the test. I accept that evidence.

A Catastrophic Impairment Designated Assessment Centre Assessment (DAC) was conducted in September 2003. The DAC opinion, based on Dr. Goodwin's review of the records, was that the paramedic scores should have been 10 and the emergency room score 11.

The GCS assesses performance in three areas to measure level of consciousness:

1. eye opening;
2. verbal response; and
3. motor response.

The technician conducts the test, fills out a standard chart with the patient's score in each of these areas and enters the total score. The chart sets out the three areas to be assessed, the possible responses from the patient and the appropriate scores for those responses. The GCS was developed as a communication tool between medical professionals. It provides clarity through specific testing, with standard scoring, as opposed to a narrative description of a patient's condition. Its purpose is to establish a baseline for patients who have experienced an altered level of consciousness. An example of the chart, containing Mr. Milson's score as assigned by Mr. Kirkconnell, is produced below:

Eye Opening	Spontaneously 4 To Speech 3 To Pain 2 None 1	2
Verbal Response	Oriented 5 Confused 4 Inappropriate Words 3 Incomprehensible Sounds 2 None 1	3
Motor Response	Obeys Commands 6 Localizes Pain 5 Withdraws to Pain 4 Flexion to Pain 3 Extension to Pain 2 None 1	2

Mr. Kirkconnell has been a paramedic for 30 years. He has used the GCS for many years and has applied it hundreds, if not thousands of times. His evidence was that he administers the test if he finds a non-responsive patient. He found Mr. Milson unconscious and combative in the car. His notes[2] give the following description of Mr. Milson, covering the period from when Mr. Kirkconnell first started assessing him (17:51) to the time he arrived at the hospital (18:12):

> "Patient found in driver's seat no seat belt on. Saying inappropriate words. Became very combative. Hitting, biting and kicking at people. Patient would not leave oxygen on and was biting at the cervical collar. Patient trapped. Guelph Fire Department used the jaws to remove driver's door. Patient very combative. Had to put extra straps on the board and the patient broke some of the pins out of the board. Two Guelph firefighters came in ambulance to restrain patient en route to the hospital".

Mr. Kirkconnell administered the first GCS test while Mr. Milson was still trapped in the car. He found that Mr. Milson did not open his eyes, except to painful stimulus. Although he did not recall this particular case, Mr. Kirkconnell testified that he would have applied painful stimulus only after eliciting no response upon asking "can you hear me?" in a loud voice. The painful stimulus would have been a sternal rub (applying pressure to the sternum). When Mr. Milson opened his eyes in response to this stimulus, Mr. Kirkconnell assigned a score of 2 for eye opening. He scored a 3 on verbal response because, although Mr. Milson was able to say words, they were inappropriate to the circumstances. Mr. Kirkconnell gave Mr. Milson a score of 2 on motor response because the sternal rub elicited an extension reaction. He explained that Mr. Milson stopped his combativeness, became rigid, pointed his toes and straightened his arms. The total score was 7.

Mr. Kirkconnell testified that Mr. Milson's combativeness told him nothing about his level of consciousness. He could have been combative for various reasons. He assumed that the combativeness was caused by a head injury. He assessed the GCS without reference to the combativeness. His second assessment, conducted in the ambulance on the way to the hospital, produced identical results.

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[2] Exhibit 1, Tab 1-Ambulance Call Report , Pages 1and 2

A third test, conducted by a nurse in the emergency room about eight minutes after arrival at the hospital, produced a score of 6 or 7. The nurse's score is exactly the same as the paramedic's in the areas of eye opening and verbal response. The records[3] show a score of 2 for motor response, but that score is placed on the chart next to "flexion to pain", which scores 3.

Ms Crawford agreed that there was an error in the chart. It could be that the score on motor response was really 3, making the total score 7 and not 6. That would mean that the nurse's score was exactly the same as Mr. Kirkconnell's in all aspects of the test.

The nurses' notes describe Mr. Milson as "combative, moving all extremities...combative trying to chew cervical collar, wiggling". The notes made by Dr. Squires, the emergency room physician, describe Mr. Milson as very combative. Dr. Squires has been an emergency room physician since 1986. His evidence was that he had no specific recall, but Mr. Milson was likely thrashing around on the stretcher and difficult to control. He attributed the combativeness to a moderate head injury. Not severe enough that Mr. Milson was not moving, but significant enough to cause combativeness.

Dr. Squires also noted the following: "opens eyes to voice, moving all limbs equally. Anterior aspect of rigid collar in mouth and biting down forcefully". His evidence was that this behaviour told him nothing about Mr. Milson's level of consciousness. He further noted: "making incomprehensible sounds. Toes downgoing". His evidence was that this was a reaction to his scratching the sole of Mr. Milson's foot, a flexion motor response.

[3] Exhibit 1, Tab 2-Clinical Notes, Guelph General Hospital, Page 12

Dr. Squires did not assign a GCS score. His evidence was that, although familiar with the GCS, he does not find it very useful in his decision making and therefore rarely documents it. He usually concentrates on providing a narrative description of the patient's condition, knowing that someone else was assessing the GCS. He agreed that a GCS score of 6 or 7 was consistent with his observations and that a range of 6 to 9 was consistent with his diagnosis of moderate brain injury. His evidence was that it would be difficult to determine an appropriate score for motor response from his narrative. To assign a score, you have to apply painful stimulus. If he did that, he did not note it. Although he might have had the GCS in the back of his mind when he made his notes, he did not make them for translation into a score.

As a neurologist, Dr. Susan Goodwin was the member of the DAC team responsible for review of the GCS scores. She is head of the Neurology Division at St. Joseph's Hospital. She trained herself in the GCS by reading a book. She has no other training on the GCS. She has applied the GCS in an ICU (Intensive Care Unit) setting, but she does not use it routinely in her practice because she does not often treat trauma victims.

Upon review of the records, Dr. Goodwin concluded that the paramedic GCS scores should have been 10 and the emergency room score should have been 11. Her opinion is that the scores do not accord with the narrative account of Mr. Milson's condition. Her main area of concern is the score for motor response. Her opinion is that it is obvious from the combativeness that he displayed that Mr. Milson was localizing to pain. It was therefore not necessary to apply a painful stimulus to obtain a score. A score of 5 for motor response should have been given immediately. Dr. Goodwin testified that a flexion or extension response implies a loss of cortical function, inconsistent with the physical activity that Mr. Milson displayed. Her approach to administering the GCS involved the patient not moving and the patient flexing or extending when the painful stimulus is applied. She does not believe it possible to have a flexion or

extension response with a patient as active as Mr. Milson. The activity would not stop. Dr. Goodwin agreed that people with head injuries are often combative.

Dr. Goodwin's score of 5 instead of 2 on motor response would bring the paramedic scores to a total of 10. Dr. Goodwin would also increase the emergency room score on eye opening to 3 instead of 2 because Dr. Squires notes "opens eyes to voice" but the nurse scored for eyes opening to pain. In her report, she indicated that the emergency room score for verbal response should also be increased to reflect "inappropriate rather than incomprehensible" words, but she could not explain how she arrived at that conclusion. In any event, without that increase, the total score in the emergency room, would nevertheless be 10.

ANALYSIS:

To succeed, the applicant must establish that:

- He sustained a brain impairment as a result of the accident;
- The brain impairment resulted in a GCS score of 9 or less;
- The GCS test was administered within a reasonable period after the accident; and
- The GCS test was administered by someone trained for that purpose.

Aviva agrees that Mr. Milson suffered a brain impairment as a result of the accident. Aviva agrees that the GCS tests were administered within a reasonable time after the accident and I have ruled that they were administered by trained technicians. However, Aviva submits that the low GCS scores were the result of assessment error, not brain impairment. Aviva agrees that GCS scores, obtained by trained technicians within a reasonable period after the accident, are presumed reliable.[4] Aviva submits however that the presumption of reliability is rebutted by Dr. Goodwin's evidence of assessor error.

[4] See *Young v. Liberty Mutual Insurance Company,* (FSCO Appeal P03-00043, June 20, 2005)

To accept Dr. Goodwin's opinion on the scores for motor response, I must be satisfied that her approach to obtaining a GCS score for motor response is right and that Mr. Kirkconnell, the emergency room nurse and Dr. Squires are wrong. I am not. There are several reasons.

First, there is no evidence that Dr. Goodwin has superior training and experience in this area. On the contrary, she has no formal training and likely less experience than Mr. Kirkconnell who has used the test numerous times, and the emergency room nurse and Dr. Squires who must regularly encounter the GCS in their practice. Dr. Goodwin is self trained, admits that she does not use the GCS regularly, referred to experience in an ICU setting in only general terms and cited no authority in support of her opinion and approach.

Second, in the circumstances of this case, I find it unlikely that two trained and experienced technicians and Dr. Squires, would take the same incorrect approach. Since combativeness is not unusual in brain injured patients, one would expect that Dr. Goodwin's theory would be explored in training and it would have been pointed out to at least one of the three people who endorsed the approach, that one need not apply painful stimulus to obtain a motor response score for a combative patient. I heard no evidence to that effect. In addition, because combativeness is not unusual in brain injured patients, Mr. Kirkconnell must have made numerous similar assessments. If Mr. Kirkconnell is taking the wrong approach, I find it likely that someone in the chain of users of the score would have pointed it out his obvious error. I heard no evidence to that effect.

Third, although there is some logic to Dr. Goodwin's opinion that a score for flexion or extension to pain is intended to reflect loss of cortical function, inconsistent with spontaneous movement, this aspect her opinion also rests on the assertion that a combative patient would not cease moving and flex or extend when painful stimulus is applied. I find that this is what in fact happened. Dr. Godwin's opinion was theoretical, referring to no personal experience in this regard. But this is what Mr. Kirkconnell said happened. He has no interest in supporting

Mr. Milson's position and I accept his evidence. This is also reflected in the score given by the emergency room nurse. In addition, Dr. Squires endorsed this possibility when he testified that, although combative, he would have to apply painful stimulus to determine Mr. Milson's score for motor response. Dr. Squires further stated that the given scores were consistent with his observations.

Fourth, assuming that Mr. Milson's combativeness is evidence that he was localizing to pain, one would still expect that he would localize to the painful stimulus applied by Mr. Kirkconnell and the emergency room nurse. I find that he did not. Because Dr. Goodwin's thesis is that combativeness would not cease upon application of painful stimulus, she offered no explanation for how this might have happened. Again, there is no reason to reject the unbiased evidence of Mr. Kirkconnell and doubt the accuracy of the records of the emergency room nurse.

I also do not accept Dr. Goodwin's opinion that the emergency room scores for verbal response and eye opening should be increased. Dr. Goodwin could find nothing in the records to support her increase of the verbal response score and her opinion on eye opening was based on the assumption that the note of "opens eyes to voice" was made by the person who assigned the score appropriate to eye opening to pain. However, the note was made by Dr. Squires who was not focussed on obtaining a GCS score, while the score was independently determined by the nurse. I find it inappropriate to discard the score of the trained technician in these circumstances.

I therefore find that the GCS scores recorded by Mr. Kirkconnell and the emergency room nurse were not compromised by assessor error. Assuming that the emergency room score for motor response was 3 and not 2, Mr. Milson had 3 identical scores of 7. Therefore Mr. Milson suffered a "catastrophic impairment" within the meaning of section 2(1.1)(e)(i) of the *Schedule*.

EXPENSES:

Each party claimed entitlement to expenses. Of the criteria I am required to consider in awarding expenses, success is the only relevant one. Based on his success, Mr. Milson is entitled to his expenses of the hearing. If the parties cannot agree on quantum, they may request a hearing within 30 days, pursuant to Rule 79 of the *Dispute Resolution Practice Code*.

May 12, 2006

Jeffrey Rogers
Arbitrator

Date

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Commission des services financiers de l'Ontario

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ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Mr. Milson suffered a "catastrophic impairment" within the meaning of section 2(1.1)(e)(i) of the *Schedule.*

2. Aviva shall pay Mr. Milson his expenses of the hearing.

3. If the parties cannot agree on quantum of expenses, they may request a hearing within 30 days, pursuant to Rule 79 of the *Dispute Resolution Practice Code*.

May 12, 2006

Jeffrey Rogers
Arbitrator

Date