Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-14-171

PANEL:	**Ms Laura Diamond, Chairperson** **Ms Linda Newton** **Ms Susan Sookram**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Ken Kalturnyk of the Claimant Adviser Office;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Andrew Robertson.**
HEARING DATE:	**May 8 and 9, 2018**
ISSUE(S):	**Entitlement to further Income Replacement Indemnity benefits.**
RELEVANT SECTIONS:	**Section 70(1), Section 83(1), Section 110(1) and Section 110(2) 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

Background:

The Appellant was injured in a motor vehicle accident (MVA) on November 30, 2010. She reported injuries to her hip, head, ribs and pelvic area. At the time of the MVA, the Appellant was employed as a safety program administrator. She was classed by MPIC as a temporary earner (with a determined employment of "Inspectors in Public and Environmental Health and

Occupational Health and Safety"). She received Income Replacement Indemnity (IRI) benefits. Her job was later terminated because of her MVA related injuries.

The Appellant received medical and physiotherapy treatment. She was referred for psychological treatment, as well as to [Appellant's physiatrist] and to a neurologist. MPIC then funded treatment by a clinical psychologist and clinical therapist to address psychological symptoms including depression and driving phobia.

The Appellant also suffered from lower leg swelling and dysfunction, for which she underwent arthroscopic surgery. MPIC took the position that these knee symptoms were not directly related to the MVA.

The Appellant also attended at the [clinic] and was diagnosed with chronic pain and an inability to work due to the MVA.

MPIC's Health Care Services medical consultant then concluded that the Appellant had recovered from the medical conditions arising from the MVA to the extent she was able to return to her pre-accident occupational duties. This opinion was provided on May 30, 2012 and was followed by a neurological assessment, an independent psychological assessment and a third party neuropsychological assessment. An independent psychiatric examination was also completed as well as a speech pathology assessment for difficulties the Appellant was having with disfluency (stuttering).

MPIC's Health Care Services psychological consultant then concluded that of her psychological diagnoses, only the Appellant's driving phobia was related to the MVA. The consultant noted a diagnosis of undifferentiated somatoform disorder, which appeared to be pre-existing the MVA. The Appellant was provided with further treatment for her driving phobia, which she discontinued.

On August 7, 2013, the Appellant's case manager issued a decision indicating that her entitlement to IRI benefits would end as of August 9, 2013 in accordance with Section 110(1)(a) of the MPIC Act, with an additional 180 days (ending February 5, 2014) of IRI (as her job was lost because of her MVA injuries). The Appellant filed an Application for Review from that decision and on March 31, 2014 an Internal Review Officer (IRO) returned her claim to the case manager to issue a new decision, reinstating her IRI benefits retroactive to February 5, 2014.

On June 19, 2014 her case manager issued a subsequent decision which, in part, stated that her entitlement to IRI would end as of August 9, 2013 but would be extended an additional one year (ending August 8, 2014) pursuant to Section 110(2)(d), due to her loss of employment.

The Appellant sought an Internal Review of this decision.

An IRO for MPIC reviewed the medical evidence as well as the Appellant's determination into employment under the category of Inspectors in Public and Environmental Health and Occupational Health and Safety. Relying upon MPIC's medical and psychological Health Care Services consultants' analysis, the IRO found that the medical evidence on file did not show that the Appellant had a physical and/or psychological impairment of function that would prevent her

from performing the essential duties of her determined employment. The case manager's decision was upheld. It is from this decision of the IRO that the Appellant has appealed.

Issue:

The issue for determination before the Commission is whether the Appellant suffers from a physical or psychological impairment of function caused by the MVA that would prevent her from performing the essential duties of her employment, thereby entitling her to further IRI benefits. The panel finds that the Appellant has shown, on a balance of probabilities, that she does suffer from a psychological impairment resulting from the MVA, which prevents her from working.

Preliminary Matters:

Prior to the appeal hearing, during the Commission's case management process, discussions between the parties revealed that there was an issue with the calculation of the IRI benefits which the Appellant had been receiving from MPIC. When the appeal hearing convened, the parties advised the Commission that the calculations had been in error, and were being updated by MPIC's case manager. The case manager was preparing a letter to the Appellant summarizing the amount owing, with interest. This would be reviewed by counsel for MPIC and issued to the Appellant, along with a cheque for the monies owing.

Accordingly, the parties were in agreement that this issue had been substantially resolved between the parties, and that, should the Commission find any monies owing to the Appellant following the appeal hearing, any monies owed would also be calculated on that basis.

The panel proceeded to hear evidence and submissions in regard to the Appellant's appeal.

Evidence and Submission for the Appellant:

Documentary Evidence:

[Appellant's family doctor #1]

The Appellant relied upon clinical chart notes and narrative reports from her family doctor, [text deleted] (between 2008 and 2011). These included notations of symptoms of anxiety and depression in her pre-MVA history, with one prescription for Effexor in July of 2008.

After the MVA, [Appellant's family doctor #1] provided a report dated December 2, 2011. He reviewed the Appellant's descriptions of her pain and stress. He felt that she was showing signs of depression and offered her a referral to a psychologist or anti-depressant. She did not wish to take any medication but was referred to [Appellant's physiatrist] for her persistent back, right leg and hip pain.

On November 8, 2011 she complained that she had developed symptoms of left face droop, increased saliva, vision problems. She once again informed him that she was under a lot of stress. He noted some drooping and saliva and referred her to [text deleted], a neurologist. He noted:

> Based on this repeat and frequent presentation of severe pain, a lot of stress, anxiety, in addition to some persistent symptoms of pain, and she is getting new symptoms, the picture is quite mixed with her stress and her pain issue with her motor vehicle accident, which she insists she used to be fine before that.
>
> From my point of view, looking at her as a whole, she is severely stressed, she is having all kinds of symptoms and it is questionable whether they are related to her motor vehicle accident or her stress and that question needs to be answered. I am getting a second opinion based on that. Until the picture is clear, her work status is not clear.

[Appellant's family doctor #1] reported again on April 11, 2012 noting the Appellant's issue was related to myalgia, arthralgia, generalized depression, anxiety and stress. He indicated that he had referred her to a psychologist, neurologist and to [Appellant's physiatrist] for chronic pain.

[Appellant's psychologist] and [Appellant's psychotherapist]

The Appellant also provided several reports from a psychologist, [Appellant's psychologist] and his associate, psychotherapist [Appellant's psychotherapist].

a) January 15th, 2012

This report provided diagnostic impressions and treatment recommendations regarding the Appellant's post MVA psychological functioning, after pre-assessment sessions.

> … The following are my initial diagnostic impressions:
>
> Axis I: Major Depressive Disorder
> Rule out Pain Disorder Associated with Both Psychological Factors and General Medical Condition
> Rule out Fibromyalgia
> Rule out Abuse of Narcotics
>
> Axis II: Deferred
>
> Axis III: MVA related injuries
>
> Axis IV: Post motor-vehicle accident stress
> Financial stress
> Relationship stress
> …

Expanding upon the symptoms and diagnoses, [Appellant's psychologist] indicated that the Appellant denied the existence of any chronic pain or marked psychological problems prior to the accident.

> … She claims she was a strong, well-functioning, and hard working person before the accident. She claims she has always worked, including running her own renovation company. She stated she has never been diagnosed with a mental disorder or been on psychiatric medications prior to the accident. I don't have any objective reasons to

> mistrust her assertions, but nor did I know [the Appellant] before the accident or do I have any reports on pre-accident functioning to objectively confirm her verbal reports. I wonder whether [the Appellant's] physician, [Appellant's family doctor #1], would be in a better position to answer the question of [the Appellant's] pre-accident functioning. ...

In regard to the relationship between the MVA and current symptoms, [Appellant's psychologist's] report states:

> … It appears that [the Appellant's] functioning deteriorated significantly after her November 2010 accident. However, the relationship between the accident and current symptoms is complex because it is mediated by significant stressors that followed, including a loss of job, a loss of primary relationship, significant financial stress, and increase in the use of narcotics. Hence, at this point I do not have enough information to make a definite statement about the causal relationship between the accident and [the Appellant's] current level of functioning. I believe the nature of this relationship will be determined with more certainty after [the Appellant] undergoes a neurological assessment and stops using opioids.

b) March 15, 2012

[Appellant's psychologist's] second report confirmed that the Appellant met the diagnostic criteria for severe major depressive disorder and was also suffering from chronic pain.

> … Her current symptoms include extreme anxiety, extreme sadness, extreme agitation, inability to concentrate, restlessness, chronic sleep deprivation, social phobia, low mood, low self esteem, and chronic pelvic pain. She also reports experiencing a significant deterioration in her concentration and short-term memory following the accident. [the Appellant] is currently experiencing high levels of stress related to her financial situation, relationship problems, lack of employment, and post-MVA stress and pain. …

The report also confirmed the Appellant was unable to return to her employment.

c) May 17, 2012

Following eight sessions of psychotherapy, this report confirmed that the Appellant still met the diagnostic criteria for severe major depressive disorder. She continued to struggle with chronic pain and driving phobia.

The report again addressed pre-accident stressors on the Appellant:

> ... [The Appellant] had undergone significant stress in the years prior to the accident. The major stressors have included surgeries, radiation, and chemotherapy treatments for

> breast cancer in 2007-2008; having the exclusive care for her sick mother while attending [College] and getting her degree in Safety and Occupational Health and Safety from 2007-2010; the death of her mother in 2010; adjustment to a new job at [text deleted] in June 2010. She stated that despite these stressors her level of functioning prior to the accident was significantly higher than following the accident.

The report also confirmed that due to her physical injuries, chronic pain, severe depression and effects of narcotic use the Appellant was not in the position to work full time, although querying whether she might be able to return to work on a gradual basis within the next two months.

d) October 18, 2012

While the Appellant still met the diagnostic criteria for severe major depressive disorder, this report also set out a diagnosis of Post Traumatic Stress Disorder (PTSD). The report noted some improvement during the course of the Appellant's last eight treatment sessions, in her receptiveness to relaxing techniques and exposure based trauma treatment to deal with her anxiety and acute sense of worthlessness. It was recommended that MPIC approve another 10 sessions of weekly cognitive behavioral treatment in order to support her and lessen her PTSD and depression related symptoms.

e) January 29, 2013

This report noted that the Appellant was still rigidly pre-occupied with her physical symptoms and was finding it very difficult to function. Her depression was more severe and her functioning level was lower.

f) September 3, 2013

[Appellant's psychologist's] office wrote to recommend further treatment in connection with the Appellant's driving phobia.

g) January 28, 2014

This report indicated that the Appellant was no longer interested in pursuing therapy at this point and a brief discharge report was provided. Although the Appellant completed eight out of fifteen driving phobia therapy sessions, she had begun to miss sessions. She was noted to be struggling with the idea of her income ending and being faced with the prospect of returning to work.

[Appellant's physiatrist]:

[Appellant's physiatrist] provided several reports. He theorized that the Appellant was suffering from chronic muscle pain, probably associated with anxiety and depression. Further reports noted anxiety, facial tics and dysarthria and enquired whether the Appellant must be suffering from PTSD. He recommended urgent psychiatric evaluation. In August 2012 he reported on her medication. He found that morphine was more effective then percocet or codeine; and a switch to hydromorphone helped considerably.

In a report dated May 13th, 2013 he stated:

> … In 3 or 4 years that I have known this lady sadly I have not been able to control her pain, but of course she has a post-traumatic stress disorder and depression…

[Independent psychologist]

The Appellant also relied on a report dated July 10, 2012 from [independent psychologist], who conducted a psychological assessment of the Appellant. [Independent psychologist] provided a diagnosis of PTSD. He noted distressing thoughts and dreams about the MVA, psychological distress when exposed to reminders of the event with avoidance symptoms, numbing of general responsiveness and symptoms of increased arousal. He also found the Appellant met diagnostic criteria for major depression with symptoms including depressed mood, diminished interests in previously enjoyed activities, insomnia, excessive guilt, fatigue and diminished abilities to

concentrate. He noted her difficulties with pain and wondered if effective treatment of PTSD and depression might improve her pain symptoms, concluding:

> All aspects of this diagnosis are directly related to the MVA of November 2010 and stem from both the trauma of the MVA itself as well as her psychological reaction to the pain she experienced from her injuries and the losses she has suffered as a result (inability to be involved in previous physical activities, relationship, work status, etc.).

He also noted that the Appellant's stutter could be PTSD related or neurological in origin and might respond to psychological intervention, recommending a neuropsychological assessment in that regard.

[Appellant's family doctor #2]

The Appellant also provided a report from her more recent family physician, [Appellant's family doctor #2]. The report dated October 15, 2013 indicated that he had made a referral to psychiatry because he felt there was a psychiatric component to her pain. [Appellant's family doctor #2's] clinical charts notes were also provided on the Appellant's indexed file.

[Appellant's anesthesiologist]

A report from [Appellant's anesthesiologist], of the [clinic] described a [text deleted] year old lady with a history of a MVA in 2010 and chronic unremitting pain. He indicated to the Appellant that there may be more then one cause of her neck and back pain, but that the neck pain appears to be myofascial in nature.

On September 23, 2014, [Appellant's anesthesiologist] provided a report that stated:

> … This patient has had chronic pain for many years. My initial letter is included for your records. At presentation to the [clinic] she has had ongoing unremitting myofascial pain after a major motor vehicle accident. She also has neuropathic pain and associated numbness and tingling. She has a facial droop from her head injury.

> I am unable to identify why you might have discontinued providing her financial support following her motor vehicle accident. Her pain and inability to work is directly related to her motor vehicle accident. …

[Appellant's psychologist #2]

[Appellant's psychologist #2] reported to the [clinic] on October 22, 2014. He indicated that the Appellant reported no formal history of mental disorder prior to her MVA but that she was currently experiencing symptoms of moderate severe depression. He noted she was willing and able to attend psychological treatment at the [clinic] and recommended that, given her moderate to severe level of major depressive symptoms, she might benefit from an increase in her dosage of antidepressants.

Evidence of the Appellant:

The Appellant testified at the appeal hearing, describing the MVA and her injuries.

She testified regarding her work history. This included continuing her education at [College] to obtain three different diplomas, her work as a health and safety officer and additional involvement in her own business partnerships.

The Appellant testified regarding her past medical history, which included diagnosis for breast cancer, and some short-term treatment for situational depression that she described as relating to her chemotherapy and radiation treatment, business stresses and her mother's death.

However, the Appellant maintained that in spite of these temporary challenges, she not only continued to work but missed very little class time. She was still very successful in her studies, finishing at the top of her class.

The Appellant also described extra-curricular activities which she was engaged in prior to the MVA. She explained that she took pride in maintaining her house, gardens and perennials, and that she was involved with her own pets as well as volunteer work with animals. She also enjoyed snowmobiling, biking and going to the dog park, as well as dinner parties and socializing with friends.

The Appellant explained that this changed for her following the MVA. She described her now limited life activities and changed or reduced social status. She discussed her driving phobia and difficulties with completing the treatment for it. She also set out the medications she currently uses, the psychological treatment she received and the pain counselling she has received at the [clinic].

The Appellant described the aftermath of the MVA in greater detail explaining her understanding of the pain she suffered after the MVA, and how it had disrupted her life.

On cross-examination, the Appellant explained that when she first began having neurological type problems (facial drooping, confusion, memory, speech problems, drooling), she tried to deny that anything was happening and carry on, in spite of feedback she was getting from friends and coworkers regarding the symptoms. Still she tried to deny anything was wrong and keep things the way they were as long as she could. However, her condition progressed, along with pain and headaches.

The Appellant was also asked whether she had previous psychological issues and explained that prior to the MVA, she had very few such issues, beyond situational difficulties surrounding life

transitions like her mother dying, cancer and business difficulties. She characterized these as isolated incidents. Even when she was prescribed medication for a short period (which occurred only once) she never needed to take the medication long enough for it to take effect.

When asked about stress at work and conflict with her coworkers (surrounding her MVA injuries) as well as a break-up with her long-term partner, the Appellant indicated that she had always been able to cope with transitions, but that, after the MVA, because of her symptoms, she did have trouble with her social network. She lost social status, and was no longer included by her friends. She was not interested in socializing with the group of people that she might fit in with after the MVA, and so did suffer some issues of social isolation.

Evidence of the Psychotherapist:

The Appellant relied upon several reports provided by psychologist, [Appellant's psychologist], and psychotherapist, [Appellant's psychotherapist], who worked with him. These reports were dated January 15, 2012, March 15, 2012, May 17, 2012, October 18, 2012, January 29, 2013, September 3, 2013, and January 28, 2014.

The psychotherapist, [Appellant's psychotherapist], also testified at the hearing and was qualified, by agreement of the parties, as an expert in psychotherapy. [Appellant's psychotherapist] explained that she had conducted 37 therapy sessions with the Appellant. Her initial diagnosis was of a major depressive disorder (with subsequent pain disorder still to be ruled out while the Appellant was undergoing further testing). Although it was not possible to determine absolutely, it seemed reasonable to both her and her supervising psychologist, [Appellant's psychologist], that these conditions, as well as the driving phobia, were triggered by the MVA. Although pre-MVA stressors were referred to in the report of May 17, 2012, they did

not consider that these stressors amounted to a pre-existing psychological disorder. They know from her medical records that she had never been diagnosed with any psychological condition and that her functioning had never suffered, even when her mother died or when she had cancer. She still went to school and continued working through these events. She was very successful at both.

[Appellant's psychotherapist] described the treatment and counselling of the Appellant for her major depressive disorder. Then, later (in August or early September 2012) the Appellant was involved in a very minor second MVA. This seemed to trigger more classical post-traumatic stress disorder symptoms, although it was arguable that the Appellant had experienced some of these before. She exhibited marked severe hyper-arousal, high emotionality, and greater avoidance of driving. Flash-backs to the initial MVA and anger towards the person who hit her, along with overall agitation, were experienced by the Appellant. This led to a diagnosis of post-traumatic stress disorder (PTSD) being included as a diagnosis at that time.

At the same time, social stressors resulting from her injuries and condition (including loss of the inability to stay on top of things at work and effects on her capacity to function in the workplace, the fallout from the end of a long-term relationship, the effects of chronic pain on her libido and financial fallout from these factors) caused the Appellant's condition to deteriorate over the next eight therapy sessions. Some improvement was achieved with a change in her pain medication, but her driving phobia continued to deteriorate. Then, as they worked with her to prepare for the end of her IRI benefits, trying to improve her job readiness by working with her on her driving phobia, the Appellant's emotional condition declined to the point of incoherency. [Appellant's psychotherapist] considered this a great setback, probably due to the therapists pushing her too hard towards improvement in a short period of time.

[Appellant's psychotherapist] did not agree with some diagnoses from other professionals which included a diagnosis of a somatoform disorder or conversion disorder. She indicated that she, along with [Appellant's psychologist], were very cautious about applying these kinds of labels to attribute pain to such factors. They tended to be cautious not to dismiss pain just because there may not be medically determined causes for it at points in time.

[Appellant's psychotherapist] indicated that the prognosis for the Appellant's PTSD was complicated, and that the longer one suffers without noticeable improvement, the poorer the prognosis becomes. In her view, the last time she saw the Appellant (in November 2014) she was not fit to return to work as a health inspector or in any capacity.

On cross-examination, [Appellant's psychotherapist] was asked about reports which had been provided by [independent neuropsychologist] and [independent psychiatrist]. Both had diagnosed a somatoform disorder after reviewing the Appellant's history with her and, in the case of [independent neuropsychologist], applying psychological testing. There were concerns about pre-existing factors. [Appellant's psychotherapist] maintained that she and [Appellant's psychologist] did not agree with those comments. Rather, the more information they received the more they were convinced that the Appellant's function post-MVA was completely different from her levels of function before the MVA. She functioned through the death of her mother and the loss of her partner, in a quite resilient way, but later leaned more towards depression, anxiety and post-traumatic stress disorder which in [Appellant's psychotherapist's] view were triggered by the MVA.

When asked about reports suggesting that the Appellant was somatically preoccupied ([independent neuropsychologist]) or had an unusual degree of concern about physical and health matters ([independent psychologist]), [Appellant's psychotherapist] indicated that while the Appellant did appear preoccupied with pain symptoms, she did not find this to be unusual. Working with people who suffered from chronic pain, she had found that the nature of pain, particularly bothersome chronic pain, did result in a preoccupation with losses in one's life which can exacerbate this. When one's world becomes small, it is easy for one's pain to become big.

Submission for the Appellant:

Counsel for the Appellant took the position that the IRD erred in finding that the medical evidence on file did not support that the Appellant had a physical and/or psychological impairment function that would prevent her from performing the essential duties of her determined employment. The IRD also erred in accepting the opinion of the MPIC psychological consultant that the diagnosis of undifferentiated somatoform disorder was a pre-existing condition.

Rather, is was submitted on behalf of the Appellant that she was not fit to return to any type of employment as of August 7, 2013, due to severe psychological problems, including major depressive disorder, anxiety, a pain disorder, PTSD and a driving phobia, all resulting from the MVA.

Beginning with [Appellant's family doctor's] note dated December 2, 2011 that the Appellant was showing signs of depression, counsel for MPIC reviewed the medical reports on file up to

May 2015. These showed that the Appellant was suffering from depression and a pain disorder as well as a driving phobia and probable PTSD.

He reviewed the psychological assessment and reports by [Appellant's psychologist] and [Appellant's psychotherapist] which diagnosed severe major depressive disorder, triggered by the MVA. Their reports recognized her pre-accident stressors and reports of some resulting symptomology in the form of short term anxiety and depression. However, they attributed her current major depression to the MVA and, following [independent psychologist's] report and reports by the Appellant of symptoms of trauma, they added a diagnosis of PTSD.

[Appellant's physiatrist's] reports, as far back as January 2012, identified chronic pain, probably associated with anxiety and depression.

None found the Appellant fit to return to her previous job.

In reviewing [independent psychologist's] report dated July 10, 2012, counsel noted the diagnosis of PTSD, major depressive disorder and a pain disorder associated with both psychological and general medical conditions. He stated that all aspects of this diagnosis were directly related to the MVA of November 2010 and stemmed from both the trauma of the MVA itself and the psychological reaction to the pain and losses she suffered as a result.

Counsel addressed both [independent neuropsychologist's] and [independent psychiatrist's] reports (as relied upon by MPIC). He queried how [independent neuropsychologist] could conclude that the Appellant exhibited an intact neurocognitive profile upon testing when she had also stated the neurocognitive tests were invalid. Further ambiguities or inconsistencies in

[independent neuropsychologist's] report included her observation that the Appellant over-reported her pain symptoms while at the same time opining that she made attempts to present herself in an unusually positive manner. He submitted that although [independent neuropsychologist] noted a pre-disposition to mood and anxiety disorders, her report did not state that the Appellant's condition was pre-existing.

Counsel examined [independent psychiatrist's] analysis of causation factors:

> In my opinion, the Specific Phobia is a direct results of the motor vehicle accident and would be considered a precipitating factor. However, the undifferentiated somatoform disorder, conversion disorder and major depression appear to be a result of extraneous social factors, which may have partially originated with the motor vehicle accident. For example, the highway phobia probably contributed to [the Appellant's] loss job. The loss of a job, in turn, may have precipitated depression, anxiety, and irritability – followed by the loss of [the Appellant's] boyfriend. I would consider the loss of job, loss of boyfriend, social isolation, financial stress and subsequent emotional difficulties to be perpetuating factors.

He submitted that [independent psychiatrist] did not refer to any factors unrelated to the MVA and that his analysis effectively recognized the MVA as a significant contributor to the Appellant's symptoms. Nowhere did [independent psychiatrist] suggest that any of these problems pre-existed the MVA.

Counsel did not take the position that the Appellant's life following the MVA was free from stressors other then the pain she was suffering. Major stressors that had been identified were the loss of her job, the breakdown of her relationship, the isolation she was forced to endure, as well as financial hardship caused by the ending of her IRI benefits. The loss of her job was due to her driving phobia, which was a direct consequence of the MVA. Her stutter and inability to complete sentences, both consequences of the MVA, led to the loss of her job. Her chronic pain condition resulted in the breakdown of her relationship and the loss of her social circle of friends.

Counsel emphasized that prior to the MVA the Appellant had indeed encountered situational stresses which led to some symptoms of anxiety and depression. However, none of these lasted very long. This was confirmed by her family doctor's chart notes which showed no notations for subsequent renewals of prescription. None of these situational episodes resulted in a referral to a psychologist for actual clinical diagnosis or treatment and there were no prescriptions for most of these incidents, other then to talk to a friend. The Appellant then went on, during and following these episodes, to enrol in [College] and pass with honors, despite the death of her mother near the end of the term. These isolated incidents demonstrate that prior to the MVA the Appellant was quite resilient and able to recover quickly from the effects of fairly significant stressors. In contrast, after the MVA, she lost that resiliency and could not cope with the many stressors that resulted as a direct or indirect consequence of the MVA.

Counsel submitted that there is overwhelming evidence that the Appellant developed severe and complex psychological conditions as a result of the MVA. Numerous medical opinions considered this psychological condition to be a consequence, direct and indirect, of the MVA. The evidence demonstrates the Appellant was not psychologically fit to return to her pre-accident job, or any kind of work, on August 9, 2013, or at any time since. This condition was a result of the MVA. Therefore, counsel requested that the Commission overturn the IRD of October 30, 2014 and reinstate the Appellant's IRI benefits retroactive to August 9, 2013 on an ongoing basis.

Evidence for MPIC:

MPIC relied upon a number of medical reports.

Upon reviewing [Appellant's psychologist's] reports, including his report of March 15, 2012, MPIC's Health Care Services psychological consultant recommended an independent psychological examination of the Appellant, to clarify her psychological diagnosis in relation to the MVA in question.

[Independent psychologist]

As a result, the Appellant saw [text deleted], a psychologist. He was asked to provide an opinion regarding diagnosis, the relationship between any underlying psychological condition in the MVA in question, as well as a recommended treatment plan and prognosis. [Independent psychologist] noted that the Appellant had no notable history of mental health concerns prior to the MVA in question but had experienced a number of life events that predisposed her to the development and recurrence of mood and anxiety disorders. His diagnosis stated:

> It seems evident from [the Appellant's] history and clinical presentation that she is currently experiencing symptoms consistent with the DSM-IV diagnostic criteria of Post-Traumatic Stress Disorder (PTSD): She has distressing thoughts and dreams about the MVA, she experiences psychological distress when exposed to reminders of the event (driving on the highway), she has several avoidance symptoms and numbing of general responsiveness, and she also has several symptoms of increased arousal. [the Appellant] also meets diagnostic criteria for Major Depression. Her current depressive symptoms include: depressed mood, diminishes interest in previously enjoyed activities, insomnia, excessive guilt, fatigue, and diminished ability to concentrate. As well, [the Appellant's] physicians have suggested that her pain symptoms may be related to psychological factors and chronic pain is association with both of the diagnosed disorders. Effective treatment of PTSD and Depression may improve her pain symptoms.
>
> All aspects of this diagnosis are directly related to the MVA of November 2010 and stem from both the trauma of the MVA itself as well as her psychological reaction to the pain she experienced from her injuries and the losses she has suffered as a result (inability to be involved in previous physical activities, relationship, work status, etc.).

[Independent neuropsychologist]

The Appellant was then referred to [independent neuropsychologist] for an independent neuropsychological exam. [Independent neuropsychologist] provided a report dated August 30, 2012. She noted that according to the records obtained from the Appellant's family physician, her premorbid history was significant for recurrent symptoms of anxiety and depression between 2008 and 2010. These symptoms appear to have been related to a number of psychosocial stressors including adjustment difficulties related to her breast cancer diagnosis, dissolution of her romantic relationship, loss of a business and death of her mother. On neuropsychological testing, [independent neuropsychologist] found no evidence of cognitive deficits. She found that the Appellant was clearly exhibiting "prominent psychological symptoms", the extent of which she did not believe had been "captured by the psychological investigation which have been performed to date."

> … My diagnostic impression of [the Appellant] is that she would definitely meet diagnostic criteria for Undifferentiated Somatoform Disorder, and that careful review of her entire medical history might reveal a pattern more consistent with a Somatization Disorder.

[Independent neuropsychologist] indicated that a thorough investigation of this issue was beyond the scope of her evaluation and recommended that consideration be given to referring the Appellant for an independent psychiatric examination.

[Independent psychiatrist]

This was followed by an independent psychiatric examination conducted by [independent psychiatrist]. [Independent psychiatrist's] report of February 25, 2013 provided a diagnosis of undifferentiated somatoform disorder and a conversion disorder, driving phobia and major depression. In regard to causation, he stated:

> In my opinion, the Specific Phobia is a direct result of the motor vehicle accident and would be considered a precipitating factor. However, the undifferentiated somatoform disorder, conversion disorder and major depression appear to be a result of extraneous social factors, which may have partially originated with the motor vehicle accident. …

In regard to prognosis for recovery, [independent psychiatrist] stated:

> [The Appellant's] psychiatric symptoms (i.e. somatoform and conversion) are usually associated with a poor short-term prognosis. Also, being off work greater than two years is a poor long-term prognostic indicator. The fact that 30 sessions of psychotherapy had little impact is yet another poor prognostic indicator (conversion symptoms such as stuttering demonstrate the disconnection between underlying emotions and cortical thought processes). On a positive ledger, [the Appellant] does not demonstrate any evidence of chronic psychiatric pathology such as schizophrenia, bipolar disorder or dementia. [The Appellant's] clinicians and therapists may consider acting a little more prescriptive in order to assist this woman towards recovery. …
>
> I do not believe that [the Appellant] can perform a 40-hour workweek as a safety program administrator. The perception of pain, anxiety, dysphoria and poor concentration all contribute to the patient's current disability. …

[Appellant's neurologist]

[Appellant's neurologist] provided three reports. He provided a diagnosis of cranial neuropathy of undetermined etiology. Further he indicated:

> Though the referring doctor had mentioned symptoms as described by the patient in the context of a motor vehicle accident, the patient herself did not mention the accident had nor did she relate her symptoms to the accident. However, from her statement that the symptoms had been present for over a year, and since the accident had occurred just over one year previously, I would presume that she felt there was a relationship. However, since I had not been aware of her physical status immediately following the accident, it is not possible for me to give a worthwhile opinion on any relationship. However, it would not be considered a probable left and apparently progressive cranial neuropathy, would occur following an accident or in relationship accident. [sic]

[MPIC's psychologist]

[Appellant's psychologist's] and [Appellant's psychotherapist's] reports, as well as reports from [independent psychologist], [independent neuropsychologist] and [independent psychiatrist] were reviewed by MPI's Health Care Services psychological consultant, [text deleted]. From [independent neuropsychologist's] comments, he concluded it was probable that the Appellant's

undifferentiated somatoform disorder would be considered pre-existing in nature and that the Appellant had no cognitive issues which would preclude her from returning to her pre-accident employment. While [independent psychiatrist] had noted depressive and anxiety symptoms, [MPIC's psychologist] concluded that [independent psychiatrist's] diagnosis was consistent with that of [independent neuropsychologist] in that he identified the claimant's undifferentiated somatoform disorder (which was only possibly related to the MVA in question) along with a conversion disorder and mild depression.

In considering [independent psychologist's] opinion that the Appellant's stuttering behavior may be a symptom of PTSD or neurological in origin, the consultant also considered a speech language pathology assessment report completed by [text deleted] dated February 21, 2013 which indicated that the Appellant's presentation (if a true speech deficit), was representative of stuttering (disfluency). It was difficult to identify the actual onset of the speech difficulties.

[Appellant's speech language pathologist's] speech therapy assessment, reviewed by the Health Care Services consultant, indicated that the Appellant's speech issues were not recognized until approximately January 2012 and thus were likely psychogenic in nature and could not be connected to the MVA. There was no evidence that the Appellant suffered a head injury in the MVA.

As a result, the consultant opined that the Appellant may benefit from further treatment involving her driving phobia as recommended by [independent psychiatrist], but that aside from the driving phobia, her psychological diagnosis resulted from disorders which were pre-existing in nature.

The consultant provided another opinion on October 27, 2015, in order to review more recent documentation, including further reports from [Appellant's psychologist] and [Appellant's psychologist #2]. The following was noted by the consultant:

> … [Appellant's psychologist] indicates that the claimant was working on return to work issues, her driving behavior, and was "doing well" at the time of her final session on November 14th, 2013.
> …
> It is interesting to note that the claimant stopped attending psychotherapy at [Appellant's psychologist's] clinic, yet has indicated (as per above) that she is unable to work due to psychological issues which she attributes to MVA…

In regard to [Appellant's psychologist #2's] conclusion that the Appellant was experiencing difficulties in coping with her pain condition in the areas of employment, household, family, social and recreational activities and that she had reported no formal history of mental disorder prior to her MVA, the consultant wrote:

> As indicated in the writer's previous review of June 18th, 2013 it was [independent psychiatrist's] and [independent neuropsychologist's] opinion that the claimant had an undifferentiated somatoform disorder on a pre-existing basis.
> …
> As indicated above, [Appellant's psychologist] documented that when he last saw the claimant in November 2013, she appeared to be "doing well" and seemed most concerned about her benefits ending. Therefore, the claimant's current depression is probably not MVA-related.

Health Care Services

Medical Consultant

The Health Care Services medical consultant also reviewed reports from [Appellant's family doctor #2] and [Appellant's orthopedic surgeon], and concluded, in a report dated April 16, 2014, that the medical evidence did not support the position that the Appellant developed a medical condition secondary to the MVA that would result in lower leg swelling or dysfunction.

A review of the reports from [Appellant's neurologist] showed a normal neurological exam and any diagnosis of cranial neuropathy and degenerative nerves was clearly not related to the MVA. The medical consultant concluded that it was not possible to establish a cause and effect relationship between the neurological symptoms and the MVA.

Submission for MPIC:

Counsel for MPIC submitted that the evidence established that MVA related injuries did not prevent the Appellant from performing the duties of her employment. He sorted the Appellant's symptoms into four broad groups of psychological, pain, neurological and psychiatric symptoms.

Counsel began with [independent neuropsychologist's] review of the Appellant's history. It noted a pre-MVA history of recurrent symptoms of depression and anxiety between 2008 and 2010 related to various psychosocial stressors. Counsel further cited the social isolation the Appellant had admitted to upon cross-examination, which he submitted was a result of differences she had with her friends involving habits of using drugs, drinking and gambling. [Independent neuropsychologist] had carefully reviewed the entire medical history of the Appellant and diagnosed an undifferentiated somatoform disorder, which she did not attribute directly to the MVA.

[Independent psychiatrist's] report was also reviewed. It was submitted that his similar diagnosis of an undifferentiated somatoform disorder stemmed from extraneous factors which may (but only may) have partially originated with the MVA.

Counsel agreed that the Appellant's highway driving phobia was a result of the MVA. But, it was submitted, it stretches the bounds of causation to say that things like the loss of a boyfriend were related to the MVA. Other factors such as job loss, social factors of self-esteem, and financial stress might be closer to the MVA, but were still too indirect to say that these developed because of it.

He submitted that the Appellant had failed to mention her history of anxiety and depression consistently to a number of caregivers, tending, as [independent neuropsychologist] recognized, to downplay this history.

Although in their testimony the Appellant and [Appellant's psychotherapist] referred to these symptoms of anxiety and depression as normal reactions to stressful situations between 2008 and 2010, counsel submitted that the Appellant had been prescribed medication for these. One cannot minimize the similarity between the pre and post MVA difficulties she suffered.

In regard to her pain symptoms, the Health Care Services medical consultant had confirmed that the Appellant had recovered from any medical conditions connected to the MVA. Therefore, somatoform and conversion issues related to reported ongoing pain must be related to her pre-existing condition, as was recognized, he submitted, by [independent neuropsychologist] and [independent psychiatrist].

Further, counsel noted that although the Appellant testified that people had noticed her neurological deficits quite soon after the MVA, they do not appear in the reports of caregivers from that time. This suggests a history of the Appellant misstating her condition when reporting information to her caregivers. A similar trend is evident in her reporting regarding her knee,

telling [Appellant's orthopedic surgeon] that she had a history of ongoing knee pain starting in approximately November 2010, following the MVA, when a file review of the documents suggests that there were no complaints of knee pain around that time. The first complaints of such pain to the case manager were in 2013.

In summary, counsel submitted that the Appellant was not a reliable historian of her own condition. Less weight should be placed upon her own narrative history of her condition, including that given to her own care providers. For these reasons, given the consultant's conclusion that the Appellant suffered from a somatoform disorder which was pre-existing in nature (based on his review of [independent neuropsychologist's] and [independent psychiatrist's] reports) and given that the stressors that would have caused the Appellant to develop depression and anxiety symptoms are at best indirectly related to the MVA, the Appellant has not met her burden to show on a balance of probabilities that the IRD was incorrect. Further, given that, on a balance of probabilities, the neurological symptoms and psychogenic speech impediment responsible for her inability to work are both unrelated to the MVA, the Commission should conclude that the Appellant did not suffer from a MVA related condition preventing her from working.

Discussion:

The relevant provisions of the MPIC Act are as follows:

> **Definitions**
> 70(1) In this Part,
>
> **"bodily injury caused by an automobile"** means any physical or mental injury, including permanent physical or mental impairment and death; (« dommage corporel »)
>
> **"temporary earner"** means a victim who, at the time of the accident, holds a regular employment on a temporary basis, but does not include a minor or a student; (« soutien de famille temporaire »)

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

83(1) A temporary earner or part-time earner is entitled to an income replacement indemnity for any time, during the first 180 days after an accident, that the following occurs as a result of the accident:

(a) he or she is unable to continue the employment or to hold an employment that he or she would have held during that period if the accident had not occurred;

(b) he or she is deprived of a benefit under the *Employment Insurance Act* (Canada) to which he or she was entitled at the time of 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:

(a) the victim is able to hold the employment that he or she held at the time of the accident;

(b) the victim is able to hold the employment referred to in subsection 82(1) (more remunerative employment);

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

110(2) Notwithstanding clauses (1)(a) to (c), a full-time earner, a part-time earner or a temporary earner who lost his or her employment because of the accident is entitled to continue to receive the income replacement indemnity from the day the victim regains the ability to hold the employment, for the following period of time:

(c) 180 days, if entitlement to an income replacement indemnity lasted for more than one year but not more than two years.

(d) one year, if entitlement to an income replacement indemnity lasted for more than two years.

The onus is on the Appellant to show on a balance of probabilities that she suffered from a physical or psychological injury, caused by the MVA, which prevents her from performing the occupational duties of her employment.

MPIC has accepted that MVA related conditions prevented the Appellant from working and required treatment benefits and ongoing IRI support through to July of 2013. The Corporation then extended a year of IRI benefits to the Appellant until July 2014, to compensate for her loss of job (due to the MVA).

After July 2013, although MPIC recognised that the expert psychologist, neuropsychologist and psychiatrist provided a number of significant DSM diagnoses, including major depressive disorder, PTSD, chronic pain disorder, undifferentiated somatoform disorder and/or conversion disorder, counsel for MPIC submitted that these were caused by factors too remote and indirect from the MVA. Counsel for MPIC took the position that these diagnoses were not causally related to the MVA but stemmed from pre-existing conditions. The sequela following the MVA to which the experts referred, such as a psychosocial stressors, did not result from the MVA. This particularly applied, it was submitted, to the Appellant's job loss, which was not due to the MVA.

The panel notes that this position is not consistent with the case manager's decisions dated August 7, 2013 and June 19, 2014. These acknowledged an extension to the Appellant's IRI benefits because she had lost her employment as a result of the MVA.

The panel has given particular weight and attention to the reports of [Appellant's psychologist] and [Appellant's psychotherapist], as well as the testimony of [Appellant's psychotherapist] at the hearing. We cannot ignore the fact that these experts saw the Appellant regularly in their practice on more then 30 occasions. Their initial diagnosis of major depressive disorder as a result of the MVA was supplemented by a further diagnosis of PTSD, after the Appellant suffered a second minor MVA. This coincided with [independent psychologist's] report of July

2012, when he provided a diagnosis of PTSD and major depression directly related to the MVA, stemming from both the trauma of the MVA itself as well as her psychological reaction to the pain and losses she suffered as a result.

While [independent psychiatrist] disagreed with the diagnosis of PTSD, he recognized a driving phobia as a direct result of the MVA and undifferentiated somatoform disorder, conversion disorder and major depression disorder, characterizing these as perhaps partially originating with the MVA.

The testimony of the Appellant and of [Appellant's psychotherapist] were consistent with that conclusion. The panel finds that the sequela the Appellant experienced as the result of the MVA (including pain, loss of job, relationship, social status, and home, along with financial pressures and loss of self esteem) caused the Appellant to suffer significant psychological symptoms. These included driving phobia, depression, insomnia, reduced libido, fearfulness, panic attacks, anxiety, flash backs, nightmares, hyper arousal, driving avoidance and stuttering.

The panel finds that these presented as a complex constellation of factors which began after the MVA and which we find resulted from the MVA.

The Appellant explained in her testimony that in the first months after the MVA she struggled to maintain her way of life, refusing to admit or give in to the symptoms of pain and distress she was experiencing. She attended physiotherapy and return to work programs and tried to work at her old job. Early reports to her family doctor expressed stress, anxiety, body aches, pain, emotional fatigue and depression.

The Appellant's evidence and the evidence of [Appellant's psychotherapist] identified a dramatic difference in the Appellant before and after the MVA. [Appellant's psychotherapist] explained that this assessment was corroborated for her and [Appellant's psychologist] by [independent psychologist's] report which included an external interview with a former co-worker of the Appellant, who had confirmed the dramatic difference in the Appellant. The Appellant, while encountering challenges and situations in her life prior to the MVA, was noted to have sought minimal intervention (through her family doctor) and carried on in a competent, resilient fashion. Her work history showed that she exhibited a high level of functioning in a work setting prior to the MVA and her testimony reflected an active social life, with volunteering and recreational activities undertaken while she worked, started her own business and furthered her education. Following the MVA, she was unable to cope with the challenges and symptoms that came her way. The overall evidence regarding the symptoms and impairments in function that the Appellant then experienced demonstrated the cascading impact of the MVA.

[Independent neuropsychologist's] note of a pre-morbid history *significant* for recurring symptoms of anxiety and depression between 2008 and 2010 records only symptoms, without a history of clinical diagnosis or clinical psychological treatment. The panel finds that a review of the family doctor's clinical chart notes did not support a conclusion of *significant history*, such that the Appellant was struggling with major impact on her functioning and/or a need for expert help. We do not find that meeting with a cancer-care social worker and a single prescription for Effexor during cancer treatment constitute a significant history of anxiety and depression. Nor do we consider anxiety and poor sleep or a recommendation to speak to a friend when the Appellant's mother died significant for a history of mental illness. The Appellant's testimony, along with her work and study history, indicate that her functioning was not impaired throughout these periods.

Although [MPIC's psychologist] relied upon [independent neuropsychologist's] and [independent psychiatrist's] reports to conclude that the Appellant suffered from a pre-existing psychological condition, counsel for MPIC could not point to any place in the report of [independent psychiatrist] which the consultant might have relied on to find a direct reference to such a condition. Counsel explained that [MPIC's psychologist's] report might cause some confusion on this point. The consultant had meant to say that this was [independent neuropsychologist's] conclusion, and that [independent psychiatrist's] report is supportive and in line with her report. A careful review of [independent neuropsychologist's] report shows reference to a pre-morbid history of anxiety and depressive symptoms related to psychosocial factors which likely predisposed her. But [independent neuropsychologist] does not refer to a specific pre-existing psychological diagnosis in her report.

The panel finds there is little evidence to support [MPIC's psychologist's] conclusion that the Appellant's psychological condition was a result of a pre-existing condition, once the reports upon which [MPIC's psychologist] himself relies are closely examined. We have been unable to give significant weight to [MPIC's psychologist's] conclusion that the Appellant suffered from a pre-existing psychological condition. Further, we accept the diagnosis of PTSD arrived at by [independent psychologist], [Appellant's psychologist] and [Appellant's psychotherapist], and find no evidence to suggest that the Appellant suffered from PTSD prior to the MVA.

Instead, we have relied upon the evidence of the Appellant, [Appellant's psychologist], [Appellant's psychotherapist] and [independent psychologist], and (to a lesser extent) [independent psychiatrist]. None of these health care professionals found that her depressive disorder, pain disorder, PTSD or driving phobia pre-existed the MVA. Instead they opined that

the Appellant's psychological condition resulted, both directly and indirectly, from the MVA. Their evidence leads the panel to conclude that the Appellant suffered from psychological conditions which included major depressive disorder and PTSD, and were not the result of a pre-existing condition.

The psychologists, psychiatrist and psychotherapist who commented upon the Appellant's employability stated that the Appellant was unfit to return to work on a full time basis. Reports from the [clinic] and [Appellant's physiatrist] supported this position. As a result of the foregoing, the panel finds that the Appellant was unable to perform the substantial duties of her employment as a result of psychological injuries resulting from the MVA.

Accordingly, we find that the Appellant is entitled to receive IRI benefits on an ongoing basis from August 2013. These IRI benefits shall be calculated in accordance with the revised calculations arrived at between the parties, and not according to the earlier calculations which defined the Appellant's IRI benefits prior to their termination.

The Commission shall retain jurisdiction in this matter and if the parties are unable to agree on the amount of compensation either party may refer this issue back to the Commission for final determination.

The Appellant's appeal is therefore allowed and the IRD dated October 30, 2014 is hereby rescinded.

Dated at Winnipeg this 22nd day of June, 2018.

LAURA DIAMOND

LINDA NEWTON

SUSAN SOOKRAM