Citation: ***K. L. v. Minister of Employment and Social Development*****, 2015 SSTGDIS 38**

Date: May 5, 2015

File number: GT-119744

GENERAL DIVISION- Income Security Section

Between:

K. L.

Appellant

and

Minister of Employment and Social Development
(formerly Minister of Human Resources and Skills Development)

Respondent

Decision by: Jeffrey Steinberg, Member, General Division - Income Security Section

Heard by Videoconference on March 31, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

K. L., the Appellant
Timothy Cullen, the Appellant's legal representative
J. T., observer

INTRODUCTION

[1] The Appellant previously applied for CPP Disability benefits on November 25, 2008, which application was denied. She did not appeal the denial. Her most recent application for CPP Disability benefits, which forms the basis of this appeal, was date stamped by the Respondent on December 29, 2010. The Respondent denied the application at the initial and reconsideration levels and the Appellant appealed to the Office of the Commissioner of Review Tribunals (OCRT).

[2] The hearing of this appeal was by Video Conference for the following reasons: i) videoconferencing is available in the area where the Appellant lives; ii) there are gaps in the information in the file and/or a need for clarification; and iii) the form of hearing respects the requirement under the Social Security Tribunal Regulations to proceed as informally and quickly as circumstances, fairness and natural justice permit.

THE LAW

[3] Section 257 of the Jobs, Growth and Long-term Prosperity Act of 2012 states that appeals filed with the OCRT before April 1, 2013 and not heard by the OCRT are deemed to have been filed with the General Division of the Social Security Tribunal.

[4] Paragraph 44(1)(b) of the CPP sets out the eligibility requirements for the CPP disability pension. To qualify for the disability pension, an applicant must:

a) be under 65 years of age;

b) not be in receipt of the CPP retirement pension;

c) be disabled; and

d) have made valid contributions to the CPP for not less than the minimum qualifying period (MQP).

[5] The calculation of the MQP is important because a person must establish a severe and prolonged disability on or before the end of the MQP.

[6] Paragraph 42(2)(a) of the CPP defines disability as a physical or mental disability that is severe and prolonged. A person is considered to have a severe disability if he or she is incapable regularly of pursuing any substantially gainful occupation. A disability is prolonged if it is likely to be long continued and of indefinite duration or is likely to result in death.

ISSUE

[7] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2010.

[8] In this case, the Tribunal must decide if it is more likely than not that the Appellant had a severe and prolonged disability on or before December 31, 2010.

EVIDENCE

Documentary Evidence

[9] In her CPP Questionnaire dated March 8, 2011, the Appellant indicated she stopped working on June 25, 2008 after going on medical leave. She had been working since July 5, 1993 as a childcare worker. She described suffering from stress, depression, back and joint pain, headaches, dizziness and lack of sleep. She stated that her legs and knees swell due to arthritis and that her ears ring all the time. Her right eye has a cataract and she feels tired most of the time. She cannot lift, squat, sit or stand for long and uses a cane and at times a walker. In 2009, she suffered a mild stroke. She also has stomach problems off and on. Between 2006 and 2009, she went to the hospital many times for panic attacks. She is prescribed Tylenol, Nexium, Citalopram and Quinine for leg cramps. She received counselling at St. Michael's Hospital, mindfulness meditation, mindful cognitive behavioral therapy (CBT) and saw

Dr. Sokolov, psychiatrist, at the Center for Addiction and Mental Health (CAMH) Mood Disorders Clinic.

[10] In support of her initial CPP Disability application, the Appellant completed a Questionnaire dated November 19, 2008. She described stress and depression, back pain and swollen knees, inability to concentrate and remember, a spinning head and stomach pain. She stated she could not lift the children at her workplace, squat or bend, was unable to focus, and would become disoriented and get panic attacks when frustrated. She described sitting/standing for 30 minutes, walking about 30 minutes to an hour, carrying 10 lbs. for a short distance and difficulty reaching and bending. She was prescribed Pariet, Celexa, Celebrex and Tylenol.

[11] The Appellant was born in 1952 and obtained her Diploma in Early Childhood Education (ECE).

[12] On December 10, 2010, Dr. Barbara Vari, family physician, completed the CPP Medical Report in support of the current CPP Disability application. She stated she knew the Appellant for 2.5 years and diagnosed 1) Depression/Post Traumatic Stress Disorder (PTSD) and 2) osteoarthritis. Dr. Vari stated the Appellant was unable to work for greater than 2 years due to depression which was primarily related to a stressful work environment and harassment of many years, but which may also be related to her past history of war trauma. She also diagnosed back and knee pain secondary to osteoarthritis. According to Dr. Vari, the Appellant has difficulty bending, lifting, squatting and sitting for long periods. She described the Appellant as tearful, feeling guilty and conflicted, having difficulty with decision making and suffering from many somatic complaints. She was prescribed Cipralex and Tylenol, had received physiotherapy with some improvement, was receiving ongoing counseling with a social worker with minimal improvement and had used antidepressants with marginal improvement. Dr. Vari described the prognosis as poor/guarded. She stated that despite "conscientious" efforts to get better, the Appellant had made only "marginal progress." Dr. Vari stated: "I fear her previous traumatic war events and then long history of harassment and poor working conditions in her last job, will make it difficult for her to recover fully".

[13] On October 1, 2009, Dr. Selchen, neurology, saw the Appellant for a neurological assessment. According to Dr. Selchen, the Appellant had been on leave since June 2008 due to

depression, anxiety and knee and back pain. She had an injury at work in 2005, experienced some problems with her knees and felt discriminated against by her employer until she quit. She saw Dr. Bayer the previous winter with episodes of vaguely described symptoms, which Dr. Selchen described as "a rather large range of other somatic phemonena." Despite intensive investigation, nothing specific was found. Dr. Selchen's neurological examination of the Appellant was normal. He did not believe she had significant vascular disease or that her episodes were Transient Ischemic Attacks (TIAs). He indicated they related predominantly to anxiety.

[14] On December 30, 2009, Dr. Chapnik, otolaryngology, saw the Appellant for right sided headaches and light-headed episodes as well as persistent right tinnitus. The otolaryngolgic examination was entirely normal. Both ear canals and drums were intact and both middle ear spaces were well ventilated. The Appellant had a slight bilateral sensory hearing loss similar to that measured in a 1997 audiogram. Because of the light-headedness, an electronystagmogram was arranged to investigate balance function. An MRI of the head was also arranged.

[15] According to a January 4, 2010 Physiotherapy Progress Discharge Report, the Appellant was treated with stretching and strengthening. She was somewhat improved. On discharge, she demonstrated an understanding of how to progress the level of difficulty of her exercises and reported an overall 49% improvement. She reported being able to sit for longer than an hour and perform more physical activities than before. She was discharged on a home program.

[16] A January 30, 2010 MRI of the head and neck was taken due to symptoms of right sided pulsatile tinnitus, momentary lightheadedness and right sided headaches. No Cerebellopontine angle lesion was detected.

[17] On February 19, 2010, Dr. Laurence Rubin saw the Appellant for consultation concerning bilateral knee pain and continued treatment with Actonel. The Appellant continued to complain of predominantly right knee pain which caused difficulty using stairs and going from a seated to standing position. The pain was intermittent and physiotherapy provided only mild improvement. Dr. Rubin noted the Appellant continued a self-directed exercise program that involved daily swimming. On examination, her gait pattern over a distance of 20 metres was within normal functional limits and range of motion of her lumbar spine was full and

unrestricted. Range of motion of the hips bilaterally was also within normal functional limits. Her right hip had range of motion from 3 to 135 degrees of flexion with moderate retropatellar crepitation and a mild effusion on the right. The majority of difficulties, both functionally and with respect to pain on the right knee, were due to patellofemoral osteoarthritis. According to Dr. Rubin, the Appellant might benefit from an intra-articular steroid injection. The Appellant wished to proceed and Dr. Rubin injected the right knee with Depo-Medrol. Given her low risk category for fracture, Dr. Rubin advised the Appellant to discontinue Actonel.

[18] On April 27, 2010, Dr. Rubin and Dr. Goligher saw the Appellant in follow up. The Appellant reported that the previous corticosteroid injection in her right knee ameliorated her symptoms by approximately 20% for a brief period. However, she continued to have significant aches and pains in her knees. Overall, the Appellant believed she was worse. She complained of pains in her hands over the thumbs, indicating that the right side was worse than the left. According to Doctors Rubin and Goligher, the Appellant had progressively worsening symptomatology and disability due to her bilateral patellofemoral osteoarthritis. She also appeared to have involvement of the carpometacarpal joints of the hands. They explained that surgical intervention has not proven very helpful for her particular type of pathology. However, they stated they would refer her to Orthopedics for assessment and consideration of arthroscopy and debridement. They also recommended she increase her Tylenol Extra Strength up to 6 tablets daily as needed.

[19] On June 23, 2010, Dr. Waddell saw the Appellant for consideration of a left knee arthroscopy for patellofemoral pain syndrome. He stated she reported a 2-3 year history of pain and swelling in the left knee with clicking and catching. She also had low back pain for which she received physiotherapy. Although Dr. Rubin injected the knee in early 2010, the Appellant reported no significant change or improvement post injection. Her symptoms were worse with stairs and going from a seated to standing position. According to Dr. Wadell, the Appellant stated that although her knee bothered her to some degree, “it did not significantly impact her work condition”. On examination, she ambulated independently without the use of an assisted device, her gait pattern was essentially normal, she was able to perform a full squat from a standing position with no apparent difficulties and she had full lumbar spine range of motion with no report of pain or discomfort. Straight leg raise was negative. Her knees demonstrated

excellent range of motion bilaterally with mild end-range pain in the left knee retropatellar. She had mild effusion on the left knee with retropatellar crepitations and a positive Clarks test. Dr. Waddell stated:

> In summary, we have a 58-year old lady with mild patellofemoral osteoarthritis of the left knee and is unresponsive to conservative measures and steroid injection. Her physical examination today demonstrated excellent range of motion with minimal findings other than mild effusion and positive patellar grind test….Before consideration of an arthroscopy, we elected to order an MRI examination of the left knee to see if there is any specific pathology or internal derangement that can be addressed via an arthroscopy .We do not think that she would be a candidate for anything more significant than this.."

[20] On December 8, 2010, Dr. Vari sent a letter to the Appellant's disability insurer. She reported the Appellant continued to suffer "considerably" from depression, anxiety and probably PTSD. According to Dr. Vari, the Appellant's symptoms related significantly to difficulties she experienced with her last job at a daycare where her experience with management was extremely stressful and traumatizing. She also suffered from osteoarthritis which resulted in bilateral knee and low back pain. Other intermittent symptoms include headaches, paresthesia, dizziness and weakness. They were often associated with depression and anxiety. Dr. Vari did not think the Appellant would be able to work. Given her depression and anxiety, she was emotionally labile, cried easily, had diminished energy and concentration, fatigued easily and had minimal reserves to deal with stress. Dr. Vari stated: "Her expectations of herself are quite high and with her emotional fragility, I fear an attempt to return to work prematurely would set her up for failure and send her into a tail spin of further depression." According to Dr. Vari, physically, the Appellant would not be able to return to work as she could not perform significant lifting and squatting required in the daycare. Dr. Vari indicated she changed the Appellant's medications and referred her to the CAMH Mood Disorders Clinic for a formal psychiatric assessment and to a community psychotherapy clinic for ongoing psychotherapy support.

[21] On January 6, 2011, Dr. Vari reported the Appellant was incapable of working between June 2008 and the present time due to medical reasons and was further incapable of performing

the duties of an Early Childhood Educator. The prognosis for a significant improvement to the point she could return to work was poor.

[22] On January 10, 2011, Dr. Stephen Sokolov, psychiatrist, CAMH, assessed the Appellant in the Mood Disorders Clinic. The Appellant reported taking Escitalopram during the previous three months and Citalopram for several years before that. She also reported a history of PTSD symptoms since living in Vietnam and nightmares, flashbacks and panic attacks. She endorsed symptoms of hypervigilance and hyperarousal. According to Dr. Sokolov, the Appellant had never been treated with medication specifically for PTSD. About 5-6 years earlier, she had experienced a conflict at work and harassment from her employer. Since then she had been off work and had experienced worsening of her mood and anxiety symptoms. She described depression, markedly interrupted sleep, decreased total sleep time, decreased appetite, marked difficulty with concentration, significant anhedonia, fatigue, cognitive slowing and restlessness. On a Quick Inventory of Depressive Symptomatology, she scored in the moderately depressed range. She also had significant generalized anxiety and worry. She scored in the moderately to severely anxious range on the Beck Anxiety Inventory and had significant social anxiety and social avoidance. She also had panic attacks which were severe in nature with partial improvement from antidepressant medication. She was previously seen and assessed at the Toronto Western Hospital (TWH) Mood Disorders Clinic and placed into a Mindfulness Group. More recently, she was followed in a group at the Department of Psychiatry, St. Michael's Hospital. According to Dr. Sokolov, the Appellant met the criteria for a Major Depressive Disorder chronic in nature and moderately severe. She also met the criteria for PTSD which was likely the primary diagnosis. Although she had some response to an antidepressant, the likely reason she did not fully respond was because the dosage was too low. Dr. Sokolov suggested an increase in Escitalopram up to 30 mg and possible referral to the Canadian Centre for Victims of Torture.

[23] A March 16, 2011 ultrasound revealed full thickness tear of the supraspinatus tendon, background supraspinatus and infraspinatus tendinosis, bicipital tendinosis and excess subdeltoid-subacromial bursal fluid in keeping with bursitis.

[24] On June 16, 2011, Dr. Hall saw the Appellant for an Upper Extremity Ambulatory Consult. He reported she was a 59 year old woman with right shoulder pain of about 5 years duration. She described decreased range of motion and swelling in her arm and previous receipt of physiotherapy and anti-inflammatories but no steroid injections. According to Dr. Hall, the Appellant had a past medical history suggestive of stroke and depression and she described right- sided facial weakness in the past. On examination, she had near full range of motion with passive painful arc and stress tenderness about her shoulder. Rotator cuff specific testing showed pain and weakness of the supraspinatus and posterior cuff. She also had positive bicipital sign. A review of her imaging suggested a full-thickness 1 cm tear of the supraspinatus tendon. Dr. Hall suggested surgery. Since the Appellant appeared reluctant, Dr. Hall recommended she continue with physiotherapy for range of motion and strengthening exercises of the shoulder. He stated he would see her in 3-4 months' time.

[25] An August 2011 Upper GI confirmed a small amount of reflux. The same month, a thyroid ultrasound revealed multiple thyroid nodules.

[26] On August 1, 2011, Dr. Vari sent a letter to the Respondent .She stated the Appellant continued to suffer considerably from depression, anxiety and probable PTSD. Her problems related significantly to her last job at the daycare where her experience with management was extremely stressful and traumatizing. She continued to see a social worker and perform mindfulness based meditation. She was assessed at CAMH which recommended she look for sources for ongoing therapy and increase her antidepressant. However, according to Dr. Vari, the Appellant could not tolerate higher doses of the antidepressant and finding ongoing therapy had been a challenge. She was recently diagnosed with a full-thickness rotator cuff tear resulting in severe shoulder pain and restriction. She was offered surgery but elected to first try conservative treatment. The pain had not improved and Dr. Vari stated she would ask the surgeon to place the Appellant on a waiting list. Dr. Vari noted that for a number of years, the Appellant had physical symptoms on the right side of her body. Some symptoms seemed to point to the diagnosis of trigeminal neuralgia which results in severe facial pain, headache, numbness and tingling. The Appellant had some mild improvement with Gabapentin. She also suffered osteoarthritis causing bilateral knee, low back and general leg pain. According to Dr. Vari, the Appellant would not be able to return to work looking after children as she could

not lift and squat. Her depression, anxiety and chronic pain diminished her energy and concentration. She fatigued easily, had minimal reserves to deal with stress, was emotionally labile and would cry easily. Dr. Vari stated: "Her expectations of herself are quite high and with her emotional fragility, I fear an attempt to return to work would set her up for failure and send her into a tail spin of further depression (I have certainly seen this happen to other patient"). She further stated: "(The Appellant) is a very conscientious citizen, with a strong work ethic. While she strives very hard to get better in order to go back to work, with her physical and psychological duties, I do not think she is able."

[27] On October 3, 2011, J. T., CUPE 2484 Local Coordinator wrote a letter stating she has known the Appellant for over 15 years. She has known her to be honest and dependable with a strong work ethic. Ms. J. T. indicated she worked closely with the Appellant on her Long Term Disability claim and appeal. She was witness to the fact the Appellant was not able to seek employment or retraining. She witnessed the Appellant's inability to function on several occasions. According to Ms. J. T., the Appellant had episodes of depression and anxiety which made it difficult for her to sleep or focus. She was often in pain, finding it difficult to stand, sit or walk for prolonged periods of time. She exhibited an intense level of anxiety and was unable to detach from the experiences she had with her previous employer. She had to cancel appointments on several occasions due to pain and tingling in her legs. She had volunteered in the Local but the length of times and availability has been extremely limited by her health.

[28] An October 18, 2011 cytopathology report confirmed a nodular goiter.

[29] On March 30, 2012, Dr. Halman, psychiatrist, assessed the Appellant. According to the Appellant, her main objective was to find a non-medical way to treat her mental illness. She reported difficulties with low mood and worsening PTSD symptoms since she stopped working in 2008. She described poor sleep, okay energy, low appetite, difficulty with concentration and forgetfulness. She was hopeful about returning to work in the future and denied any suicidal ideation. Dr. Halman indicated the Appellant had significant PTSD symptoms which had been ongoing but which worsened over the past 3 years. He stated her conflict with her previous workplace was the trigger and she felt "once again" she was "in a state of war". She endorsed flashbacks and was re-experiencing the battlefields of Vietnam. She found herself to be tense

and hyper vigilant in public spaces and at times had dissociative symptoms of derealization and depersonalization. She also endorsed some symptoms of generalized anxiety and a history of panic attacks but felt they were under control due to meditation exercises. Under Assessment, Dr. Halman stated that since the workplace harassment, the Appellant had a marked change in her mental status, was feeling persistently depressed and was suffering from worsening PTSD symptoms. He diagnosed: Major Depressive disorder, PTSD, rule out generalized anxiety disorder and a GAF of 60. He stated that Cipralex provides some benefit although he noted the Appellant might decide to go off it. Dr. Halman stated the Appellant would benefit from ongoing mindfulness based stress reduction and CBT as well as meeting with a social worker. She was also encouraged to be actively involved in the community, e.g., walking, swimming and volunteering.

Oral Testimony

[30] She was a high school teacher in Vietnam for 14 years. She attended the University of Saigon and graduated in 1975, the same year the Vietnamese government collapsed. Her father was jailed in Vietnam for 4 years. In 1989, her father, who was then in Canada, was dying of cancer. She came to Canada on a Minister's Permit and became a landed immigrant on April 5, 1989.

[31] When she came to Canada, she believed she would put her past experiences behind her. These included her brother dying in front of the family and her sister dying during the war in Cambodia. She wanted to teach high school but faced a language barrier. She attended school for English at night and started working in a factory job approximately three weeks after she first arrived in Canada. She worked in the factory for approximately one year. She also tried working in a coffee shop but was allergic to cigarette smoke. She did not believe she could teach high school due to her language and knowledge barriers. Therefore, she focused on working with children. She worked for one year as an assistant in a daycare. She attended George Brown College for two years to obtain her ECE certificate. She was hired by another daycare where she worked between 1993 and 2008 until she went on medical leave.

[32] As a childcare worker, she looked after the children. The job had a physical component. For example, she had to lift the children and change diapers.

[33] In 2005, she got injured at the daycare. She felt the daycare was mismanaged and dirty. Management harassed her, monitored her and made her feel uncomfortable and angry. They accused her of things that were not her fault in order to "push her out the door". She encountered harassment for over three years which caused her stress. Whenever she met with management and they wrongfully accused her, she would feel as though the workplace was a "warzone". She would get flashbacks of her experiences in Vietnam. She described the workplace as "toxic". She couldn't sleep. During meetings with management, she had to take sublingual medicine to calm herself down.

[34] During the period between 2005 and 2008, her doctor prescribed medication, which made her feel like a "zombie." However, she tried to focus on the children and her job. Although she took photos and videos of the daycare which she showed to public health, her complaints were never addressed. Her stress continued to build.

[35] For pain, she would take Celexa and Celebrex. She also took Cipralex and Nexium. She could not sleep and went to work feeling tired. Given her condition, she felt she shouldn't be at work. She had not yet seen a psychiatrist or psychologist.

[36] She thought about looking for work elsewhere. However, she had invested much effort into the daycare job. Nevertheless, she applied to another daycare, got an interview but did not get the job. According to the Appellant, the prospective employer knew what was going on at her existing workplace.

[37] At one point, she took one week off work, however, her doctor told her to take one month off. A manager called her at home and made false accusations against her. As a result of the harassment, she would feel angry, experience flashbacks and nightmares. She felt she might harm herself or others but realized she had to present a proper role model for the children. Her doctor recommended she think about the long-term effects to her health and in June 2008, she went on medical leave. She experienced anxiety attacks and suffered a mini-stroke. Her neurologist told her it was not a good idea for her to return to work and that "the next one would be the big one". She never returned to the job. Although she expressed interest in moving to another branch location of the childcare, the manager did not want to her to go there.

[38] After her mini-stroke, she attended physiotherapy and doctors' appointments. This was equivalent to a full-time job.

[39] She could not walk properly. She asked her doctor for a scooter. He said she had to walk every day. She required physiotherapy, a walker and a cane on account of her knees. She believes medication made her sick with stomach reflux. She thinks medication may also have caused her to suffer bone loss and made her fragile. The doctor injected her knee and she developed a cataract for which she required surgery.

[40] With treatment, medication and physiotherapy, her physical conditions have improved. She can walk without a cane for a short period of time. She practices mindfulness, has seen specialists and feels somewhat calmer. However, when she thinks about work, she still feels anxiety. Given her last workplace experience, she is anxious about attending a new workplace.

[41] Her hands have pain and she drops things. She cannot squat/bend due to her knees and has problems with her eyes. She does not believe any employer would understand her situation or allow her to call in sick as required.

[42] Between 2013 and the present, she has attended group therapy regularly monthly. She can contact her social worker at any time.

[43] She still experiences flashbacks once in a while but not with the same frequency as in 2010/11. She feels less alone or under attack knowing other people are in the same situation in which she finds herself.

[44] She does not believe she could return to work. She feels anxious just thinking about it. On one occasion, J. T. took her to a childcare convention where she was supposed to look after children. She experienced an anxiety attack and had to go to the hospital.

[45] Other triggers for her anxiety include thinking about the pressures of work. She knows she cannot meet workplace performance expectations. Current events on the news also act as triggers for her anxiety. For many years she did not own a television.

[46] She tries to cope with her daily activities. On awakening in the morning, she exercises and practices mindfulness. It makes her feel better than taking medication without any of the

negative side effects such as dry-mouth and dizziness. If she feels good, she goes out. If she does not feel good, she stays inside. How she feels on a day to day basis is unpredictable and may depend on the weather and her sleep. She has sleep apnea and uses CPAP. Although CPAP helps, at times she experiences tingling in her legs.

[47] Her doctor and social worker have advised her to perform volunteer work. When she first arrived in Canada, she used to volunteer with the Red Cross and Heart and Stroke. She currently volunteers with Out of the Cold. By doing so, she realizes she is not alone. There have been days she has planned on volunteering but has been unable to attend based on how she was feeling that day. As a volunteer, she does not have to call in sick, explain her absence or work according to a schedule with performance requirements.

[48] Her family doctor has discouraged her from returning to work and getting worse.

[49] She has followed her doctors' recommendations. Although her specialist recommended she increase her medication, she is negatively affected by the side-effects of medication. Although Dr. Hall recommended rotator cuff surgery, she wants to put this off. She saw people "cut up" in Viet Nam and therefore does not wish to undergo surgery. She would rather pursue physiotherapy and chiropractic. She has attended chiropractic every two weeks at St. Michael's Hospital for the past three years. She also does home exercise daily and participates in Aqua Fit.

[50] She takes Nexium as required for reflux. She tries to eat well, exercise and practice mindfulness. She does not take any other medication for her depression/stress. The mindfulness approach to managing her health makes her feel better than managing her condition with medication. Her doctor supports her approach. Medicine made her feel like a "zombie" and she could not function.

[51] In response to questions from the Tribunal, the Appellant clarified she does not want to pursue shoulder surgery which she feels is a last resort. She performed first aid in Vietnam and has seen people with broken bones. She does not want anything to happen to her as a result of surgery. Her family doctor suggested she try physiotherapy and chiropractic which she has

pursued. She also performs home exercises daily to manage her shoulder condition which she states has much improved.

[52] Although Dr. Sokolov recommended she be referred to the Canadian Centre for Victims of Torture, she only saw him once. Her family doctor never referred her there. She attends St. Michael's Hospital for her psychological issues.

[53] She went off Cipralex in March 2013. It caused her to experience dry-mouth and stomach upset. The pills also became difficult to swallow.

[54] She has attended cognitive and group therapy. With the benefit of her legal representative's assistance, the Appellant clarified she attended a mindfulness based stress reduction group in 2009 and 2010 (GT1-172) at Toronto Western Hospital (TWH); a meditation program at St. Michael's Hospital in 2009; group cognitive behavior and cognitive therapy at TWH in 2009 and 2010 and met with her social worker in 2008 and 2011. She has ongoing contact with her social worker and speaks with her monthly. She still attends group therapy monthly, which is run by the Mental Health Department at St. Michael's Hospital.

[55] She gets flashbacks once in a while. For example, she experienced one around Christmas 2014 and another at the time of her birthday in February 2015.

[56] While attending a childcare convention about two years ago, she experienced anxiety when she saw the children she was supposed to look after. They made her think of the children at her former workplace which caused her to experience a panic attack.

[57] She volunteered at the Red Cross and Heart and Stroke many years ago when she first came to Canada. She started volunteering for Out of the Cold in 2008. She would attend once weekly for approximately 3 hours, take people around and help cut vegetables. She is not on a set timetable and is able to work at her own pace. There are no issues if she arrives late. Her doctors told her to avoid isolation and to get out of the house, which her volunteer work satisfies.

[58] She does not think she could manage retraining or other work not involving children. Her eyes are not good for computer work. She cannot sit long in an office. She cannot carry objects in a coffee shop. She cannot handle any job.

SUBMISSIONS

[59] The Appellant submitted that she qualifies for a disability pension because:

a) Although there is no one single condition one can point to in support of a severe and prolonged disability, cumulatively she suffers from many conditions which satisfy the definition. The most significant conditions are PTSD, anxiety and her other mental difficulties stemming from her childhood in Vietnam, which have manifested themselves in Canada. They were triggered by the "warzone" type environment she experienced at her workplace in the daycare. It makes her fearful to pursue other work.

b) In the CPP Medical Report, Dr. Vari states that despite her efforts to get better, she made only marginal progress. In her letter at GT1-52, Dr. Vari states she is conscientious and hardworking but is unable to work. Given her emotional fragility, a premature attempt to return to work would set her up for failure and send her into a tail spin for further depression.

c) She cannot return to childcare work or any other job. The idea of a return to work causes her to become anxious. She is fearful about a repeat experience and is unable to regularly purse any substantially gainful occupation.

d) Her volunteer work is at her doctors' recommendations (see report of Dr. Hallman at GT1-174 who encouraged her to be active in the community).

e) Her volunteer work lacks the rigidity of expectation required in the competitive workplace, i.e., no pressure to perform.

f) She is described as hardworking. Her medical professionals do not think it is a good idea for her to return to work.

g) She also has physical ailments involving her knees, shoulder and arthritis. She has difficulty sleeping due to tingling in her legs. Although these conditions may not be disabling on their own, taken together with her PTSD and anxiety, she suffers from a severe and prolonged disability.

h) Based on a real world perspective, she cannot work. She is age 63 with a variety of challenges.

[60] The Respondent submitted that the Appellant does not qualify for a disability pension because:

a) While she may not be able to return to her previous job, she is not prevented from doing other work.

b) According to the neurologist's report, the neurological exam was normal.

c) According to the otolaryngologist's report, the assessment for headaches and lightheadedness was normal.

d) The rheumatologist diagnosed mild osteoarthritis in both knees.

e) According to the orthopedic surgeon's report, examination of the knees and back was normal.

f) According to her upper extremity specialist, she had almost full range of movement in her right shoulder and the neurologic exam was normal. He stated she could consider surgery for a tear in her right shoulder tendon and suggested physiotherapy.

g) According to the psychiatrist's report, she was moderately depressed and had some response to the antidepressant. The psychiatrist reported that the medication dosage for the PTSD was too low, increased it and suggested referral for more specialized counselling. This information does not prevent her from doing all work since she last qualified for benefits.

h) She never attempted to return to another other type of work.

i) Surgery was offered to correct the tear in the rotator cuff but she declined it. Physiotherapy was recommended but it is unknown if she pursued it.

j) According to the orthopedic opinion, her arthritis was minimal and there were no definitive findings that could be corrected by surgery.

k) Although improvements were noted in her depression and PTSD, she does not like medication and resisted optimization of her condition through increased dosages. Despite sub-optimal treatment, her GAF score still is within a manageable level placing her in a moderately impaired level of functioning. With appropriate treatment and counselling, it is reasonable that her level of function would improve.

l) Although she states she suffered a mild stroke, neurological investigations fail to support the same.

m) While she has many other medical diagnoses such as hearing loss/ringing in the ears, GI reflux, thyroid nodules and headaches, none would impair her ability to work in a suitable setting.

n) She remains active in her community and is not physically prevented from working. She has a high level of education in her home country.

o) She is capable of working in a suitable capacity.

ANALYSIS

[61] The Appellant must prove on a balance of probabilities that she had a severe and prolonged disability on or before December 31, 2010.

Severe

[62] The Tribunal is not satisfied that the Appellant's osteoarthritis, in particular her back and knee pain, rendered her incapable regularly of pursuing any substantially gainful

occupation on or before the MQP. In the CPP Medical Report, Dr. Vari referred to back and knee pain which were secondary to osteoarthritis and which caused difficulty with bending, lifting, squatting and sitting for long periods. Among her physical conditions, the Tribunal has also considered the tear of the supraspinatus tendon/bursitis detected in the March 16, 2011 Ultrasound.

[63] The Tribunal has considered the fact that in her October 1, 2009 neurology report, the Appellant's neurological examination was normal. According to the January 4, 2010 Physiotherapy Discharge Report, the Appellant reported an overall 49% improvement indicating she was able to sit for longer than an hour (as opposed to one-half hour which she described in her November 19, 2008 Questionnaire). On February 19, 2010, Dr. Rubin, who saw the Appellant for her bilateral knee pain, indicated that on examination her gait pattern over a distance of 20 meters was within normal functional limits and that the range of motion of her lumbar spine was full and unrestricted. Range of motion of her hips bilaterally was also within normal functional limits. According to Dr. Rubin, the majority of difficulties related to pain on the right knee for which the Appellant received an injection which ameliorated her symptoms for a brief period. On June 23, 2010, the Appellant saw Dr. Waddell, surgeon, for consideration of a left knee arthroscopy for patellofemoral pain syndrome. According to Dr. Waddell, her symptoms were worse with stairs and going from a seated to standing position. He did not mention any restrictions involving prolonged sitting and indicated she has no resting pain. Dr. Waddell further reported that on examination, the Appellant ambulated independently without use of an assisted device, her gait pattern was essentially normal, she was able to perform a full squat from a standing position with no apparent difficulties and had full lumbar spine range of motion. Also, her knees demonstrated excellent range of motion bilaterally with only mild end-range pain in the left knee retropatellar with mild effusion on the left knee with retropatellar crepitations.

[64] The Tribunal is not satisfied that the above findings signify a functionally disabling condition in the knees or back which would render the Appellant incapable regularly of pursuing any substantially gainful occupation including sedentary work on or before the MQP.

[65] In terms of the Appellant's right upper limb, the Tribunal is mindful of the fact that in the December 2010 CPP Medical Report, Dr. Vari reported that the Appellant had difficulty with lifting and that the March 16, 2011 ultrasound of the right extremity revealed full thickness tear of the supraspinatus tendon, background supraspinatus, infraspinatus tendinosis, bicipital tendinosis and excess subdeltoid-subacromial bursal fluid in keeping with bursitis. Certainly, on June 17, 2011, Dr. Hull reported that the Appellant had right shoulder pain of about 5 years duration. On examination, she had near full range of motion with passive painful arc and weakness of the supraspinatus and posterior cuff and positive bicipital sign, with imaging suggesting a full-thickness tear of the supraspinatus tendon. The issue was serious enough that Dr. Hall recommended surgery. The Appellant was initially reluctant to pursue surgery. Therefore, Dr. Hall recommended continued physiotherapy. However, on August 1, 2011, Dr. Vari reported to the Respondent that the Appellant's shoulder pain had not abated and that she would ask the surgeon to place the Appellant on a waiting list.

[66] Although the Tribunal is satisfied that the Appellant's right shoulder condition was functionally disabling on or before the MQP, the Tribunal is not satisfied that it was severe as defined in the CPP based on the fact she has not yet undergone all available treatment which might ameliorate her functional restrictions. The Tribunal is also not satisfied the Appellant was rendered incapable regularly of pursuing light sedentary work on or prior to the MQP. The Tribunal finds she remained capable of performing work that did not require overhead lifting, reaching, lifting or carrying using her right upper limb. Finally, the Tribunal has considered the Appellant's testimony that her right shoulder condition has improved with non-invasive treatment such as chiropractic.

[67] In any event, the Tribunal is satisfied the Appellant was rendered incapable regularly of performing any substantially gainful occupation on or before the MQP resulting from her mental disability.

[68] In her March 8, 2011 Questionnaire, the Appellant indicated she was suffering from stress, depression, headache, dizziness and lack of sleep. In her initial November 19, 2008 Questionnaire, she also described stress, depression, inability to concentrate and remember, spinning head and panic attacks. In the December 10, 2010 CPP Medical Report, Dr. Vari

diagnosed depression, PTSD and a lot of somatic complaints. On December 8, 2010, Dr. Vari reported that the Appellant continued to suffer "considerably" from depression, anxiety and probable PTSD and that her other symptoms, including headaches, paresthesia, dizziness and weakness, were often associated with depression and anxiety.

[69] Dr. Sokolov, psychiatrist, saw the Appellant on January 10, 2011 and confirmed that she met the criteria for a Major Depressive Disorder that was chronic in nature, moderately severe and which also met the criteria for PTSD which was likely the primary diagnosis. He indicated that her medication needed to be increased and suggested referral to the Canadian Centre for Victims of Torture. The Appellant testified that her family doctor did not arrange this referral. The Tribunal is unable to assign any fault or blame to the Appellant for this apparent lack of follow up and further notes the comments of Dr. Vari in her August 1, 2011 report that "Finding ongoing therapy is also a challenge".

[70] On March 30, 2012, Dr. Halman, psychiatrist, confirmed "significant" PTSD symptoms which had worsened over the past 3 years, indicating that conflict with her previous workplace was the trigger. He reported that since her workplace harassment, she had a marked change in her mental status, was feeling persistently depressed and was suffering from worsening PTSD symptoms. He diagnosed Major Depressive Disorder, PTSD and provided a GAF of 60. Although Dr. Halman encouraged the Appellant to be active in the community, e.g., walking, swimming and volunteering, the Tribunal notes he did not suggest or recommend a work trial or retraining. The Appellant testified she volunteers in the community when she is able to do so and participates in Aqua Fit.

[71] The Tribunal is satisfied the Appellant's Major Depressive Disorder and PTSD has rendered her incapable regularly of performing any substantially gainful occupation since she last worked in June 2008 and went on medical leave following her workplace conflict. The medical evidence supports a finding that the workplace conflict acted as a trigger for her PTSD, following which she has suffered from ongoing depression and PTSD. As indicated by Dr. Halman in his March 30, 2012 report: "She has no previous psychiatric history or medical issues until 2005 when she suffered a workplace incident. As well, she suffered harassment at

work following a ‘whistle-blowing’ incident. Since then, she has had a marked change in her mental status, feeling persistently depressed and suffering from worsening PTSD symptoms”.

[72] The Tribunal accepts that the Appellant’s symptoms include markedly interrupted sleep, decreased total sleep time, decreased appetite, marked difficulty with concentration, significant anhedonia, fatigue, cognitive slowing and restlessness. As noted by Dr. Sokolov in his January 2011 report, on a Quick Inventory of Depressive Symptomatology, she scored in the moderately depressed range. She also scored in the moderately to severely anxious range on the Beck Anxiety Inventory and had significant social anxiety and social avoidance.

[73] Although Dr. Sokolov suggested an increase in medication and referral to the Canadian Centre for Victims of Torture, on August 1, 20112, Dr. Vari reported that the Appellant could not tolerate higher doses of antidepressant and that finding ongoing therapy had been a challenge.

[74] The Respondent has referred to Dr. Halman’s statement that the Appellant wanted to stop taking Cipralex in the near future. The Appellant testified that she eventually discontinued Cipralex due to side effects. However, she continues to attend group therapy, practices mindfulness to help manage her anxiety and has ongoing contact with her social worker. The Tribunal finds that the Appellant has provided a reasonable explanation for her cessation of Cipralex and has further provided evidence of other efforts on her part to manage her condition.

[75] The Respondent appears to contend that the GAF rating of 60 signifies a non-severe condition. The Tribunal is satisfied, however, based on a review of all the evidence, including the totality of Dr. Halman’s report, in which he diagnosed significant PTSD symptoms and Major Depressive Disorder and described poor sleep, low appetite, difficulty with concentration and forgetfulness, flashbacks, hypervigilance in public spaces and at times dissociative symptoms, that the Appellant’s disability renders her incapable regularly of performing any substantially gainful occupation.

[76] Although the Appellant is capable of engaging in limited volunteer work, the Tribunal does not find such work to be reflective of the competitive work environment and is satisfied

her volunteer work efforts do not evidence capacity on her part regularly to pursue a substantially gainful occupation.

[77] Based on the Appellant's oral testimony and the medical record, the Tribunal is satisfied that since she stopped working in June 2008, the Appellant has been incapable regularly of pursuing any substantially gainful occupation resulting from the symptoms associated with her PTSD and Major Depressive Disorder. The Tribunal is further satisfied her disability has remained severe as of the MQP and continuously thereafter.

Prolonged

[78] The Tribunal is satisfied that the Appellant's disability was prolonged as of June 2008, when she stopped working and went on medical leave.

[79] The medical reports and Appellant's evidence relate the onset of PTSD and Major Depressive Disorder to the Appellant's workplace conflict which resulted in her going on medical leave. The medical record chronicles ongoing PTSD and Major Depressive Disorder continuously beyond June 2008. In his December 2010 CPP Medical Report, Dr. Vari stated that the Appellant's prognosis was poor/guarded and that despite her "conscientious" efforts to get better, she had only marginal progress. Dr. Vari stated: "I fear her previous traumatic war events and then long history of harassment and poor working conditions in her last job, will make it difficult for her to recover fully." On March 30, 2012, Dr. Halman confirming ongoing symptoms of PTSD and Major Depressive Disorder. The Tribunal is satisfied that the Appellant's PTSD and Major Depressive disorder are both long continued and of indefinite duration.

CONCLUSION

[80] The Tribunal finds that the Appellant had a severe and prolonged disability in June 2008 when she stopped working and went on medical leave. For payment purposes, a person cannot be deemed disabled more than fifteen months before the Respondent received the application for a disability pension (paragraph 42(2)(b) CPP). The application was received in December 2010; therefore the Appellant is deemed disabled in September 2009. According to section 69

of the CPP, payments start four months after the deemed date of disability. Payments will start as of January 2010.

[81] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security