Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-12-156

PANEL:	**Ms Laura Diamond, Chairperson** **Ms Janet Frohlich** **Ms Linda Newton**
APPEARANCES:	**The Appellant, [text deleted], was represented by [text deleted];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Matthew Maslanka.** **Interpreter: [text deleted]**
HEARING DATE:	**January 11, 12, 13, 26 and 27, 2016** **(Video: February 16, 2016)**
ISSUE(S):	**Whether the Appellant is functionally capable of holding his determined employment as a truck driver as of June 1, 2012.**
RELEVANT SECTIONS:	**Section 70(1), 71(1), 84(1), 110(1)(c) of The Manitoba Public Insurance Corporation Act ('MPIC Act'**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

Reasons For Decision

The Appellant was injured in a motor vehicle accident on August 12, 2006. He suffered injuries to his neck and back, as well as right arm and jaw and a bump on the right side of his head.

At the time of the accident he was employed as a [truck] driver with [text deleted]. As the Appellant was unable to return to work due to his injuries, he was in receipt of Income Replacement Indemnity ("IRI") benefits.

The Appellant then participated in a work hardening reconditioning program at [rehabilitation (rehab) clinic]. [Rehab clinic's] discharge report of May 8, 2007 indicated that the Appellant was fit for an immediate return to work and the Appellant's case manager ended his entitlement to IRI benefits in a decision dated June 7, 2007.

However, based on further reports from [rehab clinic's psychologist #1], a psychologist, and [Appellant's psychiatrist #1], a psychiatrist, the case manager reinstated the Appellant's entitlement to IRI benefits by letter of January 22, 2008. MPIC had determined that he suffered from a psychological condition causally related to the motor vehicle accident that prevented him from working. Various attempts at psychiatric treatment were unsuccessful.

In 2010, the Appellant's case manager referred him for further psychological assessment. Following a review of an independent psychological assessment report by MPIC's psychological consultant with the Health Care Services Team, the case manager issued a decision on May 4, 2012 confirming that the Appellant had regained the functional ability to return to his pre-accident employment.

The Appellant sought an Internal Review of this decision. An Internal Review Officer for MPIC reviewed the medical and psychological reports on the Appellant's file as well as his work history. The Internal Review Officer also reviewed video surveillance of the Appellant performing various activities between December 14 and December 30, 2011 and compared these

with a Claimant Reported Level of Function Form which the Appellant completed on September 20, 2011. Based on the totality of this information, the Internal Review Officer upheld the case manager's decision and concluded that the Appellant was functionally capable of performing the duties of a truck driver (temporary earner) and ending his entitlement to IRI benefits effective June 1, 2012.

It is from this decision of the Internal Review Officer that the Appellant has now appealed.

The issue before the Commission is whether the Appellant was functionally capable of holding his determined employment as a truck driver, as of June 1, 2012. The Commission finds that the Appellant has met the onus upon him of showing, on a balance of probabilities, that the Internal Review Officer erred in concluding that the Appellant had recovered from his MVA related psychological symptoms and was able to return to his employment.

Background:

The Commission reviewed numerous medical reports from the Appellant's indexed file. From a physical perspective, reports were provided from [rehab clinic's doctor] and his colleagues at [rehab clinic], as well as reports and sick notes from [Appellant's doctor #1] of [text deleted], Appellant's doctor #2], neurologist [Appellant's neurologist], and radiological reports.

The Appellant saw [Appellant's doctor #3] at [text deleted] and then began seeing [Appellant's doctor #2] as his general practitioner. As early as 2007, [Appellant's doctor #3] had noted signs of post-traumatic stress disorder ("PTSD") and on September 3, 2007, [Appellant's doctor #2]

noted that the Appellant suffered from chronic pain, major depression disorder, anxiety and PTSD. [Appellant's doctor #2] provided reports and testified at the appeal hearing.

Also in 2007, [rehab clinic's psychologist #1] and [rehab clinic's psychologist #2], psychologists with [rehab clinic], noted that the Appellant was suffering from a pain disorder and major depression with some anxiety symptoms, following the motor vehicle accident.

> "[The Appellant] is coping with significant pain and some physical limitations secondary to his car accident. His presentation is consistent with a diagnosis of Pain Disorder and Major Depression. He also has some anxiety symptoms. [The Appellant's] daily functioning has changed dramatically. Prior to the accident, he was working full time, was able to participate fully in family activities, and was active socially in his community. As a result of his pain and mental health symptoms, he is no longer able to do these things. His current pain management strategies are highly focused on medical intervention and he has expressed some difficulty with trusting a psychological intervention. That being said, [the Appellant] may clearly benefit from psychological interventions aimed at helping him cope more effectively with his pain, and his current emotional state. His depressive symptoms and anger are of some immediate concern. Intervention may focus on more active coping strategies, social support and anger management. Exposure based therapy and education about the nature of his anxiety may be particularly useful in targeting his pain avoidance and physiological arousal. Finally, [the Appellant] may benefit from some education around using pacing, and relaxation to help him manage his pain and improve his sleep.
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> [The Appellant] appears to be already taking an anti-depressant that may help him with his physiological arousal and depression. His dosage, however, is in the lower end of the effective range for this medication. He may benefit from a review of this medication to see if a higher dose may be appropriate. Given his fears of saying the wrong thing to treatment providers, medication may be a beneficial treatment in this context."

On August 2, 2007, psychiatrist [Appellant's psychiatrist #1] diagnosed the Appellant with major depression moderately severe, indicating that in his opinion "the DSM diagnosis and symptoms he is suffering from on the balance of probabilities are related to the motor vehicle accident". He noted that although the Appellant had not given any history of post-traumatic stress disorder, he had described severe injuries and loss of family members in the war in [text deleted].

Following a review of the reports from [Rehab clinic's psychologist #1], [Appellant's doctor #2] and [Appellant's psychiatrist #1], MPIC's psychological Health Care Services Consultant provided his opinion that the Appellant's "current psychological diagnosis of Major Depression as well as a possible pain disorder would be considered causally related to the MVA in question". Although the [rehab clinic] discharge report had indicated that from a physical point of view the Appellant could return to truck driving, [Appellant's psychiatrist #1] and [Appellant's doctor #2] both felt that the claimant was not fit to return to work. IRI benefits were reinstated on this basis.

Attempts at psychiatric treatment followed, but a report from [Appellant's psychiatrist #1] dated April 25, 2008 indicated that the Appellant was not psychologically minded, had difficulty connecting his feelings with his symptoms and was so pain-focused that the question of psychotherapy treatment did not apply.

Psychologist [Appellant's psychologist] reported on August 4, 2008, citing a high level of depression and distress with ongoing suicidal ideation but no intent. He believed the prognosis for future psychological treatment success was poor.

A psychological assessment was performed by neuropsychologist [Appellant's neuropsychologist] and dated January 7, 2009. He offered a diagnosis of pain disorder, major depression and generalized anxiety disorder. He recommended a trial of individual psychotherapy.

Treatment was attempted with [Appellant's psychologist] who reported on May 28, 2009 that he terminated treatment with the Appellant after eight sessions. [Appellant's psychologist]

indicated that the Appellant presented with a high level of suspiciousness and mistrust as well as significant distress and high levels of depression. He was not able to help him and the prognosis for future psychological treatment success was poor.

In 2010, a psychologist with MPIC's Health Care Services team recommended psychological assessment including a neuropsychological assessment for the purpose of vocational planning and MPIC referred the Appellant to neuropsychologists, [Independent neuropsychologist #1] and [Independent neuropsychologist #2], for assessment.

[Independent neuropsychologist #1] reported on June 10, 2010. He noted that the Appellant's invalid test results prevented him from arriving at a diagnosis.

[Independent neuropsychologist #2] was also unable to obtain valid test results. In a report dated November 23, 2011, she stated that she was not able to provide a diagnosis. However, she went on to opine that the Appellant did not exhibit any symptoms of a Major Depressive Disorder or PTSD. She did not find any psychological condition preventing the Appellant from rehabilitative efforts at returning to work.

MPIC's psychologist reviewed these reports and formed the opinion that at that time the Appellant did not appear to have any MVA related psychological conditions. This view was reiterated by the case manager and an Internal Review Officer for MPIC. The Appellant appealed these decisions to the Commission, and requested that the Commission obtain an assessment and report from [[independent neuropsychologist #3], a neuropsychologist. [[independent neuropsychologist #3] assessed the Appellant, reviewed the file material and video

tapes and provided reports which concluded that the Appellant had recovered from his MVA related psychological symptoms.

Evidence and Submission for the Appellant:

Evidence of the Appellant:

The Appellant testified at the appeal regarding his history and experiences in [text deleted] during the war there and his immigration to Canada. He experienced discrimination and tragedy in his home country and was very happy to come to Canada. He tried to forget everything and started looking for a job, learning English and working hard. He and his wife had [text deleted] children in Canada. He worked as a [text deleted] and in [text deleted] and then started to work driving a truck. At the time of the accident he was employed as a truck driver for a construction company and he described the work as heavy, involving moving big rocks (100 to 200 pounds).

The Appellant explained his work history and some of the difficulties which he encountered as a new immigrant, before he was able to drive. However, he was eventually very happy with his truck driving job.

He described the pain and difficulties which he experienced following the motor vehicle accident, both physical and psychological, and the treatment he sought. He described his symptoms, his pain and his medication.

The Appellant also described his meetings with [independent neuropsychologist #2] and [[independent neuropsychologist #3]. He had difficulty with the testing that was administered, stating that although he tried very hard he was confused and felt stupid and stressed out.

The Appellant also answered several questions regarding the activities depicted in the video surveillance. He indicated that he was still feeling pain, as well as dizzy and upset, but that he took medication so that he could go out, stay calm and be a comfortable person. He explained that his pain differed from moment to moment or day to day but that before he goes out he makes sure that he takes his medication and tries to remain calm.

Evidence of the Appellant's Wife:

The Appellant's wife testified at the hearing into his appeal. She had married the Appellant in [text deleted] and described their experiences there before coming to Canada. She described her husband as a loving father to their children to their family. He worked hard providing everything that the family needed including food, rent and paying for sports for the children. The family had no debts and was living only on the Appellant's salary.

However, she testified that since the motor vehicle accident everything had been upside down because the Appellant could no longer work. He was always sad, blaming himself for everything.

Before the motor vehicle accident, she described the Appellant as happy, loving Canada and happy with his income and family. But since the motor vehicle accident, it was hard for him to go out and he was often unhappy and cried.

The Appellant's wife also described the interview which she and her husband had with [independent neuropsychologist #3]. She had certain objections to [independent neuropsychologist #3]'s interview style and some of the questions which he asked them.

Evidence of [Appellant's doctor #2]:

[Appellant's doctor #2], the Appellant's general practitioner testified at the hearing into the Appellant's appeal, indicating he had been seeing the Appellant since 2006. He indicated that he could do some psychological counselling, although this was not as effective as a psychiatrist who had additional training. Therefore, he referred the Appellant to different psychiatrists for assistance and to make recommendations regarding treatment.

[Appellant's doctor #2] described the Appellant's symptoms in 2007. He believed these were suggestive of post-traumatic stress disorder and major depression. He reviewed the list of medications which had been prescribed for the Appellant. He was of the view that the Appellant had a happy family and social life prior to the motor vehicle accident, in spite of his difficult history in [text deleted]. In his view, it was the motor vehicle accident which had triggered the depression and symptoms of PTSD.

He indicated that depending on the severity of such conditions, possible relapses, and their effect on the patient, some patients can work. The Appellant fell into a "severe" category. During relapses of his condition, it would not be safe for him to drive a truck in the [text deleted] industry as this posed a risk of harm to the patient and others.

[Appellant's doctor #2] indicated that there were periods where the Appellant could behave normally and it was recommended that he attempt to be active with social interactions. It was also advisable for the Appellant to do things like exercise and participate in sporting events. He indicated that some of the medications prescribed for the Appellant might assist in this regard.

[Appellant's doctor #2] also indicated that he had reviewed the videotape surveillance of the Appellant. He had addressed it in a report dated June 1, 2015 where he indicated that in his opinion the videotapes did not represent the Appellant's clinical status. In his testimony he indicated that the videos were not taken 24 hours, seven days a week and in his impression, only represented the "trunk of the elephant".

On cross-examination, [Appellant's doctor #2] was asked to address the issue of causation and whether relapses of the Appellant's condition were always related to the motor vehicle accident. [Appellant's doctor #2] indicated that the Appellant's condition had been triggered by the motor vehicle accident. Prior to that he had been working very hard but the accident awakened symptoms of post traumatic stress. He did not believe that the termination of the Appellant's benefits was a significant traumatic event or major factor which could trigger or cause a relapse of the Appellant's symptoms. It might be the contributing factor to his stress, but in [Appellant's doctor #2's] opinion it was not a traumatic event which would go to the core of his psychological condition.

Evidence of [Appellant's psychiatrist #2]:

[Appellant's doctor #2] referred the Appellant to psychiatrist, [Appellant's psychiatrist #2], who reported to him following an assessment on August 7, 2012, noting that the Appellant's PTSD symptoms had worsened recently. The Appellant had a sense of diminished self efficacy, lowered self esteem, disillusionment and anger. His primary defences in dealing with these stressors were somatization and avoidance.

In this report, [Appellant's psychiatrist #2] also noted that with a stoppage of disability payments by MPIC, another loss event, the Appellant's coping architecture seemed to unravel. Yet, with

his negative perception of mental health professionals it was unlikely that he would be open to supportive psychotherapy at that time, although it was recommended. His medication was reviewed, with a recommendation for gradual tapering of anti-depressants.

[Appellant's psychiatrist #2] reported again on April 8, 2014. He found the Appellant's presentation to be much the same – isolated, withdrawn and anxious. He indicated that:

> "Unfortunately, [the Appellant] continues to suffer chronically from his PTSD. As part of that, the sequelae of heightened anxiety and hopelessness has locked him into a sense of negativity and hopelessness that makes it extremely difficult for him to engage in getting back to some sense of normality. Thus, he now has extreme chronic anxiety with Agoraphobia. This is an unfortunate endpoint that can occur with severe PTSD."

[Appellant's psychiatrist #2] recommended treatment with [Appellant's psychiatrist #3], a psychiatrist based at [text deleted] doing research with patients who have PTSD by using rTMS, a new non-invasive treatment being used in affective and anxiety disorders.

[Appellant's psychiatrist #2] also testified at the hearing into the Appellant's appeal. He described the condition of post-traumatic stress syndrome, adding that it makes a person fragile and not as resilient to deal with problems and stress. Those with a pre-disposition or history of depression or anxiety can then regress and the trauma of the motor vehicle accident would result in a bad reaction to that. Financial concerns and feelings of not being heard or rejected could exacerbate and add momentum to this condition.

[Appellant's psychiatrist #2] also believed that the Appellant's psychological condition had a significant effect on his ability to work as a truck driver. With his levels of anxiety and stress, his concentration could be potentially impaired. He indicated that it was possible for the Appellant to have good periods and bad periods and it was difficult to say whether two weeks of

video surveillance could be fully representative. He also indicated that it was possible that these videos were filmed when the Appellant was going through a good period. He believed that exercise would be beneficial for someone in the Appellant's condition – hopefully it would help to improve things, but it did not directly mean that he could work.

[Appellant's psychiatrist #4] Report:

Another psychiatrist, [Appellant's psychiatrist #4], provided a report dated March 27, 2014 but did not testify at the appeal hearing. When reviewing the Appellant's history he reported:

> "[The Appellant] appears to have symptoms of posttraumatic stress disorder. [The Appellant] was in [text deleted] during the [text deleted]. His family farm was attacked [text deleted] and his mother, father, one brother and one sister were killed. [The Appellant] had an obvious scar of a serious head wound. He was apparently in a coma for approximately 3 months. He was then in the refugee camp where he met his spouse. The UN assisted their migration to Canada. According to [the Appellant's] spouse, he did not dwell on the traumatic experiences when he first arrived in Canada. However, since 2006, [the Appellant] has had many more nightmares about his horrible experiences in [text deleted]. ..."

[Appellant's psychiatrist #4] found cognitive testing of the Appellant to be invalid and inconsistent with the Appellant's verbal testimony. He went on to use other standardized psychiatric approaches.

He diagnosed a major mental illness, indicating:

> "[The Appellant] appears to have posttraumatic stress disorder. He may perhaps have very mild quasi-psychotic symptoms, which are not uncommon in severe posttraumatic stress disorder. ..."

Evidence of [Appellant's psychiatrist #5]:

[Appellant's doctor #2] referred the Appellant to psychiatrist [Appellant's psychiatrist #5] who reported on October 8, 2014. Following an interview with the Appellant and his wife, [Appellant's psychiatrist #5] concluded:

> "In summary, [the Appellant] is a [text deleted]-year old gentleman who had had difficult early adult life and had been a victim to the brutalities of the war. He lost of (sic) of his family members and himself was injured and spent some time in a coma as a result. It is difficult to gauge the psychological impact of war on him due to inadequate information. It appears that upon immigration to Canada, he made a good life for himself and his family. However, he was seriously injured and as a consequence disabled in 2008 when he was involved in a motor vehicle accident. He has since been struggling to recover from disabilities at physical and psychological level.
>
> He had been suffering from depression, anxiety, and some symptoms of PTSD since the motor vehicle accident, which appear to be refractory. These disabilities make him unsuitable for work.
>
> In my opinion, his prognosis is very poor given his poor response to the medications and difficulty in benefitting from psychotherapy considering communication difficulties as well as limitation caused by persistent and overwhelming anxiety."

[Appellant's psychiatrist #5] also testified at the hearing into the Appellant's appeal. He described post-traumatic stress disorder as a DSM diagnosis based on clusters of disability and functional impairment resulting from exposure to trauma or learning that close friends and family had been exposed to trauma. It is a mental health problem which requires treatment in all domains, including medication, optional psychotherapy and social interventions to improve skills which have been lost. He described a component of anxiety where the person feels under threat, whether real or imagined and has symptoms of breathlessness, heart racing and wanting to run away. He stated that depression also affects five percent of that population.

[Appellant's psychiatrist #5] indicated that depending on the severity of the symptoms, one may or may not be able to function in their family and job, or in activities of daily living. He indicated that a motor vehicle accident could cause symptoms of post-traumatic stress disorder, anxiety and depression as it can be felt to be an insult to personal integrity. Many cases have been reported where a motor vehicle accident has caused PTSD. However, [Appellant's psychiatrist #5] did not agree that a discontinuation of MPIC benefits and the resultant financial stress could cause that level of depression or PTSD. Social stressors such as job loss etc. could

be contributory or complicating factors to an already existing vulnerability, but the loss of a job or financial issues could not in his view cause PTSD. These are not viewed as catastrophic in the DSM. The event has to be a greater magnitude causing one to relive the trauma of man-made or natural disaster.

[Appellant's psychiatrist #5] also gave evidence regarding the possibility of relapse and normal periods of functioning.

Submission for the Appellant:

Counsel for the Appellant submitted that the Internal Review decision should be set aside and the Appellant's benefits reinstated.

He noted that [independent neuropsychologist #3] had based his conclusions on the videotaped evidence, which was a serious contradiction because somebody doing these things could still be disabled. He asked that the panel set aside [independent neuropsychologist #3's] report as he had been paid for the report by MPIC and was in a conflict of interest position. This was a breach of natural justice. Counsel for the Appellant believed that [independent neuropsychologist #3] was biased, even though it was the Appellant's previous counsel (the Claimant Adviser) who had requested that the Commission obtain a report from him.

Counsel noted that [independent neuropsychologist #3] had agreed that a motor vehicle accident could be a cause of PTSD. Clearly the motor vehicle accident was the cause of the Appellant's condition today. [Appellant's doctor #2] had testified that the discontinuation of IRI benefits could not be a cause of PTSD. It could be a trigger or stressor but it could not be the cause. Even [independent neuropsychologist #3] agreed with this. Before the motor vehicle accident,

the Appellant had never heard of or known of PTSD. Even after his experiences in the war in [text deleted] both he and his wife said that he was living a happy life. He was functioning well and fit for work. He started having these symptoms of PTSD after the motor vehicle accident, when the motor vehicle accident brought back the memories of the war.

[Independent neuropsychologist #3] testified that the Appellant could shop and exercise and still be disabled. It was submitted that the Appellant could function well for short periods of time, but that does not mean that he was able to work.

The Appellant had been hard working prior to the motor vehicle accident, but now could not work because of the motor vehicle accident. He had paid his premiums to MPIC which should assist him and not avoid its responsibility by hiding behind concepts of causality and functioning.

Evidence and Submission for MPIC:

MPIC relied upon the various medical reports found on the Appellant's indexed file, with particular emphasis on the reports of [independent neuropsychologist #2] and [independent neuropsychologist #3], as well as video surveillance evidence and the testimony of [independent neuropsychologist #3] at the appeal hearing.

Excerpts from the video surveillance which depicted the Appellant performing various activities between December 14 and December 30, 2011 were viewed by the panel and the parties during the appeal hearing. In particular, during the testimony of the Appellant, excerpts from the video tape surveillance were viewed and the Appellant asked to comment upon them. The video tape

had been viewed by [independent neuropsychologist #3] and by [Appellant's doctor #2] prior to the appeal hearing.

In addition, counsel for MPIC asked the panel to view the video tapes in their entirety, not just the excerpted sections he had highlighted during the appeal hearing. The parties agreed that the panel should view the complete videotaped DVD's after the appeal hearing, and the panel did so, after the conclusion of the hearing, on February 16, 2016.

In submitting that the Internal Review decision was correct, counsel for MPIC relied upon the reports of [independent neuropsychologist #2], [MPIC's psychologist] and [independent neuropsychologist #3], as well as the testimony of [independent neuropsychologist #3]. He noted that [Appellant's psychiatrist #2] did not see the Appellant for the first time until August of 2012, some months after his benefits had been terminated. [Appellant's psychiatrist #5] did not see the Appellant until 2014. Although he conceded that [independent neuropsychologist #3] had not seen the Appellant until 2013, counsel argued that this situation was different since [independent neuropsychologist #3] had full access to the medical material on file and had viewed the video surveillance which the psychiatrists, [Appellant's psychiatrist #2] and [Appellant's psychiatrist #5] had not. Nor had [Appellant's psychiatrist #2] or [Appellant's psychiatrist #5] provided an opinion regarding causation in connection with the Appellant's psychological condition.

Counsel submitted that the Appellant's testimony was not reliable when compared to the videotaped evidence. Further, his level of function reports to MPIC contrasted with the videotaped evidence. The Appellant reproduced invalid testing results on three separate occasions with three separate professionals.

[Independent neuropsychologist #2] Report:

[Independent neuropsychologist #2] assessed the Appellant on November 15, 2011 and reported on November 23, 2011. She undertook a clinical interview with the Appellant, a file review of all provided medical, psychiatric and psychological records, and conducted several psychological tests. Her report reviewed the medical file in detail and included behavioural observations from the interview. [Independent neuropsychologist #2] found that obtaining an understanding of the Appellant's current psychological status was not possible due to difficulties obtaining detailed information from him in interview, as well as due to his pattern of non-credible responding across all objective psychological measures performed. Because of this, she was not able to provide a DSM-V-IR diagnosis as requested.

However, she noted that the Appellant did not appear to be exhibiting any symptoms of a Major Depressive Disorder or PTSD at that time. Although he was frequently angry and agitated, using dramatic language to express himself, his thoughts were logical and goal-oriented. Although he was somatically preoccupied with issues of chronic pain and pain related disability, she did not believe his history or performance was consistent with a diagnosis of a pain disorder. She also noted that symptom exaggeration was present. In [independent neuropsychologist #2's] view, the Appellant's previous difficulties with symptoms of trauma relating to his experience in [text deleted] might be contributing to his feelings of anxiety, persecution and mistrust of people in positions of authority. She also recognized difficulty with coping, which significantly limited him seeking out the help he may need to have a healthier, happier life.

[Independent neuropsychologist #2] concluded:

> "Thus, while my recommendation would be that [the Appellant] would likely benefit from some psychotherapy aimed at issues of stress management, anger management, and addressing some of his patterns of maladaptive coping, to the best that I am able to determine, these issues do not appear to be causally related to the car accident in question, and would likely be best addressed through the public mental health care system, should he be willing to seek out this type of help.
>
> In response to your inquiry regarding [the Appellant's] employability, in light of the apparent absence of any current serious mental health concerns (such as any current symptoms of a Major Depressive Disorder, Anxiety Disorder, or more serious mental health concern), there does not appear to be any psychological condition present other than [the Appellant's] firmly entrenched view of himself as permanently disabled which would prevent [the Appellant] from being able to engage in rehabilitative efforts including a graduated return to work to a level of employment suited to his physical abilities at this time."

Psychological Consultant Reports:

The Appellant's file and [independent neuropsychologist #2's] report were reviewed by MPIC's psychological Health Care Services consultant in a report dated February 3, 2012. The consultant found that the Appellant seemed quite committed to his belief that he was completely disabled and yet was not able to articulate the symptoms that caused him to be disabled. Based on [independent neuropsychologist #2's] report, the consultant believed that the Appellant was exaggerating his psychological and somatic symptoms and that he did not have any specific Axis I Psychological Disorder that would be considered motor vehicle accident related. His conclusion was that:

> "Based on the review of the file documentation, including [independent neuropsychologist #2's] recent third party examination of the claimant, it is now the writer's opinion that the claimant does not appear to have any MVA-related psychological conditions. As such, there is no medical requirement for any psychological treatment. Furthermore, based on the review of the file documentation, there is no indication that the claimant could not return to his pre-accident employment, from a psychological perspective, if he chose to do so."

The psychological consultant undertook another extensive review of the Appellant's file, along with the videotaped surveillance and documentation, on June 12, 2012. It was noted that the

Appellant's "demonstrated ability to run on several occasions" was inconsistent with the significant chronic pain behaviour that he described to [independent neuropsychologist #2]. The Appellant did not appear to demonstrate any pain behaviours in the video tapes and appeared to be functioning in a normal and mentally healthy manner. There was no evidence of any facial grimacing or pain behaviour demonstrated, in contrast to the Appellant's report to [independent neuropsychologist #2] that he suffered from chronic unbearable pain in several parts of his body. He was also observed to be able to engage in strenuous physical exercise for over a half-hour with no significant pain behaviours demonstrated.

Therefore, the consultant concluded that the Appellant's reported symptoms and significant level of physical and psychological dysfunction was not consistent with his observed activities over the numerous days of surveillance that were taken. He was observed to function in what would be considered a normal fashion and this strengthened the opinion of the consultant from his memorandum dated February 3, 2012 that, consistent with the opinion of [independent neuropsychologist #2], the Appellant did not demonstrate any symptoms of a major depressive disorder or post-traumatic stress disorder. There was no evidence of somatic focus or pain-related behaviour observed, consistent with [independent neuropsychologist #2's] opinion of extreme symptom exaggeration and probable malingering.

> "The surveillance information also provides further support that the claimant has no specific MVA-related psychological condition that would preclude him from returning to his pre-accident employment as a truck driver as indicated in the writer's earlier memorandum."

Evidence of [independent neuropsychologist #3]:

[Independent neuropsychologist #3] provided three reports and also testified at the hearing into the Appellant's appeal. He explained that he had reviewed a package of documents from the Appellant's medical file as well as three DVD's of video tape surveillance. He met with the

Appellant and his wife and spoke with [Appellant's doctor #2] as well as MPIC's Special Services. He attempted to administer psychometric tests with a technician, but found the test results to be unreliable.

[Independent neuropsychologist #3] reviewed the Appellant's previous trauma through his family's tragic circumstances and experiences in [text deleted]. He also testified regarding his understanding of the circumstances of the motor vehicle accident. While this might have created some symptoms regarding traumatic anxiety or driving anxiety, he testified that he would have expected such symptoms to be reasonably short lived. However, for the Appellant, recovery did not occur. There was no resumption of normal functioning and the Appellant experienced significant severity in symptoms, both physical and psychological, resulting in his referral to [rehab clinic] for rehabilitation. [Independent neuropsychologist #3] noted some areas of sub-maximal performance in the Appellant's file, including psychological barriers to engage in the testing process. It was clear that there was an abundance of psychological factors influencing his outcome including not being receptive to education and pain focused and self-limiting behaviour.

[Independent neuropsychologist #3] reviewed reports from the physiotherapist [Appellant's physiotherapist]. Finally, he reviewed [independent neuropsychologist #2's] report and the videotaped surveillance evidence.

It was [independent neuropsychologist #3's] view that the Appellant's invalid test results were a result of his malingering, intentional behaviour. There were clear validity issues.

[Independent neuropsychologist #3] also indicated that the surveillance was a central piece for him and that without surveillance his opinion would have been different. In his view, the

videotaped surveillance represented an individual functioning in a manner uncontaminated by verbal report and how he might appear to doctors. It is the claimant in his real world. He testified that he reviewed the videos and material and saw a man who was carrying on life normally, visiting, shopping, taking his son out, driving and sitting through indoor soccer games. He vigorously exercised, walked, ran, slipped than smiled, and looked like he was engaging in normal life. This was very different from what he had read in the Appellant's file. What he saw in the video was someone who, with fluidity, got in and out of cars, bent down to pick things up off the floor, shopped, picked up bags and heavy water jugs, sat for over an hour and did not look like he was in pain. He looked comfortable in the VLT lounge as well as in the gym and soccer place. There was no evidence of sedation and the presentation of the Appellant looked normal. It looked like he had recovered and was a robust healthy looking man. Although he had concerns about the invalidity of [independent neuropsychologist #2's] and [independent neuropsychologist #1's] testing results, as well as his own, for him the video was dramatic, definitive and very strong evidence that the Appellant had recovered from his motor vehicle accident related condition.

[Independent neuropsychologist #3] agreed that the Appellant appears to have deteriorated after the videotape surveillance was conducted, but this was more likely because his benefits had been terminated. Although PTSD symptoms would not likely be triggered by the termination of benefits, as PTSD is generally a response to life-threatening stressors, administrative decisions can still be stressful.

Submission for MPIC:

Counsel for MPIC submitted that by the time the Appellant saw [independent neuropsychologist #2] and at the time of the video surveillance, he had regained his ability to hold his determined

employment. This formed the basis of his benefits coming to an end. The Appellant had been provided with rehabilitation support following the motor vehicle accident. At the time of the motor vehicle accident he had only been employed with his employer for 81 days. He had been classified as a temporary earner.

During the period of his recovery, he was reluctant at most attempts at rehabilitation. He attended at [rehab clinic] but was not responsive to psychological treatment. There was no objective evidence on file that contradicted the physical findings that the Appellant could return to work as of May 4, 2007. While further information from [rehab clinic's psychologist #1] and [Appellant's psychiatrist #1] caused MPIC to provide the Appellant with IRI benefits due to psychological barriers preventing a return to work, the Appellant was not receptive to psychological intervention. Testing by [independent neuropsychologist #1] was invalid. [independent neuropsychologist #2] also found her test results to be invalid.

[Independent neuropsychologist #3] then did a forensic analysis of the medical material as well as the videotaped evidence and set his mind to whether there was a causal connection between the Appellant's stated inability to work and the motor vehicle accident. This differed from the analysis conducted by [Appellant's psychiatrist #5] and [Appellant's psychiatrist #2] who were not asked to provide reports regarding a causal connection.

[Independent neuropsychologist #3's] review of the videotaped evidence led him to note striking evidence of an ability to function. He was able to conclude, based on this videotaped evidence that, in his professional opinion as a clinical psychologist the Appellant was functioning normally. There were no signs of sedation, guarded behaviour or displays of pain. From this he was able to conclude that the Appellant appeared to have recovered from any motor vehicle

accident related psychological issues and that this recovery would have occurred prior to the videotaped surveillance.

Therefore, MPIC was relying upon the reports of [independent neuropsychologist #3] and [MPIC's psychologist] and their opinions that the Appellant was not prevented, by any motor vehicle accident related psychological condition from returning to work.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities, that the Internal Review Officer erred in finding that by June 2012 he did not suffer from a condition arising out of the motor vehicle accident which prevented him from working.

The MPIC Act provides

> 70(1) In this Part,
>
> **"accident"** means any event in which bodily injury is caused by an automobile; (« accident »)
>
> **"automobile"** means a vehicle not run upon rails that is designed to be self-propelled or propelled by electric power obtained from overhead trolley wires; (« automobile »)
>
> **"bodily injury"** means any physical or mental injury, including permanent physical or mental impairment and death;

Application of Part 2

71(1) This Part applies to any bodily injury suffered by a victim in an accident that occurs on or after March 1, 1994.

Entitlement to I.R.I. after first 180 days

84(1) For the purpose of compensation from the 181st day after the accident, the corporation shall determine an employment for the temporary earner or part-time earner in accordance with section 106, and the temporary earner or part-time earner is entitled to an income replacement indemnity if he or she is not able because of the accident to hold the employment, and the income replacement indemnity shall be not less than any income replacement indemnity the temporary earner or part-time earner was receiving during the first 180 days after the accident.

Events that end entitlement to I.R.I.

110(1) A victim ceases to be entitled to an income replacement indemnity when any of the following occurs:

(c) the victim is able to hold an employment determined for the victim under section 106;

The panel found the evidence of both the Appellant and his wife to be consistent and credible.

His work history, as described by them and in the documents on the indexed file, did show several work transitions. The panel finds that these were explained by the Appellant and his wife and were consistent with the nature of his status as a new immigrant (with the language and

transportation challenges this entailed), his experience as a newly trained truck driver and the nature of the trucking industry itself. The panel does not find that the Appellant's work history prior to the motor vehicle accident was adversely impacted by a history of mental or emotional instability.

The Appellant's wife, in particular, was very clear about what the Appellant was like in his work and interpersonal relationships before the motor vehicle accident, and the difficulties and differences which arose after the motor vehicle accident. The panel finds that there was little or no evidence that symptoms of post-traumatic stress disorder were interfering with the Appellant's employability, social function or family relationships prior to the motor vehicle accident.

It was generally accepted by the parties that the motor vehicle accident then acted as a trigger which caused the Appellant to suffer from a psychological condition which included PTSD symptoms and depression, preventing him from working. Both [rehab clinic] psychologist, [rehab clinic's psychologist #1], and psychiatrist [Appellant's psychiatrist #1] recommended treatment for the Appellant's condition, but treatment efforts were not successful. The Appellant was in receipt of IRI benefits.

Medical Evidence:

The Appellant was then assessed by a number of psychologists and psychiatrists.

Overall, the expert evidence showed a difference between the opinions and approach of the psychological experts and that of the psychiatrists involved. The panel has found it useful to trace back and review some of these reports from the indexed file and the testimony of the expert witnesses, in order to obtain some perspective regarding these various approaches.

General Practitioners:

The general practitioners who first treated the Appellant following the MVA noted symptoms of post-traumatic stress disorder secondary to the MVA.

[Appellant's doctor #3], [text deleted], first noted post-traumatic stress disorder on August 4, 2007, stating:

> "To whom it may concern at MPIC.
>
> This note is to certify that [the Appellant] is suffering from post-traumatic stress disorder, secondary to MVA: October 12/06."

[Appellant's doctor #2] [text deleted] noted on September 3, 2007 that the Appellant suffered from chronic pain, major depression disorder, anxiety and PTSD.

[Appellant's doctor #2] reported on September 27, 2010 noting the Appellant's diagnosis of PTSD, MDD, IBS and chronic pain syndrome with the above psychiatric conditions being related to his accident of 2006. He confirmed this in another report dated July 21, 2012. The same diagnosis was provided in a medical report to Service Canada dated November 9, 2012.

Another letter dated November 1, 2012 from [Appellant's doctor #2] confirmed that:

> "Since the MVC on Oct. 12, 2006, he has been suffering from symptoms consisting of Post Traumatic Disorder, Major Depression Disease and Anxiety…"

A letter from [Appellant's doctor #2] dated June 1, 2015 stated:

> "Since the MVC in Oct. 12, 2006, he has been suffering symptoms consisting of PTSD, MDD and anxiety…

> [The Appellant] was assessed by three psychiatrists and multiple psychologists, all of them confirmed that the aforementioned psychiatric illnesses and I believe the same were attributed to MVC on Oct. 2006. [The Appellant] was seen by the following Doctors:
>
> 1. [Appellant's psychiatrist #2]
> 2. [Appellant's psychiatrist #1]
> 3. [Appellant's psychiatrist #5]
> 4. [Appellant's psychologist]
> 5. [Appellant's doctor #4]
> 6. [rehab clinic's psychologist #1]
> 7. [rehab clinic's doctor]"

[Appellant's doctor #2] testified before the Commission that he accepted the opinions of these psychiatrists and relied upon their diagnoses to continue with treatment of the Appellant.

Psychiatrists:

[Appellant's psychiatrist #1], in a report dated August 2, 2007 found that the Appellant did not have a pre-motor vehicle accident history of Post Traumatic Stress Disorder, noting the Appellant had worked at heavy jobs since his arrival in Canada. He diagnosed major depression, causally related to the motor vehicle accident and requiring treatment.

His follow-up report of April 25, 2008 indicated that treatment attempts were not successful.

> "[The Appellant] is not psychologically minded. He has difficulty connecting his feelings with his symptoms. He is so pain focused therefore the question of psychotherapy treatment does not apply."

[Appellant's psychiatrist #2] provided reports dated August 7, 2012 and April 8, 2014. He also testified before the Commission. His diagnosis was one of post-traumatic stress disorder with prominent depressive symptoms. In 2012, he concluded that the Appellant's condition was severe. [Appellant's psychiatrist #2] connected the Appellant's diagnosis with the motor vehicle accident, along with his pre-motor vehicle accident experiences. However, he did not see the

Appellant until after the termination of benefits, and he agreed that the termination of the Appellant's benefits could also be a trigger for post-traumatic stress disorder symptoms.

This is consistent with his statement in his report dated August 7, 2012:

> "However, with stoppage of disability payments by MPI, another loss event, [the Appellant's] coping architecture seems to unravel and brought to fore the central conflict he is faced with. [the Appellant's] central conflict is between a conscious wish to be less incapacitated, better functioning, self-efficacious, and an unconscious fear that recovery will both lead to an uncontrolled expression of his own rage and free significant others (wife, children) to express their resentment against him if he is not protected by illness. In many ways, the current situation offers the opportunity to help provide Ahmet with more adaptive coping skills and help deal with his repressed anger and rage. However, given his seeming negative perception of mental health professionals, it is unlikely that [the Appellant] will be open to supportive psychotherapy at this time."

[Appellant's psychiatrist #5] provided both written reports and testimony at the hearing. His report of October 8, 2014 provided a diagnosis of post-traumatic stress disorder, depression and anxiety.

> "… It appears that upon immigration to Canada, he made a good life for himself and his family. However, he was seriously injured and as a consequence disabled in 2008 when he was involved in a motor vehicle accident. He has since been struggling to recover from disabilities at physical and psychological level.
>
> He had been suffering from depression, anxiety, and some symptoms of PTSD since the motor vehicle accident, which appear to be refractory. These disabilities make him unsuitable for work.
>
> In my opinion, his prognosis is very poor given his poor response to the medications and difficulty in benefitting from psychotherapy considering communication difficulties as well as limitation caused by persistent and overwhelming anxiety."

In his evidence before the Commission, [Appellant's psychiatrist #5] did not agree that the termination of MPI benefits could be the kind of stressor that would produce post-traumatic stress disorder symptoms. In his view, a loss of job does not meet the criteria for a PTSD trigger.

Rather, he testified that such triggers must be catastrophic man-made or natural disasters where one fears for their own life or their loved ones.

[Appellant's psychiatrist #5] testified that he was confident in the abilities of [Appellant's psychiatrist #2] and [Appellant's psychiatrist #1], whose reports he had reviewed. He was of the view that, based both upon these reports and the presentation of the Appellant when he saw him in June 2014, he was unable to work. He found the Appellant to be seriously disabled with a poor prognosis for recovery.

[Appellant's psychiatrist #4] did not testify at the hearing, but provided a report dated March 27, 2014. His diagnosis of major mental illness, with the Appellant appearing to have post-traumatic stress disorder and possibly mild quasi-psychotic symptoms (not uncommon in severe post-traumatic stress disorder) is set out in that report. He noted the Appellant's history of taking anti-depressants for 8 years and recommended aggressive PTSD treatment, ideally in-patient treatment. His summary included a diagnosis of depression and anxiety secondary to a probable diagnosis of post traumatic stress disorder. He noted that he did not seem psychologically minded which can be a hindrance for psychological therapy.

This echoed comments made by [Appellant's psychiatrist #1] when he noted that the Appellant was pain focused, but could not connect his problem with his symptoms.

Psychologists:

The evidence and reports of the psychologists sometimes took a different approach.

Initially, [rehab clinic's psychologist #1], a psychologist working with [rehab clinic], provided a diagnosis, on March 2, 2007, of a Pain Disorder and Major Depression. He recommended exposure based therapy and education about the nature of his anxiety.

> "[The Appellant] is coping with significant pain and some physical limitations secondary to his car accident. His presentation is consistent with a diagnosis of Pain Disorder and Major Depression. He also has some anxiety symptoms. [The Appellant's] daily functioning has changed dramatically. Prior to the accident, he was working full time, was able to participate fully in family activities, and was active socially in his community. As a result of his pain and mental health symptoms, he is no longer able to do these things. His current pain management strategies are highly focused on medical intervention and he has expressed some difficulty with trusting a psychological intervention. That being said, [the Appellant] may clearly benefit from psychological interventions aimed at helping him cope more effectively with his pain, and his current emotional state. His depressive symptoms and anger are of some immediate concern. Intervention may focus on more active coping strategies, social support and anger management. Exposure based therapy and education about the nature of his anxiety may be particularly useful in targeting his pain avoidance and physiological arousal. Finally, [the Appellant] may benefit from some education around using pacing, and relaxation to help him manage his pain and improve his sleep.
>
> [the Appellant] appears to be already talking an anti-depressant that may help him with his physiological arousal and depression. His dosage, however, is in the lower end of the effective range for this medication. He may benefit from a review of this medication to see if a higher does may be appropriate. Given his fears of saying the wrong thing to treatment providers, medication may be a beneficial treatment modality in this context."

[rehab clinic's psychologist #1's] psychological assessment report dated October 17, 2007 noted symptoms highly consistent with post-traumatic stress disorder and offered a diagnosis of Anxiety Disorder with Traumatic features. He clearly stated that the anxiety and current stress appeared to be primarily related, both in context and onset, to his automobile accident.

The Appellant was then assessed by a clinical neuro-psychologist, [independent neuropsychologist #1], who reported on June 10, 2010. He was not able to confirm any neuro-psychological deficits, and noted invalid results, which precluded him from arriving at a clear

diagnostic impression. Recognizing the limitations of the invalid assessment results, [independent neuropsychologist #1] indicated he was not able to arrive at a specific diagnosis.

MPIC then sought an independent assessment from neuropsychologist, [independent neuropsychologist #2]. [Independent neuropsychologist #2] was also unable to obtain valid results. She provided a report dated November 23, 2011, indicating that due to the Appellant's interview responses and pattern of non-credible responding across all objective psychological measures performed, she was not able to provide a diagnosis as requested. She believed some of the test scores indicated symptom exaggeration or somatic malingering. She then went on to state:

> "Unfortunately, obtaining an accurate understanding of [the Appellant's] current psychological status was not possible due to difficulties obtaining detailed information from [the Appellant] in interview as well as due to his pattern of non-credible responding across all objective psychological measures performed. Because of this, I am not able to provide a DSM-IV-IR diagnosis as requested.
>
> However, on the basis of his presentation and reported symptoms, [the Appellant] does not appear to be exhibiting any symptoms of a Major Depressive Disorder to PTSD at this time. He neither reported nor demonstrated any sign of depressed mood or symptoms of psychomotor retardation, nor did he either report or exhibit any obvious symptoms of PTSD, either relative to his pre-accident experiences in [text deleted] or to the accident in question. …"

She did not find any psychological condition which was a barrier preventing the Appellant from engaging in rehabilitative efforts at returning to work and stated:

> "Thus, while my recommendation would be that [the Appellant] would likely benefit from some psychotherapy aimed at issues of stress management, anger management, and addressing some of his patterns of maladaptive coping, to the best that I am able to determine, these issues do not appear to be causally related to the car accident in question, and would likely be best addressed through the public mental health care system, should he be willing to seek out this type of help."

In a report dated February 3, 2012, the psychological Health Care Services consultant for MPIC relied upon [independent neuropsychologist #2's] examination of the Appellant to form the opinion that:

> "… the claimant does not appear to have any MVA-related psychological conditions. …"

The Commission requested an independent report from psychologist, [independent neuropsychologist #3]. [Independent neuropsychologist #3] reviewed [independent neuropsychologist #2]'s opinion, and many other reports on the Appellant's file. He also viewed subsequent video surveillance of the Appellant conducted in December of 2011. [Independent neuropsychologist #3] provided an independent psychological examination report dated March 3, 2014, a follow-up letter dated March 6, 2014, and a report dated November 30, 2014.

He also testified at the appeal hearing.

In his report of March 3, 2014, [independent neuropsychologist #3] reviewed a number of reports on the Appellant's medical file and interviewed the Appellant and his wife. He placed a great deal of emphasis upon [independent neuropsychologist #2's] report as well the videotaped surveillance of the Appellant which he viewed. In his report he stated:

> "Based on my review of all the documentation that I have had access to, [the Appellant] sustained musculoskeletal injuries and, a possible fractured right clavicle in the motor vehicle accident in question, he was seen to develop significant psychological sequelae early post-injury, and for some time thereafter, to a time that is generally unknown, but prior to probably [independent neuropsychologist #2's] assessment reported on as of November 23, 2011, and as of the video surveillance as of December 2011, at which time his functioning had apparently normalized given the normal functioning that was evident in the surveillance material.
>
> More likely than not, his mental state subsequently deteriorated following the termination of his income replacement benefits in June 2012, with this spoken to by the

> Counselor who he saw, [text deleted], and as was apparently evident in terms of his clinical presentation and, as per his wife's collateral information, on this current assessment.
>
> This was to the level where he presented with an apparent major Depressive Disorder – severe, and with unknowns about whether or not he continues to have non-mental health-related physically based sequelae given the earlier history of his normative functioning on the video surveillance dating to December 2011, …
>
> The predominant cause of his exacerbated mental state and apparent Major Depressive Disorder was the benefit termination that he has dealt with dating to June, 2012."

At the appeal hearing [independent neuropsychologist #3] emphasized that the video tapes he viewed were compelling, as the Appellant looked completely normal on those tapes. He agreed with [independent neuropsychologist #2's] conclusions as well.

[Independent neuropsychologist #3] was asked how both he and [independent neuropsychologist #2] were able to form opinions despite the invalid testing results, and whether or not the Appellant's behavior leading to the invalid testing could have been caused by mental illness. [Independent neuropsychologist #3] indicated that he was not concerned that [independent neuropsychologist #2] had provided a negative diagnosis in spite of the invalid testing results, since he believed she had been asked to assess the Appellant's psychological functioning in general. He also indicated that not all of the tests were affected by mental health issues. Further, he indicated that his opinion might have been different had he not had the opportunity to view the video surveillance evidence, which he described as compelling.

Video Surveillance:

It was clear from the video tapes viewed by the panel that the Appellant had physical capabilities. He was seen to exercise on an elliptical trainer vigorously and with some stamina for an extended period. He was also seen moving around, walking and even running in the

streets, in and out of cars. He was seen sitting for long periods of time on a soccer stadium bleacher. He was viewed lifting large gallon bottles of drinking water with apparent ease and coordination.

The Internal Review Officer quite correctly described many of these activities. He then concluded:

> "The decision to end your entitlement to IRI benefits is supported by the file information. Although the case manager relied on medical information available when the decision was rendered, I find this is further supported by the video surveillance evidence (which was not available to your case manager or myself until after the hearing of July 3, 2012)."

However, physical capabilities were not the issue in the appeal before the panel. On June 1, 2012, the Appellant was not in receipt of IRI benefits for any physical condition or disability. MPIC had found much earlier that the Appellant was physically able to work. He was then considered unable to work and paid IRI benefits due to the psychological effects of the motor vehicle accident. Both parties agreed that MPIC had initially accepted a causal relationship between the Appellant's psychological condition and the motor vehicle accident and that benefits were paid for a period.

A case manager's decision of January 22, 2008 stated:

> "… Based on this review, it was determined that your motor vehicle accident psychological condition would have led you to be incapable of returning to work following the work hardening program at [rehab clinic]. Therefore, as a result of this review, your IRI benefits will be reinstated as of June 25, 2007."

MPIC's position was that by the time the Appellant saw [independent neuropsychologist #2] in November 2011 and the surveillance videos were taken in December 2011, the Appellant had recovered from any effects of the motor vehicle accident. The cause of any psychological difficulties which he might have had at that point was to be found in the termination of his

benefits, and not from physical or psychological injuries stemming from the motor vehicle accident. By that point, [independent neuropsychologist #3] testified, the Appellant seemed perfectly normal and both [independent neuropsychologist #2] and [independent neuropsychologist #3] supported termination of his benefits.

But while the Appellant seemed physically capable, what was not apparent to the panel from the video tapes was much indication as to the Appellant's mental state. The panel noted that he did not seem outwardly engaged, communicative or socially outgoing. In the video tapes from his son's soccer games or practices, he paced, stood or sat, for the most part alone, and with only occasional responses to what appeared to be greetings from other fans. In the gym, he seemed to choose the most isolated station and equipment, although many others were available closer to other people. The Appellant remained on a single machine, located at the wall. In the VLT lounge he sat by himself, and was not seen to interact with other patrons. In none of these situations was the Appellant seen to be particularly animated or socially engaged.

The panel also noted that the Appellant's participation in gym activities was recommended by a number of his caregivers, and some questions were put to [independent neuropsychologist #3] in this regard.

For example, in an [rehab clinic] report dated May 8, 2007, it was stated:

> "[The Appellant] was provided with a home-based exercise program based on the exercises he participated in during his rehabilitation program. He displayed a full understanding of the execution of the exercises and stretches taught during his program and understood the importance of continuation of the exercises. The home program is provided in an effort to assist him in maintaining the functional gains he has made to date and to facilitate future gains."

[Independent neuropsychologist #3] agreed that physical exercise is an important part of a rehabilitation plan even for those with mental illness, and that it is often recommended to assist with mood stabilization. In regards to soccer and grocery shopping, [independent neuropsychologist #3] testified that activating, mobilizing, and watching soccer might assist the Appellant to be engaged. Participating in these activities does not necessarily mean a patient is better, but that they are attempting to reclaim their life.

[Appellant's doctor #2] also commented upon the video tape evidence in his letter dated June 1, 2015:

> "[the Appellant's] PTSD and major depression disorder symptoms have been severe and have been happening most of the time since the diagnosis despite the medications and other therapies. …
>
> In my opinion video tapes taken by MPI do not represent [the Appellant]'s clinical status."

[Appellant's doctor #2] testified that these videos do not represent an accurate depiction of the Appellant's condition, referring to them as the "trunk of the elephant", with the rest of the elephant missing.

[Appellant's psychiatrist #2] testified that exercise would be beneficial for the Appellant and that an ability to exercise did not necessarily mean he could work. When asked whether the period of time in the dates of the video tapes reflected the Appellant's condition, he could not say how fully representative that was. A patient might be fine for one month and then relapse, and it was possible that when the videotaping was done, the Appellant had been in good condition.

[Appellant's psychiatrist #5] indicated that it was difficult to conclude from the limited period of the video tapes that an individual was perfectly functional. He indicated that such a conclusion would have to be related to a generalized global psychiatric assessment, since a person could have some periods when they were doing okay.

This idea of symptoms waxing and waning was also examined by the panel. Some of the Appellant's caregivers testified that with a condition like PTSD and depression, the Appellant is not in a constant state. Rather, symptoms can wax and wane depending upon many factors.

One such factor can be medication. The Appellant testified that he would take large dosages of pain killers in order to be able to go to the gym or to go out and function at all. Many notes regarding the level of medication which the Appellant was taking are found on the Appellant's file. [Independent neuropsychologist #3] noted that the Appellant's medication could have impacted upon the symptoms displayed at the time of [independent neuropsychologist #2's] examination in November of 2011. [Appellant's psychologist], a psychologist, expressed concern regarding the level of medication prescribed for the Appellant in reports dated August 14, 2008 and May 28, 2009.

Conclusions:

[Appellant's psychiatrist #5] indicated that a patient meets the criteria for diagnosis of PTSD, if PTSD symptoms happen most days and most parts of the day for a period of up to six months. Following this diagnosis, the panel finds that the evidence before us does not establish that the Appellant was recovered from his accident- related PTSD symptoms in November and December 2011.

He had been assessed and diagnosed as suffering from PTSD by various psychiatrists, including [Appellant's psychiatrist #2], [Appellant's psychiatrist #4] and [Appellant's psychiatrist #5]. He was taking three different anti-depressants, but, according to several caregivers, was treatment resistant. [Appellant's psychiatrist #4] described this as follows:

> "[The Appellant] is a [text deleted]-year-old man with a probable diagnosis of post traumatic stress disorder. His depression and anxiety are secondary conditions. [The Appellant] appears to have endured traumatic experiences of the magnitude that very frequently cause significant psychiatric symptoms. It is not uncommon that individuals with PTSD have periods of reasonable functioning. However, unpredictable social stresses can sometimes trigger severe PTSD symptoms. It is my clinical impression that [the Appellant's] primary diagnosis is posttraumatic stress disorder and that many of the physical symptoms are likely related to significant physical tension. [The Appellant] does not appear to be psychologically minded and this can be a hindrance for psychological therapy. He does not seem to have responded dramatically to any of the psychiatric medications prescribed thus far. However, I do not believe I have an accurate representation of his medication history, since [the Appellant] did not recall all of his medications."

He recommended aggressive PTSD treatment, ideally in-patient treatment. However, even after referral to a [text deleted] program for treatment of PTSD and depression/anxiety, a report from [Appellant's psychiatrist #3], dated May 22, 2015, indicated that the Appellant was not a responder to 16 sessions of treatment.

The panel was left to weigh the evidence from the Appellant's caregivers, and the psychiatrists who treated or assessed him, against the view of the psychologists (in particular [independent neuropsychologist #2], [independent neuropsychologist #3] and [MPIC's psychologist]) who opined that any cause of the Appellant's inability to work, by December 2011, was not due to psychological symptoms arising out of the motor vehicle accident.

The panel notes that these psychologists, relying as they did upon psychological testing, seemed to have been somewhat limited or frustrated by the difficulty in achieving reliable testing results

for the Appellant. This seems to have led some of them at least, to either conclude that the Appellant was better or to fail to connect his problems with the motor vehicle accident.

In contrast, many of the psychiatrists found, as early as 2007 and as late as 2014, that the Appellant suffered from psychological conditions, including PTSD symptoms, which had been triggered by the motor vehicle accident and were preventing him from working.

[Appellant's psychiatrist #1] diagnosed a Major Depressive Episode causally related to the accident.

Although he was not asked to comment on causation when the Appellant was referred to him by [Appellant's doctor #2], [Appellant's psychiatrist #2] testified at the appeal hearing that the Appellant's history of severe traumatic events made him less resilient to problems and stress. When exposed to the trauma of a car crash he was predisposed to have a bad reaction to that event. Further financial concerns and feelings of rejection can exacerbate and add momentum to that condition.

[Appellant's psychiatrist #5] stated, both at the appeal hearing and in his report of October 8, 2014 that the Appellant suffered from "depression, anxiety and some symptoms from PTSD since the motor vehicle accident, which appear to be refractory. These disabilities make him unsuitable for work."

The psychiatrists who assessed the Appellant between 2007 and 2014 took into account his presentation at several points in time, his failure to respond to significant pharmacological treatment or to benefit from attempts at psychotherapeutic intervention. The panel notes that the

Appellant also failed to respond to the rTMS therapy administered by [Appellant's psychiatrist #3].

Having viewed the video tapes, reviewed the medical reports and considered the evidence of the Appellant, his wife, caregivers and of the expert witnesses, we find that the weight of the evidence supports the Appellant's position that he was unable to work due to a psychological condition arising out of or triggered by the motor vehicle accident. We do not find that [independent neuropsychologist #3] was biased and do not doubt the sincerity of his carefully considered evidence. [independent neuropsychologist #3's] reports and testimony were thorough, and he presented the clear opinion that [independent neuropsychologist #2's] report and the activities shown on the video surveillance led him to conclude that there was nothing wrong with the Appellant (related to the accident) that would prevent him from working in late 2011. But the panel does not find either [independent neuropsychologist #2's] opinion or the video surveillance to be as convincing as [independent neuropsychologist #3] did. We have placed greater weight upon the consistent opinions of the various psychiatrists who assessed the Appellant and concluded that he continued (and continues) to suffer from symptoms of PTSD and depression triggered by the motor vehicle accident.

We find as a result, that the Appellant has met the onus of showing on a balance of probabilities that the Internal Review Officer erred in finding that by June 2012, he did not suffer from a psychological condition arising out of the motor vehicle accident which prevented him from working. The Internal Review Officer erred in finding that the Appellant was able to hold his determined employment of truck driver as of June 1, 2012. The Appellant's appeal is allowed and the decision of the Internal Review Officer dated September 27, 2012 shall be set aside.

Dated at Winnipeg this 15th day of April, 2016.

LAURA DIAMOND

JANET FROHLICH

LINDA NEWTON