BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

AMANDA DANIEL,

Claimant,

vs.

KROGER STORES/KWIK SHOP,

Employer,

and

ACE INSURED,

Insurance Carrier,
Defendants.

FILED

MAR 09 2017

WORKERS COMPENSATION

File No. 5045173

ARBITRATION DECISION

Head Note Nos.: 1801, 1803, 1804, 3701

STATEMENT OF THE CASE

Amanda Daniel, claimant, filed a petition in arbitration seeking workers' compensation benefits from Kroger Stores/Kwik Shop Inc. (hereinafter Kwik Shop) and its insurer, Ace Insured a result of an injury she sustained on May 17, 2010 that arose out of and in the course of her employment. This case was heard in Cedar Rapids, Iowa and fully submitted on September 15, 2016. The evidence in this case consists of the testimony of claimant, Joint Exhibits 1 – 6, Claimant's Exhibits 8 – 28 and Defendants' Exhibits A – M. Both parties submitted briefs.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

ISSUES

Whether claimant is still entitled to temporary total benefits or has reached the end of temporary benefits and is entitled to permanent partial benefits.

If the claimant is entitled to permanent benefits, the extent of claimant's disability.

The commencement date of any permanent benefits.

Assessment of costs.

FINDINGS OF FACT

The deputy workers' compensation commissioner, having heard the testimony and considered the evidence in the record, finds that:

Amanda Daniel (Amanda), claimant, was 25 years old at the time of the hearing.

Amanda suffered physical and psychological injury that arose out of and in the course of her employment. The primary issue in this case is whether Amanda has reached maximum medical improvement and that she should start receiving permanent partial or permanent total benefits or should temporary benefits continue. Amanda has psychological injury as well as a physical injury, hepatitis–C[1], as result of her work injuries.

On May 17, 2010, Amanda was at work alone at a Kwik Shop store in Cedar Rapids. At approximately 4:00 a.m., Keith Elson, Jr. held her at knife point, kidnapped her and forced her to his apartment where he sexually assaulted and raped Amanda. Some records report that Mr. Elson had been watching claimant for months. (Exhibit 3A, page 9) Amanda was able to obtain a knife and stabbed her attacker twice. Amanda was stabbed as well. Amanda was able to break free and she barricaded herself in the bathroom. Amanda remained barricaded for about five hours when the Cedar Rapids Police Department, after viewing the surveillance tapes at the Kwik Shop determined the identity of Mr. Elson, and broke down the door of Mr. Elson's apartment and rescued Amanda. (Ex. H, pp. 9, 16, 17) The kidnapping lasted about seven hours. A four day trial, in which Amanda testified, was held in October 2011. Mr. Elson was found guilty and sentence to life imprisonment without parole. (Ex. H, pp. 10, 11)

On May 17, 2010, Amanda was taken to the Mercy Medical Center Emergency Department in Cedar Rapids, Iowa. The laceration was treated. A victim advocate was called, but Amanda declined services at that time as he was a male advocate. (Ex. 1, p. 4) Later a female victim advocate provided assistance to Amanda. (Ex. 1, p. 6) In July 2010, Amanda had a miscarriage and D&C that was related to the assault. (Ex. 3A, p. 9; Ex. 5, p. 1)

Amanda was referred by the Cedar Rapids Police Department to Sarah Tawil, LMHC-NCC. (Tr. p. 10) Amanda had five sessions with Ms. Tawil, ending on August 24, 2010. (Ex, 1, pp. 1 – 4) Amanda later received treatment from Penny Clark, M.A., L.M.H.C., A.T.R. This treatment started in August 2010. (Tr. p. 20) Amanda sees Ms. Clark about every two weeks. (Ex. D, p. 9) Ms. Clark supported claimant through the criminal trial. Claimant was receiving treatment from Ms. Clark at the time of the hearing. Amanda also receives treatment from female resident physicians at the University of Iowa Hospital and Clinics (UIHC). (Tr. 11) These

[1] This condition has been treated and was not disabling at the time of the hearing and appears to be in remission. (Tr. p. 49)

residents generally change yearly. She sees them every two to three months primarily for medication management. (Ex. D, p. 9)

Amanda testified that both Ms. Clark and the resident physicians at the UIHC do not believe claimant is at maximum medical improvement (MMI). (Tr. p. 11)

Amanda said that over the past year she has noticed improvement in her condition. She was able to drive to her attorney's office by herself. She can go out to a park if she has a friend or family member with her. (Tr. p. 12) Amanda believes she is making gradual improvement and would like to attend school. (Tr. 12)

Amanda left high school before her work injury. After her injury Amanda obtained a GED. (Ex. E, p. 5) She did not have to attend classes; she took a pre-test then the test. (Tr. p. 28) After her injury claimant has taken two college classes. One class was not on campus, it was a resource center and a longtime friend attended the same class. Amanda was able to complete this class. The second class was at a community college and claimant dropped out as she could not sit in the classroom and was fearful to go from the parking lot to the classroom. (Tr. p. 13) For a time period after her injury Amanda was living with her mother and assisted her mother with her mother's in-home day care. (Tr. p. 30)

Amanda's work history before working at Kwik Shop consisted of working for restaurants and fast food outlets. (Ex. E, pp. 6, 7)

Amanda has played in a dart league with family and friends since her injury. (Tr. p. 39) The dart league plays in bars. (Tr. p. 41)

Amanda met with Naomi McCormick, Ph.D., one time in 2013. She has not been examined by Dr. McCormick since that time. (Tr. p. 14)

Amanda said she never met with Michelle Holtz or Strickland Associates, who prepared a vocational report. (Tr. p. 16) Amanda said she did not think she could do any of the jobs due to panic or anxiety attacks. (Tr. p. 17)

Amanda testified that defendants required her to see Jeff Jaeger, Ph.D. Amanda said that she would not have voluntarily gone to see a male therapist. (Tr. p. 19) Dr. Jaeger told claimant that he was going to do exposure therapy with her for her PTSD. (Tr. p. 20) Claimant's unrefuted testimony was that Dr. Jaeger recommended, as one of the exposures, that she go to an unfamiliar bar by herself. Amanda testified that she thought that advice was wrong for any woman, let alone herself. (Tr. p. 20)

There is evidence that at times Amanda was not as compliant with taking her medication as recommended by her health care providers. At the time of the hearing, claimant was compliant with her medication. (Tr. pp. 47, 48)

Since 2010, Amanda has lived in a number of apartments. She has always had roommates or family members to live with. (Tr. p. 24) She has had relationships with two boyfriends. (Tr. pp. 24, 25) At the time of the hearing Amanda was living with her friend, her friend's child and her friend's husband. Amanda watches the child for a time each day that her friend goes to work. (Tr. p. 40)

On August 20, 2010, Ms. Clark was authorized by the defendants to treat Amanda for trauma. (Ex. 3A, p. 9) Ms. Clark diagnosed Amanda with Post Traumatic Stress Disorder (PTSD) and found that her GAF (Global Assessment of Functioning) was 35. (Ex. 3A, p. 13) A September 9, 2010 psychotherapy note indicates that EMDR and exposure therapy was discussed. (Ex. 3A, p. 15)

On August 29, 2011 Ms. Clark wrote,

> Amanda continues to struggle with symptoms [*sic*] post traumatic stress disorder and have [*sic*] experienced changes in these symptoms depending on how close or far away trial dates have occurred. It is the understanding of this therapist that court was originally scheduled for August 2010, and has been continued now 5 times, with the last continuance occurring this month. In July 2011, Amanda was subpoenaed to a disposition [*sic*] in which the perpetrator's lawyer was able to review and question Amanda as a witness about trial evidence prior to court. Although it may seem that Amanda has been "stuck" with symptoms of anxiety and depression remaining the same, Amanda shows resilience through her on-going attendance at therapy and willingness to try new ways of coping with her trauma throughout the last year knowing that she still has to go to court, will have to face her perpetrator, and "re-live" the story of her trauma in a public setting. She continues to come to therapy regularly and continues to be willing to discuss and practice ways of increasing her participation in daily life. She has attempted to return to activities that have previously given her a sense of enjoyment in life which requires the support of her father or a close friend in order to feel safe. There have been many occasions that Amanda has reported making attempts at leaving her apartment, but this continues to be difficult for her. It is the recommendation of this clinician that Amanda continues with individual therapy. Due to the severity of Amanda's symptoms, it is not recommended that she return to work at this time. Return to work will be evaluated per request of Sedgwick until after Amanda has had the opportunity to gain some closure to her trauma following trial.

(Ex. 3A, pp.28-29)

Ms. Clark had been providing counseling to claimant through St. Luke's Counseling. In November 2014, Ms. Clark provided treatment to Amanda through Psychiatric Associates in Iowa City. The record contains office notes from

November 20, 2014 through May 24, 2016. Most of these notes are only partially legible.

On May 6, 2011, Daniel Tranel, Ph.D., ABPP/Cn, performed a neuropsychological assessment. His summary and conclusion was,

> Our comprehensive evaluation of Ms. Daniel indicates that her cognitive functioning is intact. She has average intellectual abilities, and normal memory, speech, and language, perception, construction, attention and concentration, orientation, judgment, planning, reasoning, and decision-making. Evaluation of Ms. Daniel's psychological status indicates that she has many symptoms of PTSD, with related significant depression and anxiety. These conditions are chronic, as it has been almost a year since the traumatic event. Ms. Daniel's psychiatric conditions are attributable to the May 17, 2010 abduction and assault.
>
> The most pressing issue currently is Ms. Daniel's treatment. She reports some degree of satisfaction with Ms. Clark and with Jennifer Blume, and she trusts those treating professionals, and we recommend that she continue treating with them. We would also strongly recommend additional psychological and psychiatric treatment. A female PhD-level clinical psychologist in her area (there are several such providers, and information is available through the Iowa Psychological Association) is recommended, and we would envision that Ms. Daniel would receive regular weekly treatment from such a provider for a year or two. In addition, Ms. Daniel may derive benefit from antidepressant and/or anxiolytic medication, managed by a psychiatrist with experience treating PTSD and major depression and anxiety. These treatments should help reduce or eliminate her psychiatric problems, and help get her back to work and back to a fully functional level of interpersonal and occupational functioning. We also recommend an expedient resolution of the legal trial regarding her case, as this would facilitate Ms. Daniel's capacity to benefit from treatment.
>
> It is our expectation that with appropriate treatment, Ms. Daniel will be capable of overcoming her psychiatric problems and returning to a healthy and fully functional level of interpersonal and occupational functioning, commensurate with her background, education, and training. Her psychiatric condition is chronic and severe, though, and she will require aggressive, extensive, and high-caliber treatment. She is not capable of working at the current time, and we feel that she should refrain from attempting to go back to work until her legal situation is resolved and her psychiatric condition is improved. Placing her back in the convenience store environment at this time, even under the safest possible conditions, is likely to aggravate her psychiatric problems. At worst, we would expect

> her condition to be improved and at MMI within 12 to 24 months; with resolution of the legal situation and aggressive psychological treatment, this may happen sooner. Re-evaluation of her psychiatric status is recommended, after the treatments outlined above and resolution of the legal case.

(Ex. 6, pp. 8, 9)

On November 26, 2011, Dr. Tranel wrote an addendum to his report. He noted claimant had not been provided the care that he recommended, which included a Ph.D. level clinical psychologist and a psychiatrist experienced in treating PTSD and anxiety disorders. (Ex. 6, p. 13)

Jennifer Blume, ARNP began providing medication to Amanda for her PTSD and general anxiety disorder. (Ex. 4, p. 4) On June 1, 2011 and October 1, 2011, ARNP Blume wrote she was unable to say when Amanda could return to work or be at maximum medical improvement. (Ex. 4, pp. 6, 12)

Amanda started receiving psychiatric services at the University of Iowa Hospital and Clinics (UIHC) in March 2012. At that time, Amanda Nerin Abu Ata, M.D., wrote that Amanda, "continues to have prominent symptoms of post-traumatic stress disorder including hypervigilance, avoidance, nightmares, triggers, and panic attacks and this is affecting the quality of her life." (Ex. 5, p. 4) The diagnosis was,

> AXIS I: Posttraumatic stress disorder. Chronic. Panic disorder. Depression not otherwise specified.
>
> AXIS II: Defer.
>
> AXIS III: Rape, abduction in 05/2010. Migraines.
>
> AXIS IV: Moderate to severe with a lack of social support system, finance, not being able to work.
>
> AXIS V: Global Assessment of Functioning is 30-40.

(Ex. 5, p. 4) On August 18, 2012, Dr. Abu Ata wrote that Amanda's severe symptoms prevented her from working or taking full time classes. (Ex. 5, p. 19) On October 3, 2012, Dr. Abu Ata informed defendants' attorney that Amanda was not able to return to work. (Ex. 5, p. 28) On December 20, 2012, Dr. Abu Ata wrote,

> In the long term, I would expect to space out the visits that address medication management, to be tentatively every 3 months or so, given that she is able to have medications refilled and not run out (such as this visit). It is important that Amanda continues psychotherapy, which she is seeing Penny Clark for, and will leave it up to her therapist and Amanda to

> decide on frequency of psychotherapy visits needed. I am not able to estimate when Amanda is able to go back to work yet. She has made palpable progress since her initial trauma, and has been able to leave her room, be social with family, go outside (though to limited placed [*sic*]) and complete one class (thought under limited circumstances). This speaks for a good prognosis in the future, and expectation of continued progress given continued therapy and medications. The medications (effexor and Topamax) that she was on decreased her PTSD symptoms, and at this point, the work towards her being able to go back to work relies heavily on psychotherapy and skills acquired from it.

(Ex. 5, p. 36)

On June 14, 2013 Jeffery Jaeger, Ph. D. examined Amanda at the UIHC. He said she had PTSD and recommended she would benefit from evidence based evidence-based treatment and would evaluate at the next appointment Amanda's interest in prolonged exposure therapy, or cognitive processing therapy. (Ex. 5, p. 47) On September 10, 2013, Dr. Jaeger had the second prolonged exposure session with Amanda. Dr. Jaeger noted that failure to complete this form of treatment could have an adverse ability to recover from her PTSD. (Ex. 5, p. 64)

A report on November 22, 2013 from Jennifer Donovan, M.D., states, "She [Amanda] notes it was difficult to meet with Dr. Jaeger at UIHC as he was male and it triggered her anxiety." (Ex. 5, p. 73) Dr. Donovan recommended Amanda continue to work on getting out of the house to places she feels comfortable such as the pet store and darts. (Ex. 5, p. 79)

On September 19, 2014, Amanda was seen at the UIHC due to a positive test for hepatitis–C. (Ex. 5, p. 96) On July 28, 2015, the UIHC reported the hepatitis–C treatment had worked and to monitor for three months for possible relapse. (Ex. 5, p. 158) On July 27, 2016, Stephanie Dee, PA-C, noted Amanda had a successful treatment and there were no restrictions or limitations. (Ex. 5, p. 180)

On December 31, 2014, Anisha Boetel, M.D., PGY3, noted "PSTD symptoms continue to be quite prominent and disabling." (Ex. 5, p. 125)

On May 25, 2016, Michael Morais, M.D., noted an overall worsening of PTSD and mood symptoms, which was around the anniversary of her attack. (Ex. 5, p. 180) On July 5, 2016, Dr. Morais responded to a series of questions from claimant's attorney. Dr. Morais stated that she was unable to predict future improvement when she was asked if Amanda was at MMI for her PTSD and panic disorder. (Ex. 4, pp. 6, 7) She agreed Amanda's therapist, Penny Clark, was in the best position to determine if Amanda will improve with continued psychotherapy for her PTSD and panic disorder and whether she can return to the workforce. (Ex.26, pp. 5, 6) Dr. Morais did not

believe Amanda could return the workforce at the time of her response and noted it could change. (Ex. 26, p. 6)

Naomi McCormick, Ph.D., issued four reports in this claim. Dr. McCormick conducted an independent medical examination and issued her report on April 7, 2013. Dr. McCormick spent about 90 minutes in a diagnostic interview with Amanda. (Ex. 7, p. 1)

Dr. McCormick noted that Amanda, like many survivors of sexual trauma has frequently changed her residence since the assault. (Ex. 7, p. 4) Dr. McCormick wrote,

> Time, supportive counseling, and regular psychiatric care have reduced Ms. Daniel's depression since 2011, with PTSD remaining highly elevated due to the patient's avoidant comping, which the MCMI-III indicates has increased significantly since previous assessment. Supportive psychotherapy and palliative psychiatric care have failed to alleviate the patient's work and trauma-related psychiatric injury. Unintentionally, it is likely that supportive counseling and compliance with the patient's insistence that she could never work with a male heath care provider have both served to increase Ms. Daniel's conditioned anxious avoidance and dependent withdrawal. Rigorous cognitive behavior therapy (CBT), including prolonged exposure therapy to reduce sensitivity to trauma reminders, is highly recommended to prepare Ms. Daniel for vocational counseling and a return to the workplace.

(Ex. 7, p. 13) Dr. McCormick's diagnosis was,

> Axis 1: 309.81 Posttraumatic Stress Disorder, 311 Depression not otherwise specified.
>
> Axis I: 799.9 Diagnosis deferred (there is an increased presence of avoidant, dependent, and negativistic or self-defeating personality traits since 2011)
>
> Axis III: Rape, abduction on 05/20/2010; migraines
>
> Axis IV: Moderate to severe instability in social support system; occupational and financial stress
>
> Axis V: Current GAF = 40-45 (major improvement in several areas)
> Highest Past Year = 45-50 (serious symptoms)

(Ex. 7, p. 17) She found that claimant was not at MMI. (Ex. 7, p. 17) Dr. McCormick recommended prolonged exposure therapy and/or cognitive processing therapy. She recommended Dr. Jaeger at the UIHC to provide this treatment. (Ex. 7, p. 18) She believed that claimant's treatment with Ms. Clark was ineffective and that Amanda

should be able to work with a male doctor. She also recommended vocational counseling. (Ex. 17, p. 21) Dr. McCormick stated that claimant was not capable of returning to work at that time. (Ex. 7, p. 22)

On June 6, 2014, Dr. McCormick wrote defendants' counsel a letter. She said that claimant had poor attendance and was noncompliant with treatment with Dr. Jaeger. (Ex. 7, p. 34) Based upon a belief that claimant was able to play darts with her family in a bar four days a week, she opined that Amanda could be capable of work in a protective setting. (Ex. 7, p. 35) She stated Amanda was atypical of the average trauma survivor and that Amanda was insufficiently compliant with psychiatric care. Dr. McCormick did not believe further psychological or psychiatric care would improve her outcome and stated claimant was at MMI. (Ex. 7, p. 36)

Dr. McCormick suggested the following guidelines and restrictions in order for claimant to return to work.

> 3) I believe that the Claimant could return to full-time work, providing the following supportive employment protocol is followed. For a minimum of six months, she should have close supervision and guidance from the same experienced rehabilitation expert or manager. During the first two months, work should be part-time with at least 30 minutes of individual guidance per week from the manager. In week one, the Claimant should work no more than two hours daily for five-days/week. In week two, she should work a maximum of three hours daily. In week three, the goal should be for four hours of daily work. In week five, the goal should be for five hours of daily work. In week six the goal should be for six hours of work per day. In week seven, the goal should be for seven hours of daily work. By week eight, the goal should be full-time work (8 hours daily, 5 days per week).
>
> 4) After full-time work is resumed, the rehabilitation expert or manager should continue to provide guidance and support to the Claimant, with reduced supervision (e.g. 15 minutes of individual time with the Claimant each week until the Claimant has worked for six months total).
>
> 5) The following workplace restrictions are also recommended for the Claimant:
>
> a) Permanent restriction: The Claimant should never work alone. The presence of trusted co-workers is needed to reduce the risk of potential PTSD symptoms.

b) Temporary restriction: Daytime work only for the first two years or resumed employment.

c) Temporary restriction: A managerial employee is available on the premises during the Claimant's entire work shift for the first six months of employment.

d) Permanent restriction: The job site has a relatively stable workforce, making it likely that at least some of the co-workers are familiar to the Claimant.

e) Temporary restriction: High security work areas (e.g. employers require identification badges and credentials for entry into the work area) for the first year of resumed employment.

f) Permanent restriction: The employer strictly upholds woman-affirming policies on sexually appropriate behavior in the workplace and employee safety.)

(Ex. 7, pp. 36, 37) Dr. McCormick recommend claimant work as a teacher's aide, in a large well-managed daycare or preschool, telephone/computer support services and office work. (Ex. 7, p. 37)

On February 17, 2015, Dr. McCormick updated her June 6, 2014 letter to defendants' counsel. She repeated that claimant was at MMI and has not received significant benefit from counseling in March of 2013. (Ex. 7, pp. 38, 39) Ms. McCormick set forth the similar recommendations as to how to integrate claimant back into a job as in the June 6, letter. Her recommendations were,

> I believe that the Claimant could return to full-time work, providing the following supportive employment protocol is followed. For a minimum of six months, she should have close supervision and guidance from the same experienced rehabilitation expert or manager. During the first two months, work should be part-time with at least 30 minutes of individual guidance per week from the manager. In week one, the Claimant should work no more than two hours daily for five-days/week. In week two, she should work a maximum of three hours daily. In week three, the goal should be for four hours of daily work. In week five, the goal should be for five hours of daily work. In week six, the goal should be for six hours of work per day. In week seven, the goal should be for seven hours of daily work. By week eight, the goal should be full-time work (8 hours daily, five days per week).
>
> 1) After full-time work is resumed, the rehabilitation expert or manager should continue to provide guidance and support to the

Claimant, with reduced supervision (e.g. 15 minutes of individual time with the Claimant each week until the Claimant has worked for six months total).

2) The following workplace restrictions are also recommended for the Claimant:

a) Permanent restriction: The Claimant should never work alone. The presence of trusted co-workers is needed to reduce the risk of potential PTSD symptoms. (*I no longer believe, as conjectured in my June 6, 2014 draft, that during the first year of employment, she needs to work in a "high security " area in which employees wear identification badges" since this would greatly restrict employment opportunities and prevent her from employment in an informal warm, work environment like a well-staffed "Mom and Pop["] business*).

b) Temporary restriction: Daytime work only for the first year of resumed employment.

c) Temporary restriction: A maximum for 40 hours per hour work during the first year of resumed employment.

d) Temporary restriction: A managerial employee is available on the premises during the Claimant's entire work shift for the first six months of employment.

e) Permanent restriction: The job site has a relatively stable workforce, making it likely that at least some of the co-workers are familiar to the Claimant.

f) Permanent restriction: The employer strictly upholds woman-affirming policies on sexually appropriate behavior in the workplace and employee safety).

g) Permanent restriction: The Claimant should not be expected to have an occupation that requires direct contact with blood.

(Ex. 7, pp. 42, 43)

Penny Clark was deposed on January 22, 2016. (Ex. C, pp. 1 -25) She started seeing Amanda in August 2010 and except for the time Dr. Jaeger saw Amanda, she has been providing treatment. (Ex. C, pp. 2, 3) Ms. Clark estimated that at least one quarter of the patients she treats have PTSD. (Ex. 5, p. 25) Ms. Clark agreed that it could be helpful to have vocational counseling for Amanda in addition to the counseling she is providing. (Ex. C, p. 25)

Ms. Clark also agreed with Dr. McCormick that in order for Amanda to return to work she would not work alone and be in a safe trusted environment. Ms. Clark did not believe claimant could work in retail or food/bar and telephone or office-computer work due to the variable environments. She also questions whether claimant could work as a teacher's aide due to the fact the teachers and aides must work with children with behavior disorder diagnoses. Ms. Clark did agree that if Amanda found a good well-managed daycare she might be able to work in such a setting. (Ex. C, p. 9)

Ms. Clark noted that Amanda would need to be able to get good sleep and eat well before she could go back to work. Ms. Clark testified that there was still room for significant improvement in Amanda's health. (Ex. C, p. 10) When asked if claimant could go back to work in any kind of employment Ms. Clark said, "I think, if she had a support and a step-by-step plan with someone she trusted, I think that there could be a path in that direction." (Ex. C, p. 11) Ms. Clark opined that Amanda's abilities were likely to improve, slowly but surely. (Ex. C, p. 9) Ms. Clark did not believe that Amanda could go out and work in a normal working environment at the time of her deposition. (Ex. C, p.13)

Ms. Clark responded to a series of questions from Amanda's attorney on July 5, 2016. Ms. Clark disagrees with Dr. McCormick's conclusions about many items including that Amanda is at MMI and can return to work. (Ex. 27. pp. 1 – 6) Ms. Clark stated that Amanda still had room for significant improvement in her mental condition. She was unable to predict when Amanda might reach MMI. (Ex. 27, p. 6)

Amanda filed a petition for alternate care and a decision was issued on October 14, 2014. (Ex. 21, pp. 1 – 7) This decision was not appealed and became a final decision of the agency. That decision found that defendants lost the right to direct care.

The defendants authorized and performed surveillance and investigation of the claimant. Sixteen (16) hours of surveillance were authorized. (Ex. H. p. 1) The report and DVD were reviewed. The DVD surveillance was performed in July 2012. It shows claimant on a porch and then some persons come to the house. The report by the investigator shows some Facebook comments around the time of the assault and around the time of the verdict in the criminal trial. The report also attached copies of newspaper articles about the crime and searches of public records. None of the information appears to be relevant as to the issue of whether claimant is at MMI and the extent of her disability.

On June 10, 2015, Michelle Holtz, B.A., prepared an employability assessment/industrial disability report. (Ex. J, pp. 1 – 17) Ms. Holtz, based upon Dr. McCormick's reports that claimant was at MMI and could return to work with a supportive work protocol and with the assistance of a local vocation counselor. She opined Amanda could obtain full-time employment in the local labor market. (Ex. J, p. 8) Ms. Holtz identified a number of potential jobs that generally were in the medical

facilities or education/preschool/daycare areas. She also identified some clerical and customer service types of positions. (Ex. J, pp. 10 – 16) Based upon the assumption that Dr. McCormick was correct, she opined claimant had a 50 percent loss of earning capacity. (Ex. J, p. 17)

I find that Amanda currently has PTSD disorder and a panic disorder. Due to her disorders she has avoidant personality traits, cannot be in new and unfamiliar settings, and has limited ability to travel to new areas. I found that at the present time Amanda has a 100 percent loss of earning capacity. I find June 1, 2016, as the date that Dr. Morais stated she was unable to predict future improvement, (Ex. 26, p. 5) is the date of MMI for Amanda.

I find that Amanda's gross earnings were $310.62 and that she was single and entitled to 1 exemption at the time of her injury. Using the rate book in effect at the time of the injury, Amanda's weekly rate is $212.78.

Amanda has requested costs of a filing fee ($100.00), service costs ($13.91), transcript of Penny Clark deposition ($111.70) and transcript of Amanda's deposition ($87.50). (Ex. 28, p. 1)

RATIONALE AND CONCLUSIONS OF LAW

Iowa law provides that a mental injury is an injury compensable under Iowa's workers' compensation laws.

In Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995), the Iowa Supreme Court determined that a purely non-traumatic mental injury is compensable under the Iowa Act. Causation for mental injury is divided into factual or medical causation and legal causation. The question to be asked related to medical causation is whether the employee's injury is causally connected to the employee's employment.

The question for legal causation to be applied after medical causation has been proved is whether "the mental injury 'was caused by work place stress of greater magnitude than day-to-day mental stress experienced by other workers employed in the same or similar jobs,' regardless of their employer." The court has declared that "[a]lthough evidence of workers with similar jobs employed by different employers is relevant, evidence of the stresses of other workers employed by the same employer with the same or similar jobs will usually be most persuasive and determinative on the issue." While the standard of legal causation is an issue of law, the application of that standard to a particular scenario results in an outcome determinative finding of fact by the agency.

> Where there is a sudden traumatic event such as a robbery, there is no requirement to produce evidence that the stress was greater than experienced by a similarly situated employee. (Footnotes omitted)

15 Lawyer, Workers' Compensation § 4:7 (2016).

In Brown v. Quik Trip Corp., 641 N.W.2d 725 (Iowa 2002), a Quik Trip employee claimed a work-related mental injury after witnessing a shooting, and being involved in a robbery. The court in Brown held that if a mental injury was caused by an event of a sudden, traumatic nature, and was an unexpected cause or unusual stress, the legal test detailed in Dunlavey was not required, and the injury is considered to be compensable. The court noted that unlike Dunlavey, there was a readily identifiable stress factor, i.e., the robbery. Id. at 729. The court, in citing a Wyoming Supreme Court case regarding mental injuries, noted:

> Where a mental injury occurs rapidly and can be readily traced to a specific event, . . . there is a sufficient badge of reliability to assuage the Court's apprehension. Where, however, a mental injury develops gradually and is linked to no particular incident, the risk of groundless claims looms large indeed.

Brown at 728 (citation omitted).

The court in Brown found a claimant may satisfy the requirement of establishing legal causation by showing the claimant was subject to an event that was sudden, traumatic and unexpected. Id. at 729. See also Village Credit v. Bryant, No. 11-1499, filed May 23, 2012 (Iowa Ct. App) Unpublished, 819 N.W. 2d 427 (Table) (Teller at credit union found to have mental/mental injury after being held up on two occasions by same suspect); Schuchmann v. Department of Transportation, File No. 5035676 (App May 20, 2013) (Claimant found to have mental/mental injury after viewing charred body of driver killed in burning car wreck); Valdez v Tass Enterprises, File No. 5027740 (App. May 25, 2011) (Claimant found to have mental/mental injury after being held up at gunpoint and bound by tape); Johannsen v. Midwest Contractors, File No. 5013120 (App. January 30, 2007) (Claimant found to have mental/mental injury after witnessing horrific motor vehicle accident and narrowly escaping injury).

Amanda has a mental injury as defined by the Brown case. The parties have agreed to that fact.

Dr. McCormick strongly states that Amanda should have evidence based exposure therapy and/or cognitive counseling for her to make a significant recovery from her PTSD. Dr. McCormick states that the therapy by Ms. Clark is unhelpful and should be terminated. She also believes that claimant is at MMI and could return to work if a structured protocol and vocational supports were in place.

I do not find her opinions convincing. She had limited contact with Amanda in 2013. Since that time she has not had any personal contact, although has been given all of the available medical records. It is inconsistent for her to hold that Amanda needed a certain type of therapy to address her PTSD, state that Amanda's therapy with Ms. Clark is ineffective and then hold that claimant's PTSD has been ameliorated to the extent that claimant can return to work. It is Dr. McCormick's opinion that Amanda's treatment has been ineffectual. I find that she over relies upon the fact that claimant was in a dart league. Claimant testified credibly that her dart activities involved family and friends for the most part and was in a safe and familiar environment. Certainly Dr. McCormick and Dr. Jaeger are qualified mental health professionals. Dr. Jaeger has recommended exposure therapy. That might be the best way to treat Amanda's PTSD. But the fact of the matter is Amanda has not successfully undergone such treatment.

Dr. McCormick recommended many conditions to allow Amanda to return to work. (Ex. 7, pp. 42, 43) It is clear that the conditions required are not that of competitive employment. Amanda has a GED with little work experience and will unlikely be able to bargain for such accommodations with an employer. The return to work assumes, among other items, that there is the ability to phase in the number of hours, control shifts and only work daytime, have the manager employer available for 6 months, a stable workforce and an employer that strictly upholds woman-affirming policies on sexually appropriate behaviors and employee safety. There is no convincing evidence that all of the requirements would be available to Amanda based upon the jobs identified by Ms. Holtz or recommended by Dr. McCormick.

Teacher's aides can be required to assist with children with differing abilities including behavior or other issues in a regular or resource room setting. Working at schools would expose claimant to many "strangers" at once.

I do not find that claimant has the ability to perform the jobs identified by defendants without significant accommodation.

It is important to remember that Amanda at the time of the hearing was limited even in her ability to drive to unfamiliar locations, and had to drop-out of a community college class on campus. Her reaction and recovery from the PTSD may be atypical, but it is real for her and confirmed by Ms. Clark and the resident physicians at the UIHC.

Defendants have not been able to find a qualified female mental health provider, other than the resident physicians at UIHC to provide ongoing treatment. Those physicians have not found claimant to be at MMI. Certainly Dr. McCormick and Dr. Jaeger are very qualified mental health professions. Dr. Jaeger has recommended exposure therapy. That might be the best way to treat Amanda's PTSD. But the fact of the matter is Amanda has not successfully undergone such treatment.

Dr. Morais was unable to predict future medical improvement. Ms. Clark believes claimant will improve, however is not able to offer any reasonable prediction as to when Amanda would be at MMI. Is it possible she will have significant improvement? It is possible. It is also possible that some triggers could cause a regression. Given the length of time since her injury in 2010 and unpredictability if Amanda will improve, I find she is at MMI. The claimant's ability to be in the public and engage in activities appears to wax and wane. While there are a number of possible dates to find claimant at MMI, I find that claimant is at MMI as of the date Dr. Morais held she could not predict further improvement, July 5, 2016.

In assessing an unscheduled, whole-body injury case, the claimant's loss of earning capacity is determined as of the time of the hearing based upon industrial disability factors then existing. The commissioner does not determine permanent disability, or industrial disability, based upon anticipated future developments. Kohlhaas v. Hog Slat, Inc., 777 N.W.2d 387, 392 (Iowa 2009).

Assessments of industrial disability involves a viewing of loss of earning capacity in terms of the injured worker's present ability to earn in the competitive labor market without regard to any accommodation furnished by one's present employer. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 158 (Iowa 1996). See also, Thilges v. Snap-On Tools Corp., 528 N.W.2d 614, 617 (Iowa 1995) ("[W]e are satisfied that the commissioner was correct in viewing loss of earning capacity in terms of the injured worker's present ability to earn in the competitive job market without regard to the accommodation furnished by one's present employer.").

Amanda has limited education. She is young and intelligent. She has survived a horrendous attack, but not without injury. Her PTSD and panic disorder is extremely limiting in her ability to be competitively employed. I found that Amanda has a 100 percent loss of earning capacity. I find that, as of the date of the hearing, she is permanently and totally disabled.

Certainly everyone involved in this case wants Amanda to recover and be able to work. Given her age it is likely that sometime she may be able to do so and the parties can close the indemnity portion of this case though an agreement or review-reopening. But, looking at a snapshot at the time of the hearing, Amanda is permanently and totally disabled.

I feel compelled to comment on one aspect of this case, although it did not influence my rationale and conclusions in this case. Surveillance was used in this case. It was a remarkably insensitive and potentially dangerous tactic in this case. The claim was admitted. There was no substantial evidence to show that Amanda was hiding information from the defendants. Amanda's social media accounts and other reports were not in conflict with the information provided to defendants. The insurance administrator, Sedgwick, CMS, has shown an astounding lack of common sense to use surveillance on Amanda — a victim who was watched, kidnapped and raped by her assailant.

I find that the costs claimant has requested in the amount of $313.11 pursuant to rule 876 IAC 4.33, shall be paid by the defendants.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay claimant permanent total disability benefits for so long as she is permanently disabled at the weekly rate of two hundred twelve and 78/100 dollars ($212.78).

Permanent total benefits commence on July 5, 2016.

Defendants shall have credit for benefits previously paid.

Defendants shall pay claimant costs of three hundred thirteen and 11/100 dollars ($313.11).

Defendants shall file subsequent reports of injury as required by this agency pursuant to rule 876 IAC 3.1(2).

Signed and filed this 9th day of March, 2017.

JAMES F. ELLIOTT
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876 4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be in writing and received by the commissioner's office within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.