Citation: ***K. P. v. Minister of Employment and Social Development*****, 2015 SSTGDIS 50**

Date: June 1, 2015

File number: GT-121417

GENERAL DIVISION - Income Security Section

Between:

K. P.

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 In person on May 25, 2015, Toronto, Ontario.

REASONS AND DECISION

PERSONS IN ATTENDANCE

K. P., the Appellant

Richard Levin, the Appellant's legal representative

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on May 15, 2008. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Office of the Commissioner of Review Tribunals (OCRT) and this appeal was transferred to the Tribunal in April 2013.

[2] The hearing of this appeal was by In person for the following reasons:

a) The issues under appeal are complex; and

b) The form of hearing respects the requirements 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 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.

[7] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2007.

[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 the MQP.

EVIDENCE

Documentary Evidence

[9] In the CPP Questionnaire dated May 12, 2008, the Appellant stated he stopped working in March 2005 as a CNC punch press operator due to injury. He had been working at the job since July 1999. He completed Grade 12 and attended one year at Georgian College to study general carpentry and construction skills. He received on the job training. He is unable to stand longer than 5-10 minutes, sit longer than 20-30 minutes and is unable to walk any distance. He has received nerve blocks to help control his pain levels and is prescribed Tylenol 3, Duragesic, Percocet, Zanaflex and Elavil. He is on a waiting list for the Sunnybrook Pain Clinic and uses a cane. He attended the Canadian Back Institute (CBI), however his private disability insurer stopped payment.

[10] In the CPP Medical Report dated March 26, 2008, Dr. Aldridge, family physician, reported he knew the Appellant for six months and started to treat him for his main condition in September 2007. He diagnosed i) myofascial pain syndrome (piriformis syndrome) chronic

back pain and ii) lumbar facet joint syndrome. He stated the Appellant had chronic back pain for three years. He will attend Sunnybrook Pain Clinic and is prescribed Duragesic, Zanaflex, Tylenol 3, Percocet and Elavil. Dr. Aldridge reported a moderate response to weekly lumbar nerve blocks and otherwise, no response at all. He stated that the prognosis was guarded.

[11] In an undated CPP Medical Report date stamped received by the Respondent on April 17, 2008, Dr. Axler, family physician, stated he knew the Appellant for 31 years. He diagnosed chronic low back pain of many years duration. According to Dr. Axler, on March 13, 2005, the Appellant was sitting on a chair at home which broke. He fell on the floor and experienced sudden low back pain which has persisted. He noted the Appellant was seeing Dr. Aldridge, a pain specialist, and Dr. Gofeld at Sunnybrook hospital. He is prescribed Fentanyl patches, Tylenol 3, Amitriptyline and Zanoflex and will receive diagnostic nerve blocks at Sunnybrook. He moves slowly and has decreased range of motion in all lumbar spine movements. Neurovascular exam of the lower limbs was normal. Dr. Axler reported that the low back was discolored due to constant use of a heating pad. According to Dr. Axler, the prognosis was guarded as the Appellant had chronic continuous pain for three years and would probably always have pain. He indicated the Appellant can stand for 5-20 minutes and stated he cannot work, perform house work or prepare food. He requires assistance with washing, shaving and doing laundry. He can walk for 10 minutes, uses a cane and spends most of his time at home. If he sits he constantly uses heat. Without heat, he can sit 10-15 minutes. He cannot bend, uses an assistive device to pick things off the floor and needs help getting around.

[12] According to an April 15, 2005 Albany Medical Clinic report, the Appellant was diagnosed with low back pain. Compared to a previous examination of the lumbosacral spine from September 2001, there was slight interval progression in degenerative disc changes at L1-2 and L2-3. Anterior degenerative osteophytic lipping was also seen at these levels.

[13] According to an October 11, 2005 report of Dr. Godfrey, physiatry, the Appellant's CT scan showed progression of change at L2-3. According to Dr. Godfrey, the Appellant had only temporary relief from taking Tylenol 3 and was having difficulty getting a good night's sleep. On November 1, 2005, Dr. Godfey reported that the Appellant continued to have significant pain, was unable to sleep and experienced pain on sitting any length of time. He indicated the

Appellant required a more aggressive exercise program and referred him to the Canadian Back Institute (CBI).

[14] On July 13, 2006, the Toronto Western Hospital (TWH) Functional Restoration Program (FRP) issued a Multidisciplinary Initial Assessment to determine the Appellant's suitability to participate. The assessors reported no psychological contraindication to the Appellant's attendance. The diagnostic impression was that of 1. Pain Disorder Associated with Psychological Factors and a General Medical Condition and 2: Nonspecific Low Back Pain with Radicular Symptoms. The assessors recommended that the Appellant attend the FRP.

[15] On September 11, 2006, TWH FRP issued its Initial Treatment Report. They indicated the Appellant started treatment on August 21, 2006. The goal of treatment was to assist with pain management and vocational redirection.

[16] On September 13, 2006, TWH FRP issued its Discharge Summary and Recommendations. The Report assessors stated the Appellant demonstrated the ability to perform activities at a level that would be classified as within the "limited" physical demand level as defined by the National Occupational Classification (NOC) physical demands level. They set out the following permanent functional precautions: avoid repetitive or prolonged forward flexion or twisting of the lumbar spine; ability to alternate between sitting, standing or walking as needed; and load handling within the "limited" physical demand level. They stated the Appellant continued to meet the DSM-IV criteria for Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. However, his depressive episode was in remission. On Axis V, a GAF score of 71 to 75 was provided. From a psychological perspective, they reported no specific restrictions preventing the Appellant from returning to gainful employment.

[17] On November 8, 2006, CBI Physiotherapy (CBI) issued an Occupational Rehabilitation (OR) Interim Progress Report. They indicated the Appellant was able to frequently lift 10 lbs. waist to waist and waist to shoulder and was able to complete reaching, cable and weighted exercises. He was noted to be independent in all self-care activities and was encouraged to increase his daily chores/activities.

[18] On January 12, 2007, CBI issued another OR Interim Progress Report. They reported the Appellant had attended 32 sessions. They stated he was independent in all self-care activities and was encouraged to increase his daily chores/activities. They noted he had not returned to work and had been encouraged to investigate other employment while attending treatment in order that return to work transition could be provided. They indicated he attended the program up to 1 and 1.5 hours per day, three days per week, demonstrated 10 minutes of continuous sitting and reported he was able to sit for up to 1 hour at a time at home. He also demonstrated the ability to continuously stand for 25 minutes and was observed to lean on an adjacent workstation for 10 out of the 25 minutes. They recommended he continue to attend treatment for the next 3 weeks and stated he reported he was unable to tolerate daily sessions.

[19] On February 7, 2007, Julie Stitt, registered physiotherapist, CBI, reported to Dr. Axler that she was working with the Appellant to increase his function. She noted he reported consuming large quantities of Tylenol 3 and Percocet. Ms. Stitt asked Dr. Axler to better manage the Appellant's medications. She indicated the Appellant was encouraged to see a vocational counsellor to discuss future employment as it was not expected he would be able to return to his previous employment due to "lift and prolonged standing expectations".

[20] On April 18, 2007, CBI issued its OR Discharge Report. According to the Report assessors, the Appellant attended 79 out of 90 treatment sessions. They indicated he was often reluctant to participate due to reported low back and knee pain. He also reported fatigue due to poor sleep. They indicated he often expressed "negativity" and appeared unmotivated "(at times unwilling)" to progress in his program. They further indicated his low back range of motion continued to be limited by reported pain. On discharge, he had lifting tolerance of 21 lbs. waist to shoulder and 15 lbs. waist to stool height on a frequent basis. However, reported right knee pain and cane use resulted in limited progress with below waist lifting and carrying activities. On discharge, the Appellant reported he was able to sit for more than one hour on his chair at home while using a heating pad. He was encouraged to use heat moderately for 20 minutes maximum and to continue attempting progression of his sitting tolerance in different types of chairs to help with the potential return to new employment. His standing tolerance continued to be about 25 minutes.

[21] A March 9, 2007 MRI revealed spondylitis changes of the lumbar spine. Disc material appeared to abut the S1 nerve root at the L5-S1 level.

[22] On June 18, 2007, Dr. Lexier, orthopedic surgeon, completed an Independent Medical Examination at the request of the Appellant's disability insurer to assess the Appellant's claim for ongoing disability benefits. According to Dr. Lexier, the Appellant sustained a lumbar region strain and contusion. Dr. Lexier diagnosed mechanical low back pain secondary to degenerative disc disease. He noted the September 13, 2005 CT which revealed thinning of the disc spaces and mild diffuse disc bulging at L2-L3; and the March 2009 MRI which confirmed desiccated discs, narrowing at various disc levels and a small broad based central disc which appeared to abut the right S1 nerve root. According to Dr. Lexier, the Appellant achieved his pre-injury functional level and did not demonstrate any restrictions. He stated he would not impose any limitations with respect to the Appellant's daily activities and ability to work in his pre-disability job capacity. In his opinion, the Appellant's perceived restrictions and limitations, e.g., inability to stand for more than 20 to 30 minutes, etc., were inappropriate given his diagnosis and findings on examination. In Dr. Lexier's opinion, the Appellant had achieved maximum medical recovery from his soft tissue injuries sustained in the March 2005 fall. He stated there were no medical contraindications that would preclude him from participating in a gradual return to work rehabilitation program.

[23] On September 24, 2007, Dr. Kraemer, orthopedic surgeon, saw the Appellant regarding his low back. He referred to the low back injury with significant low back pain, and noted the Appellant was off work for a period of time and had reported being sent back to work by his insurance company to a position involving heavy lifting and walking. According to Dr. Kraemer, the Appellant indicated he was having a lot of trouble with severe pain. Initially the pain would radiate down the left leg however after starting work it also radiated down the right leg. Dr. Kraemer stated: "In summary, this patient has back-dominant low back pain, which limits his activities and is exacerbated by heavy labor work. Surgery would not help". He further stated: "Based on the exacerbation of his symptoms with his current work, I am doubtful that he will be able to continue and will likely need to go to permanent modified work or be retrained to a sedentary occupation. With regard to his recreational activities, he has not been able to resume playing his base guitar due to the sitting and standing limitations."

[24] On October 12, 2007, Dr. Aldridge reported to Dr. Axler that the Appellant's back pain was aggravated on sitting longer than 2 hours and standing longer than 15 minutes. His pain was also made worse with walking more than one block. He was taking Tylenol 3, 4 to 8 tablets daily and Percocet, 2 to 4 tablets daily while at work. The Tylenol 3 and Percocet reduced his pain by 50 to 60 percent. According to Dr. Aldridge, the Appellant became sedated when taking Tylenol 3 and Percocet. Dr. Aldridge stated: "Significantly, he takes a lot more opioids while he is working compared to when he is at home". He indicated the Appellant was working at a metal shop on modified duties during the previous four weeks on a part-time basis and was slowly returning to full- time duties on a graduated basis. According to Dr. Aldridge, the Appellant was "quite resentful" of the independent medical assessor who had cleared him to return to work. On examination, the Appellant had moderate marked tenderness of his right - left L3/4 and L5/S1 paravertebral areas, a positive left sacroiliac irritation test and positive right and left piriformis test. Dr. Aldridge diagnosed lumbar facet joint syndrome and sacroiliac irritation with some piriformis muscle spasm (myofascial pain). He recommended the Appellant restart physiotherapy and undertake a trial of nerve blocks to see if he could palliate his pain. He also strongly recommended consideration of a trial of long-acting opioids.

[25] On October 24, 2007, Dr. Aldridge reported he gave the Appellant some lumbar paravertebral nerve blocks the previous week which provided significant relief for 5-6 days. He noted that although Dr. Axler started the Appellant on Codeine Contin, the Appellant failed to obtain relief. Dr. Aldridge recommended that the Appellant be switched to Duragesic patch if an increased dose was not helpful.

[26] On January 9, 2008, Dr. Aldridge informed the Appellant's disability insurer that the Appellant reported obtaining excellent pain relief for 5-6 days with each lumbar paravertebral nerve block administered. However, the procedure did not enable him to return to his workplace as he would experience severe back pain exacerbations when he attempted to perform his work regimen. He stated the Appellant tried a number of longer acting opioids for his chronic pain with no success including Codeine Contin, Oxycontin and Hydromorph Contin. Dr. Aldridge stated: "Indeed, these medications did not allow him to function in his workplace. Currently (the Appellant) is not working due to the severity of his back pain. (The Appellant) takes Tylenol #3, Percocet and Zanaflex 4 mg BID for his pain at the present". On examination, the

Appellant had moderate to marked tenderness of his L3-4 to L5-S1 paravertebral areas and a positive right and left piriformis test. Dr. Aldridge diagnosed piriformis syndrome (myofascial pain) and lumbar facet joint syndrome and stated: "His prognosis is poor and it is my clinical opinion that he will not be able to return to his former job in the foreseeable future. It is my recommendation that (the Appellant) be sent for career retraining in a field that involves no lifting of any sort (i.e. sedentary work, etc.)."

[27] On April 7, 2008, Dr. Gofeld, Pain Management Program, Sunnybrook Hospital – Diagnostic Nerve Block and Pain Control Clinic, assessed the Appellant for his low back pain with radiation to his buttocks, posterior thigh and occasionally to his lower left leg. He stated the Appellant was "practically unable to work ever since" his fall injury, being "on and off modified duties and finally got fired from his work, which was associated with walking and sitting." He noted the Appellant was put on Tylenol 3, had physiotherapy, had tried Percocet, was on a Fentanyl Patch and was receiving paravertebral bloc injections. Dr. Gofeld wrote: "However, even with that he was unable to resume his work and enjoy physical activities." He further stated: "Nearly everything exacerbates the pain, including standing, sitting and walking". On examination, SLR test was positive for back pain. He noted that the low back was markedly discolored and skin fragile secondary to prolonged use of a heating pad. He found fairly diffuse tenderness starting at L2 to L5 both midline and bilaterally. He reported that the MRI showed L1-2, L2-3 degenerative disc disease with Modic type 2 anterior endplate changes and L5-S1 degenerative disc disease with slight disc bulging. Under Impression, Dr. Gofeld noted co- morbidities including obesity and smoking. He stated he could not "exclude influences of being on insurance compensation from his manual labour" but added: "the patient seems to be genuine and motivated for a good outcome." He stated he would perform a diagnostic L2 dorsal root ganglion block as a first step in the diagnosis of the Appellant's pain, which he thought was discogenic.

[28] On February 9, 2010, Dr. Finkelstein, Diplomate, American Academy of Pain Management, Director, Toronto Headache and Pain Clinic, reported he saw the Appellant regarding his ongoing back complaints and Long-Term Disability claim. He described the March 16, 2005 injury in which the Appellant was sitting on a chair which broke, fell on his side and developed the immediate onset of low back pain, which he described as a stabbing

sensation with overall dull ache in the low back radiating into the right posterior thigh to knee. It was made worse with changes in weather, prolonged sitting, standing and walking. He could not sit or stand for longer than 30 minutes. Dr. Finkelstein noted the Appellant was off work for 3 years after the 2005 injury and had received Long-Term Disability. He stated the Appellant reported being "forced" back to work on a modified graduated scale. The Appellant reported working three days per week on light duties for about seven weeks. He would leave early or miss work because of the severity of his back pain. After several weeks, he returned to a full-time work schedule**.** He was unable to carry out the job demands, was fired by his employer and had not worked since. On examination, he had bilateral tenderness over the L4-5 and L5-S1 vertebrae. His S1 joints revealed bilateral tenderness. Palpation over the QL musculature revealed tenderness with associated spasm. Range of motion testing revealed limited flexion due to pain and limited extension. Dr. Finkelstein diagnosed: i) biomechanical derangement, lumbosacral spine; ii) disc bulging, L2-S1 with degenerative changes; iii) non- restorative sleep disorder; and iv) obesity. He stated: "This 32 year old gentleman has a long history of low back pain. His pain became worse after a fall at home. He complained of chronic and daily pain that has affected his ability to work and attend to his normal daily activities. His MRI revealed multiple disc bulges in the lumbar spine with associated degenerative changes." Dr. Finkelstein stated that despite extensive physical therapy, trials of medications and interventional management, the Appellant continued to have pain which was not adequately controlled. He further noted that WSIB FRP diagnosed him with "pain disorder associated with psychological factors and a general medical condition". Dr. Finkelstein stated the Appellant required psychological management in the form of cognitive behavioural therapy and coping strategies for his chronic pain condition. He indicated he did not believe the Appellant would benefit from Botulinum toxins and that the current pain management involving injections was not providing any long- term relief but was more palliative in nature. He suggested the Appellant might benefit from Nabilone, a synthetic cannabinoid. He stated: "In his present condition, I cannot see (the Appellant) holding down some form of gainful employment. Until such time that his pain is better controlled, he attends a weight loss clinic to lose a significant amount of weight and undergoes cognitive behavioural therapy, his chances of returning as a functioning member of society will be poor".

[29] On February 16, 2010, Dr. Aldridge, reported that the Appellant had low back pain for 5 years after falling out of a chair. The following day, the Appellant experienced back pain which has been a "constant phenomenon" since then. The Appellant described his current pain as aching/burning/stabbing and 10/10 in intensity with radiation to the legs. It was aggravated with sitting more than 15-30 minutes, standing more than 10 minutes and walking more than one block. He was prescribed Tylenol 3, Elavil, Baclofen and Fentanyl 100 mcg every 3 days. Dr. Aldridge stated he had followed the Appellant for the past 28 months on a weekly basis for neural blockade which provided significant but transient relief for the back pain. He noted the Appellant had received physiotherapy which provided transient pain relief. Dr. Aldridge further noted the Appellant last worked in 2007 before which he had been off work for 3 years. He returned to work in a modified capacity for 7 weeks. He was then required to return to his usual duties including lifting between 6-65 lbs. of sheet metal on a regular and repetitive basis. According to Dr. Aldridge, the Appellant explained he was unable to function due to his low back pain. As a result, his position was terminated. Dr. Aldridge reported that the Appellant was seen at Sunnybrook pain clinic by Dr. Gofeld, anesthesiologist, on April 7, 2008. The working diagnosis was lumbar discogenic pain. A pulse radiofrequency of the L2 dorsal root ganglion was performed on May 14, 2008 however, it failed to provide lasting back pain relief. Dr. Aldridge stated the Appellant "has had severe, constant low back pain symptomatology for the past 5 years. Over the course of time, the patient's pain has progressed in severity such that his occupational function has declined to the extent that he is no longer able to perform any of his duties, which would include those of a modified capacity." Dr. Aldridge noted he had closely followed the Appellant over the past 28 months and stated: "I can confidently state that (the Appellant) has made every attempt to address his pain and return to the workforce." He further stated: "In regard to the patient's physical status, it is my clinical opinion that it is extremely unlikely that (the Appellant) will be able to return to the workplace in the foreseeable future. His lumbar spine range of motion is significantly reduced; this impairment, not to mention the intensity of constant and severe pain, has a significant impact on a worker's ability to perform their daily functions." According to Dr. Aldridge, the Appellant met the Healthcare of Ontario Pension Plan (HOOPP) definition of total and permanent disability.

[30] On April 7, 2010, the Ministry of Community and Social Services notified the Appellant that he was found to be a person with a disability under the Ontario Disability Support Program Act (ODSP).

[31] On November 15, 2010, Dr. Bain, respirology, saw the Appellant in the sleep clinic due to unrefreshed sleep with excessive daytime sleepiness and feeling exhausted all day long. According to Dr. Bain, the Appellant had a high pretest likelihood of obstructive sleep apnea. He arranged an overnight polysomnography. On January 18, 2011, Dr. Bain reported that the Appellant's sleep study demonstrated moderate obstructive sleep apnea. He stated the Appellant would derive benefit from nasal CPAP. He noted, however, that chronic pain also contributed to his sleep problems and that it remained to be seen how much CPAP would reverse matters. On March 10, 2011, Dr. Bain indicated the Appellant adapted to CPAP fairly well. He felt there was subtle improvement in the Appellant's sleep consolidation and variable improvement in restfulness of his sleep and daytime well-being.

[32] On February 7, 2013, David Antflick, Registered Rehabilitation Professional Vocational Evaluation Specialist, issued a Vocational Assessment in which he described the Appellant's status including his potential future earning capacity as a consequence of the accident. He indicated he reviewed the medical file, interviewed the Appellant and administered vocational tests. Mr. Antflick's summary of the file included a review of the following reports and information:

- On February 17, 2007, Standard Life decided to decline Long-Term disability benefits as of September 19, 2007;

- A March 2007 MRI of the back confirmed: "Spondylitic changes of the lumbar spine … At the L5-S1 level disc material does appear to abut the right S1 nerve root";

- In April 2007, Dr. Wiley thought that an interpretation of the Appellant's symptoms as not having an organic basis was not acceptable. He indicated that an MRI confirmed that the probable level of the disc lesion was at L4-L5 and L5-S1;

- In April 2007, the Appellant was discharged from therapy at CBI. On discharge, it was noted that he reported pain and fatigue and was often a reluctant participant due to pain and fatigue. A report to Standard Life indicated he had reduced range of motion limited by pain and required a cane for ambulation and balance. He could sit for an hour and stand for 25 minutes. The report did not clear him for any form of employment;

- In April 2007, due to pain the Appellant was unable to complete several phases of an FAE evaluation conducted by Mobile Assessment Centre at the request of the insurer;

- Around the same time, Dr. Axler indicated the Appellant had limitations involving prolonged sitting and standing and was restricted with respect to bending, twisting and lifting;

- On June 20, 2007, Dr. Lexier concluded the Appellant was capable of participating in a gradual return to work rehabilitation program and diagnosed mechanical low back pain secondary to degenerative disc disease. He also indicated the Appellant reached his "pre injury functional level and could return to his full duties as a CNC punch press operator. He noted, however, that the Appellant was on numerous medications, that his low back pain was always present and that he used a cane;

- On July 11, 2007, Standard Life informed the Appellant there were no medical contraindication preventing him from participating in a RTW program and returning to his position as a CNC operator;

- A graduated return to work plan was devised by the insurer and employer. On September 14, 2007, the Appellant was given the option of returning to the workplace on a Return to Work (RTW) modified program or told his benefits would be terminated. The RTW program started with reduced hours. Each week increased hourly attendance by one hour. He worked in modified duties, sitting and deburring parts for about 7 weeks gradually building up his hours

and duties. Mr. Antflick wrote: “He all the while was on opioid medications to relieve him from his pain, which made him drowsy and intoxicated. He also had no medical support during his work trial. He struggled to maintain his modified employment and told me he often complained of his difficulties to his superiors but his complaints went unheeded. In his work trial he left work early 5 times early in September 2007 and twice in October due to pain. He also failed to report to work on three days because he called in sick. On September 15 he apparently left work without informing anyone.”;

- “After 7 weeks of working and barely enduring his pain, his employer and insurer wanted him to go back to his CNC job, which he could not do. He required therapy during his work trial and he wondered how much pain he had to endure to keep his job and how he would be able to do his CNC job without further harming himself while taking opioid medications.”;

- On September 24, 2007, Dr. Kraemer opined it was doubtful he would be able to continue with his work and would likely need to go to permanent modified work or be retrained to a sedentary occupation;

- By October 12, 2007, Dr. Aldridge thought he had a lumbar facet joint syndrome, sacroiliac irritation and piriformis muscle spasm (myofascial pain). He recommended a trial of nerve blocks and resumption of other therapies and long- acting opioids. He did not feel the Appellant would be able to return to his former job in the foreseeable future;

- From September 14, 2007 to November 10, 2007, he worked as a turret operator. On November 2, 2007, he informed his employer that due to low back pain, he was incapable of performing his essential duties of a CNC Punch Press Operator. He was terminated effective November 2, 2007;

- On December 5, 2007, Dr. Aldridge declared the Appellant was unable to work due to severity of his back pain and would not be able to return to his former job for the foreseeable future. In April 2008, Dr. Gofeld thought he

had several comorbidities that required attention and provided steroid injections which did not provide permanent relief. In November 2008, Dr. Shapero provided one lumbar facet diagnostic nerve block. It was negative, which suggested that the low back pain did not stem from the lumbar facet joints;

- On June 1, 2009, the Appellant was accepted as a person with a disability under the ODSP. In February 2010, Dr. Finkelstein, Toronto Headache and Pain Clinic, indicated he could not see the Appellant holding down gainful employment;

- On February 16, 2010, Dr. Aldridge indicated he thought it extremely unlikely the Appellant would be able to return to the workplace in the foreseeable future. He thought he met the HOOPP definition of being totally and permanently disabled.

[33] According to Mr. Antflick, there was compelling medical evidence to support the opinion that because of the accident, the Appellant suffered from significant injuries to important body parts needed to execute his essential employment tasks and which precluded a return to functioning in his pre-accident way. Mr. Antflick stated the Appellant had returned to "non- medically sanctioned" modified duties (deburring) but when the program was completed, he was directed back to his pre-accident operator's work. Because of pain, he could not meet his employer's hourly or production expectations and was immediately terminated. According to Mr. Antflick, given the Appellant's impairments as cited by his treating doctors and chronic pain, he was not able to accomplish the essential physical tasks of his pre- accident employment and any employment suited to his education, training and experience. Mr. Antflick noted Dr. Aldridge and Dr. Finkelstein opined that the Appellant was unable to perform the essential activities of any employment. According to Mr. Antflick, the Appellant could not meet a reasonable employer's expectations in terms of hours or productivity in employment that was suited to his education, training and experience. He stated the Appellant has no unique skills or educational accomplishments needed for alternate occupations within his capability and that his current academic test results demonstrate comparatively weak academic skills, insufficient for

immediate college level programming without upgrading. In his opinion, the Appellant continued to suffer from a substantial impairment in his day-to- day activities and ability to work. His prognosis for return to work continued to be extremely poor given the chronicity of his pain symptoms, functional impairment, lack of treatment, extraordinary use of opioid medications and general unreliability. He further opined that a return to school with his pain and various physical and psychological changes would be an "impossible endeavor." He noted the Appellant had not attended school in many years and experiences interfering pain, functional limitations and psychological issues daily that affect concentration and focus as well as fatigue commonly experienced with long-term use of opioid medication. He further noted that forward flexion and prolonged sitting required to peer into a computer screen would place the Appellant at a large disadvantage.

[34] On August 21, 2013, Dr. Aldridge completed a medical legal evaluation report. He provided a detailed history and set out a diagnostic impression of Chronic Pain Disorder associated with a general medical condition and psychological factors. He stated that as "the painful symptoms have persisted for 8 years, in my clinical opinion, the Appellant will have permanent chronic pain and significant and permanent occupational impairment to work in his chosen profession at pre-disability levels." He indicated the Appellant's functional ability had declined evidenced by his inability to complete the graduated return to work program in 2007.

Oral Testimony

[35] LTD sent him back to work. He still had pain. He had numerous days he took so much pain medication he could not do more, safely be in the shop or get home. The employer sat him in the furthest area of the shop and got mad at him when it took him too long to return to his work station after break or lunch. His duties consisted of sitting in a chair, getting up, grabbing some metal parts, sitting down and filing them. He never achieved his target. He got "flak" for not working fast enough.

[36] The modified work did not prepare him to return to his former job as a punch press operator, which involved lift large pieces of metal. He would only file small pieces of metal. The modified job was never offered on a permanent basis. Even if it were offered, he could not perform the job duties due to the demands of sitting and walking. Due to pain, his attendance

would also be unreliable. As an example of his unreliability, he explained he intended to arrive at the hearing at 8:30 am. However, his pain slowed him down getting dressed and getting to the hearing. He arrived at 9:50 am. On some days, his pain is so bad he cannot get out of bed or go to the bathroom. This can happen at least 2-3 days weekly. Between winter and summer and summer and winter, he is in high levels of pain and is unable to do anything. He sits in bed and tries to read or watch TV.

[37] Since 2005, he does not feel he could work. His pain feels like a "clenching" in his back. It can travel down his buttock. He experiences constant numbing pain. If he walks or sits, he feels the pain going down his left leg above the knee and to the back of the leg. He has fallen on occasion after his leg has given out due to pain. Therefore, he has used a cane since 2005. His pain is the same now as it was in 2005. On a good day, his pain is 7 out of 10; on a bad day, the pain is 10 out of 10. He gets bad days quite a bit. He spends his time reading or watching TV.

[38] He had a girlfriend. The relationship recently ended. She was his "lifeline". She helped him to shower, wash and shave. He felt humiliated and frustrated relying on others. He would prefer to work. He cannot wash his clothes or cook his meals. He lives with his mother. She helps him to get food. He had hoped to have a house and family by now. His future holds more of the same.

[39] His opioid medication was discontinued after he started taking larger and larger quantities just to get to sleep at night. He tried to overdose a few times because he was constantly depressed. He became frustrated being in pain all the time with no break. Since his medication was discontinued, he uses more heat, Tens and recumbency to manage his pain. Surgery was ruled out due to risk.

[40] He used to receive nerve block injections but they stopped working. He tries to stay away from Acetaminophen.

[41] When he returned to modified work in or around September 2007, he started working 3 hours daily. Each week his hours would increase by one hour until he was working 11 and one half hours per shift. He would work every Friday, Saturday and Sunday. He would drive to work which was about 15 minutes away. He would have to get up about once every 10-15

minutes and walk approximately 10 feet to get metal parts to deburr. He would carry what he could. The metal parts would weight approximately 5 lbs. He would sit while deburring. The sitting caused pain. The act of deburring itself did not cause pain. However, walking, sitting, and stooping over to get parts added to his pain. Even if the job only involved sitting, he does not feel he could have managed due to pain caused by sitting. After sitting 15 minutes, his back pain would increase. No one ever offered him modified work involving just sitting.

[42] He agrees with Mr. Antflick's summary of his attendance and absence from modified work: he left work 5 times early in September and twice in October due to pain. He recalls calling in sick. However, he does not recall leaving work on one occasion without informing his supervisor. He does not believe he ever completed an entire weekend shift due to pain.

[43] During modified work, he was on opioid medication (long-acting) T3s, Percocets and muscle relaxants. They had side-effects. One medication caused him to have serious mood swings (Amitriptyline). He had poor energy and was fatigued. He would go into work feeling tired. He complained to his supervisors about being in constant pain and having to get up to get parts. They yelled at him about how long it took him to walk to and from the bathroom. He complained about having to sit in the farthest area of the shop. He did not meet his target deburring pieces of metal.

[44] At the start of November 2007, the employer told him to run a punch press. He said he could not do so as the metal sheets were too heavy. He was also tired from not getting a good night’s sleep and was on opioid medication, which meant that running a machine would be dangerous. They took him to HR which told him to get a note from his doctor. He was terminated while he was getting the note.

[45] At the MQP, he was living at his mother’s home. He can drive between one-half hour and 45 minutes. However, he does not drive often. He takes his mother to go grocery shopping. The grocery store is approximately 3 minutes away from where they reside. While she does the shopping, he sits in the car or stretches out in the back of the van. He does not walk the grocery store aisles as doing so would increase his pain.

[46] His mother or girlfriend would make his meals. He cannot stand or sit and cook. They would also do his laundry. He cannot bend to load/unload the machines. His girlfriend would do his cleaning as he could not bend or stand.

[47] He has had to give up hobbies such as fishing, playing softball, pool, and playing bass guitar. The guitar is too heavy to lift and place on his lap. He could not play for long while seated due to pain.

[48] He currently sees Dr. Truscott, family physician, who replaced Dr. Axler who retired. He has not seen Dr. Aldridge since his opioid medication was discontinued.

[49] Between the MQP and today, there is no job he could perform consistently. He does not know how he will be day-to- day. His pain caused him to arrive late at the hearing today. He could not manage retraining for the same reason.

[50] He completed Grade 12 and one year of a college carpentry construction skills program. He was hired right out of college. At first, he grinded metal and then worked as a general laborer. He worked his way up to punch press operator.

[51] If he was not on opioid medication, he could not have performed the modified work. Without opioid medication, he could not perform similar work. Things are worse now because he is not taking medication which helps take the edge off the pain.

[52] He currently gets around 3-4 hours sleep a night if lucky. At the time of modified work, due to the opioids he would get drowsy and sleep.

[53] He had an overdose attempt this past November or December. He did not discuss it with his doctors. He has since given some thought about discussing it with them.

[54] The Appellant showed the Tribunal his exposed back. It is covered with mottled brownish marks over the entire bottom half. The marks appear blotchy and brown and have the appearance of scars and abrasions. They are caused by the heating pad.

SUBMISSIONS

[55] The Appellant submitted that he qualifies for a disability pension because:

a) He has been severely disabled since March 16, 2005.

b) He qualified for short-term and long-term disability benefits from his workplace disability insurer and was accepted as a person with a disability by ODSP on June 1, 2009.

c) He first applied for CPP disability benefits based on severe, chronic back pain, knee pain and fatigue following the March 2005 incident where he sustained a low back injury after falling off a chair. He was gainfully employed full-time as a CNC Punch Press operator between 1999 and the date of injury. He received long- term disability benefits until September 18, 2007. During that time, he remained under medical care and required ongoing use of Tylenol with Codeine, Percocet and Elavil.

d) A March 2007 MRI confirmed spondylitic changes of the lumbar spine. Disc material appeared to abut the right S1 nerve root at L5-S1. In April 2007, his treating orthopedic surgeon confirmed that his ongoing and significant symptoms had an organic basis and that surgery may be mandated.

e) He participated in a rehabilitation program administered by the CBI in April 2007. He was noted to be a reluctant participant due to reported low back pain, knee pain and fatigue due to poor sleep. On discharge, he demonstrated reduced range of motion limited by pain, continued to require a cane and continued to be dependent on his family for meal preparation and household tasks. He could sit for an hour but was dependent on a heating pad. He could stand for approximately 25 minutes but was not cleared to return to any form of employment. An attempted return to work on light duties in September 2007 was unsuccessful. He was terminated from his position in November 2007.

f) Dr. Lexier, retained by the LTD insurer, confirmed in his June 2007 report that the Appellant suffers from mechanical back pain secondary to degenerative disc disease;

was consuming between 3 and 30 Tylenol 3 a week, 10 Percocet a month and 4 Amitriptyline every night; ambulates with a cane; has a scar to his back from using a heating pad; gained 54.5 lbs. since the onset of disability and has low back pain daily.

g) In his February 16, 2010 report, Dr. Aldridge, the treating Pain Management Specialist, reported that the Appellant has had severe constant low back pain symptomatology for the past 5 years. On February 9, 2010, Dr. Finkelstein, Director, Toronto Headache and Pain Clinic and Specialist in Pain Management, diagnosed biomechanical derangement lumbosacral spine, disc bulging L2-S1 with degenerative changes, non-restorative sleep disorder and obesity. Dr. Bain, respirology, reported on the Appellant's non-restorative sleep and indicated that his chronic pain contributed to his sleep problems.

h) This is a "textbook" chronic pain case with recognizable underlying pathology detailed in an MRI which reveals significant disc degeneration and possible nerve abutment. The Appellant was vulnerable to the effects of the fall.

i) His chronic pain is unremitting. He has poor sleep hygiene and he has required significant consumption of opioid medications taken orally, by injection and by patch. By the end of 2013/start of 2014, Dr. Aldridge tapered him off his opioid medication to which he developed an addiction. He has been off those medications since 2014 and has not been able to utilize medication for pain mediation. He relies on a heating pad, which has scarred his back, hot baths, rest and remaining sedentary. He has gained over 100 lbs. (357 lbs. currently) which creates a vicious cycle of impairment. He cannot exercise which creates additional weight. This has largely been his circumstance since 2005.

j) His return to work was problematic as it was a plan conceived between the insurer and employer without input from medical or otherwise appropriately trained professionals. It was not a legitimate return to work plan. A position was created for him. He was placed in a small room and given small metal bits with edges which he had to sand (deburr). This was a way to pass time. There was no retraining or attempt to find a modified job for him until the seven weeks were up at which time he was told to return to his punch press.

k) Six months before the termination of benefits, the insurer told the Appellant that six months later, they would terminate his benefits, i.e., a presumptive denial.

l) Between 2005 and 2007, the Appellant was entirely reliant on his LTD insurer for funds, treatment, restoration of function, attendance at chronic pain programs and vocational retraining.

m) He did not try to return to work due to his chronic pain state. He cannot work on a consistent and reliable basis. Some days are better than others but his situation is unreliable and unpredictable. This makes him unemployable. No employer will take him on based on an "if and when" basis. His reliance on opium medications also disabled him. In combination, they had a devastating impact.

n) He presents with intense constant low back pain which radiates down the leg on walking.

o) Dr. Soroc, a defence oriented physiatrist, saw the Appellant in 2006 after the insurer denied short- term benefits. She concluded he was falling into a chronic pain state. Activity such as walking and sitting would exacerbate the pain. Heat and recumbency would alleviate pain as would medication on a temporary basis. She noted he gained weight and that attempts at therapeutic exercise precipitated more pain. She detected significant discoloration in his lumbar region due to use of a heating pad. On examination, he could barely forward flex. Lumbar extension was almost non-existent and lateral flexion was restricted. The limiting factor was back pain. She concluded he would probably fail if he resumed work at that time and expressed concern he was developing chronic pain. She recommended psychological evaluation and course of psychotherapy with emphasis on behavioural modification, none of which was implemented by the disability insurer.

p) In August 2005, Dr. Godfrey, physiatrist, saw the Appellant and recommended a CT scan. He stated the Appellant had back pain made worse by activity and could not sleep at night.

q) The Respondent appears to accept that the Appellant's condition deteriorated after the MQP. However, the medical records support a finding his condition became severe after the 2005 and prior to the MQP. Before the fall, he was working and doing well. There is no period he was not disabled after the fall.

r) Some assessors took the approach if he became more active and lost weight, he could return to work. They did not comment on the disabling nature of pain or horrible side-effects of long- term use of opioid medication.

s) He cannot do retraining until his pain is first properly managed and he obtains sleep restoration. The TWH FRP has been mischaracterized as something designed to return him to work. It was designed to assist with improving pain management, quality of life and possible vocational redirection. It was not a Work Hardening Program. His pain has not been successfully managed and the effects of opioids left him unable to function.

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

a) According to the family physician's April 2008 report, he injured his lower back in March 2005. This left him with ongoing back pain, decreased range of movement in the lower back and limitations with prolonged sitting/standing/walking. Although these limitations would certainly interfere with some types of work, CPP considers the ability to perform all forms of employment, be it full-time or part-time.

b) In June 2007, an orthopaedic surgeon reported that there were no medical contraindications due to the back condition that would prevent a gradual return to work.

c) Another orthopaedic surgeon noted in September 2007 that he attempted a return to work, however, due to heavy lifting and walking, his back pain worsened. The most recent MRI of the lower spine did not identify a disc herniation or pressure on the spinal nerves. The specialist recommended permanent modified

work or retraining for a sedentary occupation. There is no information on file to indicate attempts at other less physical or sedentary types of work.

d) His pain management physician noted in January 2008 that he had reported excellent pain relief for 5 to 6 day after the nerve blocks but had not been able to return to his previous work place. It was suggested that a career change be made to a field that did not require lifting. This does not support a severe condition that prevents all forms of work at the MQP.

ANALYSIS

[57] The Appellant must prove on a balance of probabilities that he had a severe and prolonged disability on or before the MQP.

Severe

[58] A number of reports in the medical record state or imply that the Appellant retained residual capacity to perform light work. They include the following:

(i) September 13, 2006 TWH FRP Discharge Summary and Recommendations indicating that the Appellant demonstrated ability to perform activities at a level that would be classified as within the "limited" physical demand level as defined by the NOC physical demands level.

(ii) June 18, 2007 report of Dr. Lexier, orthopedic surgeon, who reported that the Appellant achieved his pre-injury functional level and did not demonstrate any restrictions. Dr. Lexier stated he would not impose any limitations with respect to the Appellant's daily activities and ability to work in his pre-disability job capacity.

(iii) September 24, 2007 report of Dr. Kraemer, orthopedic surgeon, who indicated that the Appellant's back-dominant low back pain, is exacerbated by heavy labour work and that he would likely need to go to permanent modified work or be retrained for a sedentary occupation.

(iv) January 9, 2008 report of Dr. Aldridge, stating that in his clinical opinion, the Appellant would not be able to return to his former job in the foreseeable future. He recommended that the Appellant be sent for career retraining in a field that involves no lifting of any sort, i.e. sedentary work, etc.

[59] Upon careful consideration of the above reports and medical record as a whole, the Tribunal is not satisfied the Appellant was capable regularly of pursuing any substantially gainful occupation on or before the MQP.

[60] In terms of the September 13, 2006 TWH FRP report, although the Report assessors stated the Appellant met the "limited" physical demands level as defined by the NOC physical demands level, they also set out the following permanent functional precaution or restriction: have the ability to alternate between sitting, standing or walking as needed.

[61] The Tribunal interprets Paragraph 42(2)(a) of the CPP as being concerned with the capacity of an applicant to work in a meaningful and competitive work environment and finds the comment of the Pensions Appeal Board (PAB) in *L.F. v. MHRSD* (October 5, 2010, CP 26809 (PAB) relevant to the facts of this case, where the PAB stated:

> It cannot be said to be a meaningful and competitive environment where an employer may have to make accommodations, as is the case of the Appellant, by creating a flexible work environment to enable him to have a job that he would not otherwise be able to perform in a normal competitive work environment and to put up with occasional absences from work.

[62] On the facts of this case, the Tribunal finds that any prospective employer would have to create a flexible work environment to accommodate the Appellant's functional restrictions which require him to retain the ability to alternate between sitting, standing and walking as needed.

[63] The Tribunal has also considered the Appellant's requirement of frequent positional change in the context of a "real world" analysis as required by the Federal Court of Appeal decision of *Villani v. Canada (Attorney General)*, 2001 FCA 248 (CanLii), [2002] 1 F. C.

Malone J.A addressed this requirement *in Garrett v. Canada (Minister of Human Resources Development*), 2005 FCA 84 (CanLii) as follows:

> [2] Subparagraph 42(2)(*a*)(*i*) of the Plan requires the person to be "incapable regularly of pursuing any substantially gainful occupation." Isaac J.A. in *Villani v. Canada (Attorney General)*, 2001 FCA 248 (CanLII), [2002] 1 F.C. 130, considered these words and concluded at paragraph 38 as follows:
>
> This analysis of subparagraph 42(2)(*a*)(*i*) strongly suggests a legislative intention to apply the severity requirement in a "real world" context. Requiring that an applicant be incapable regularly of pursuing any substantially gainful occupation is quite different from requiring that an applicant be incapable at all times of pursuing any conceivable occupation. Each word in the subparagraph must be given meaning and when read in that way the subparagraph indicates, in my opinion, that Parliament viewed as severe any disability which renders an applicant incapable of pursuing with consistent frequency any truly remunerative occupation. In my view, it follows from this that the hypothetical occupations which a decision-maker must consider cannot be divorced from the particular circumstances of the applicant, such as age, education level, language proficiency and past work and life experience. [Emphasis in original]
>
> In the present case, the majority failed to cite the Villani decision or conduct their analysis in accordance with its principles. This is an error of law. In particular, the majority failed to mention evidence that the applicant's mobility problems were aggravated by fatigue and that she would have to alternate sitting and standing; factors which could effectively make her performance of a sedentary office or related job problematic. This is the 'real world' context of the analysis required by Villani.

[64] The Tribunal is satisfied that the Appellant's restrictions affecting prolonged sitting and need for frequent positional change, would make his performance of sedentary work "problematic" if not improbable.

[65] The Tribunal has also carefully reviewed the June 18, 2007 report of Dr. Lexier, orthopedic surgeon. Although Dr. Lexier did not find any medical contraindications that would prevent a gradual return to work, he did, however, diagnose mechanical back pain secondary to degenerative disc disease. He noted the Appellant was consuming between 3 and 30 Tylenol 3 weekly, 10 Percocet's a month and 4 Amitriptyline every night. He further noted the Appellant ambulated with a cane.

[66] The Tribunal is satisfied the Appellant's significant pain, which has required heavy dosages of strong opioid analgesics, constitutes evidence of a medical contraindication which would prevent a gradual return to work, let alone a return to his previous job as contended by Dr. Lexier. Also, in his August 21, 2013 report, Dr. Aldridge, who has greater familiarity than Dr. Lexier with the Appellant's ongoing condition, raised concerns about Dr. Lexier's findings, which the Tribunal accepts call into question Dr. Lexier's conclusions. In terms of Dr. Lexier's opinion that the Appellant had no restrictions with respect to his daily activities and ability to work in his pre-disability occupation. Dr. Aldridge stated: "I do not understand how this conclusion was arrived at, considering the extremely poor results obtained at the time of discharge from the functional restoration program on September 13, 2006. Specifically, the patient was classified at the "limited demand" physical level … Considering the physically demanding nature of his occupation, requesting that (the Appellant) return to his regular work duties at this point in time was not fair to the patient and extremely likely to result in failure (as it did)".

[67] The Tribunal also carefully considered Dr. Kraemer's September 24, 2007 report. Although Dr. Kraemer stated that the Appellant could not return to his former job in the foreseeable future (which opinion, the Tribunal notes, further calls into question Dr. Lexier's conclusion), he stated he would likely need to go to permanent modified work or be retrained for a sedentary occupation. Dr. Kraemer concluded his report stating: "With regarding to his recreational activities, he has not been able to resume playing his base guitar due to the sitting and standing limitations." The Tribunal finds this comment significant. To the extent the Appellant was unable to pursue recreational guitar playing at home due to sitting/standing limitations, this raises a very real issue in the Tribunal's mind as to his capacity regularly to pursue any substantially gainful occupation in the competitive labour market.

[68] Although Dr. Aldridge suggested the Appellant might be considered for career retraining in a field that did not involve any lifting, the Tribunal is satisfied the medical record supports a finding the Appellant has significant limitations involving prolonged sitting. In his October 11, 2005 report, Dr. Godfrey indicated that the Appellant had pain when sitting for any length of time. On July 13, 2006, TWH, FRP issued its Multidisciplinary Initial Assessment. Their diagnostic impression was that of a pain disorder associated with psychological factors

and a general medical condition and nonspecific low back pain. As previously noted in the Discharge Summary and Recommendations, TWH FRP noted the following permanent functional precaution in terms of future employment: the ability to alternate between sitting, standing or walking as needed. They further indicated the Appellant continued to meet the DSM IV criteria for the Axis 1 clinical problem of a Pain Disorder Associated with both psychological factors and a general medical condition. According to the CBI January 12, 2007 interim report, the Appellant demonstrated 10 minutes of continuous sitting and reported he was able to sit up to 1 hour at a time at home. In CBI's April 18, 2007 Discharge Report, they noted the Appellant reported he was able to sit for more than one hour on his chair at home with use of a heating pad. He was encouraged to use heat up to 20 minutes only and continue "attempting progression of his sitting tolerance". As previously noted, Dr. Kraemer raised a red flag concerning the Appellant's sitting (and standing) capacity in relation to recreational guitar playing.

[69] The Tribunal has also considered the Appellant's actual modified work experience in assessing his capacity to perform sedentary work. In his October 12, 2007 report, Dr. Aldridge reported that the Appellant's back pain was aggravated with sitting longer than two hours. He noted the Appellant was taking Tylenol 3, 4 to 8 tablets daily and Percocet, 2 to 4 tablets daily while at work. According to Dr. Aldridge, Tylenol 3 and Percocet reduced the Appellant's pain by 50 to 60%. Dr. Aldridge stated that the Appellant became sedated when taking these medications. He wrote: "Significantly, he takes a lot more opioids while he is working compared to at when he is at home". In his February 9, 2010 report, Dr. Finkelstein reported that the Appellant reported he was "forced" back to work in 2008 (query 2007) on modified graduated scale and that for about seven weeks, he worked three days per week on light duties. He would have to leave early or miss work because of the severity of his back pain. In his February 7, 2013 report, David Antflick, Registered Rehabilitation Professional Vocational Evaluation Specialist, reported, based on his review of the file, that the Appellant was on opioid medication to relieve him from his pain while he performed modified work. They made him drowsy and intoxicated. According to Mr. Antflick, the Appellant advised him that he struggled to maintain his modified employment and complained of his difficulties to his superiors. During the work trial, he left work early 5 times in early in September 2007 and twice in October due to

pain. He also failed to report to work on 3 days because he called in sick. On September 15, he apparently left work without informing anyone.

[70] The Appellant testified that while performing modified duties he would experience back pain after sitting for 15 minutes. Although having to get up, stooping to pick up small metal parts and carrying them back to his work station also aggravated his pain, the Tribunal accepts that sitting was among the core activities which aggravated his back pain.

[71] The Tribunal is satisfied the Appellant does not possess residual capacity to perform modified sedentary work. He was only able to perform modified light work in the fall of 2007 upon consuming significant opioid analgesics to manage his pain. Even then, he had to leave work early and was absent due to his pain.

[72] In conclusion on this point, the medical record and Appellant's evidence support a finding the Appellant has significant restrictions involving prolonged sitting, which the Tribunal finds rules out most, if not all, sedentary work in the competitive labour market.

[73] The Tribunal has also considered the Appellant's broader impairment and real world factors for the purpose of concluding his disability is severe as defined in the CPP. As noted by Mr. Antflick, a return to school, given his pain and various physical and psychological challenges, would be an "impossible endeavor". His pain, functional limitations and psychological issues would affect concentration and focus. He would have to contend with fatigue commonly experienced with long-term use of opioid medication. Although the Appellant testified he is now off opioid medication, he is even more reliant on heat, Tens and remaining recumbent to manage his pain. Mr. Antflick also noted that forward flexion and prolonged sitting which are required if peering into a computer screen, would place the Appellant at a "large disadvantage.

[74] The Tribunal is satisfied based on a careful review of the medical record and Appellant's testimony that he suffered the onset of a severe disability as of March 2005 following his home accident at which time he was rendered incapable regularly of pursuing his previous job and any other substantially gainful occupation.

Prolonged

[75] The Tribunal is satisfied that the Appellant suffered the onset of a prolonged disability in March 2005 when he sustained injury to his back falling off a chair. Since that time, despite receiving numerous treatments, therapy and medication as described in great detail in the medical record, he continues to suffer debilitating and intractable pain, which affects his function, including prolonged sitting, standing, and walking.

CONCLUSION

[76] The Tribunal finds that the Appellant had a severe and prolonged disability in March 2005, 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 May 2008; therefore the Appellant is deemed disabled in February 2007. According to section 69 of the CPP, payments start four months after the deemed date of disability. Payments will start as of June 2007.

[77] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security