Citation: ***A. P. v. Minister of Employment and Social Development*****, 2015 SSTGDIS 68**

Date: July 6, 2015

File number: GT-119301

GENERAL DIVISION - Income Security Section

Between:

A. 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 by Videoconference on May 26, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

A. P., the Appellant

Surinder Sangha, 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 March 2, 2011. 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 Videoconference for the following reasons:

a) Videoconferencing is available in the area where the Appellant lives

b) There are gaps in the information in the file and/or a need for clarification; and

c) 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.

Preliminary issues

Late Filed Documents (GT-7)

[3] This appeal was originally scheduled to be heard on January 6, 2015. The Appellant and her legal representative failed to attend the videoconference hearing scheduled for that day. The Tribunal Member (the "Member") requested Tribunal staff to contact the Appellant's legal representative to explain his and the Appellant's non-attendance. Initially, the legal representative stated he was unaware of the scheduled videoconference. The Tribunal employee advised the legal representative that the Notice of Hearing (the "Notice") was sent by registered

mail to his address and that someone in his office signed for it. He then indicated he was sick all week, had been unable to participate and asked if the matter could be rescheduled.

[4] On January 7, 2015, the Tribunal Case Management Officer (CMO) advised the legal representative he needed to submit an adjournment request in writing to the Tribunal. On January 16, 2015, the legal representative submitted a written adjournment request stating he was mistaken about the hearing date which he thought was January 16, 2015. He asked that his client not be prejudiced by his mistake.

[5] On January 23, 2015, the Tribunal granted an adjournment and sent the parties Notice which set a new hearing date of May 26, 2015. The Tribunal also set a revised Filing Period of March 27, 2015 and Response Period of April 27, 2015.

[6] On April 17th, 2015, the legal representative sent the Tribunal a submission with attached medical reports. On April 21, 2015, the Tribunal returned the submission and documents to the legal representative because the materials contained documents unrelated to the Appellant's appeal. He was asked to resend the information he intended the Tribunal to receive.

[7] On May 14, 2015, the Appellant refiled a submission with enclosures with the Tribunal. Once again, the enclosures contained documents unrelated to the Appellant's case. Therefore, on May 21, 2015, the Tribunal resent the documents to the legal representative and again asked him to resend the information he intended the Tribunal to receive.

[8] On May 23, 2015, the legal representative resent a submission with enclosures to the Tribunal (GT-7). On May 25, 2015, a copy of GT-7 was shared with the Respondent.

[9] At the start of the hearing, the Tribunal advised the legal representative that the revised Filing Period to submit documents with the Tribunal was March 27, 2015. Even taking into account the legal representative's previous efforts on April 17, 2015 and May 14, 2015 to file his submission with enclosures with the Tribunal, he attempted to file them after the revised March 27, 2015 Filing Period had expired. The legal representative submitted that his client should not suffer the consequences of his mistake. The Tribunal indicated it would reserve its decision on admissibility and provide the Respondent with an opportunity to make submissions on the admissibility and contents of GT-7.

[10] On May 29, 2015, the Tribunal sent a copy of GT-7 to the Respondent and stipulated that if the hearing had to be continued to deal with the Respondent's submissions, it would be reconvened by teleconference. If no further evidence was required, the Tribunal would proceed to complete its decision upon receipt of submissions, if any, from the Respondent.

[11] On June 9, 2015, the Respondent prepared an Addendum Submission, which it sent to the Tribunal. It took the position the additional evidence labelled GT-7 does not support a determination that the Appellant was disabled on or before the MQP.

[12] The Tribunal exercised its discretion to admit GT-7 into evidence given i) the relevance of the documents to the issue before it and ii) the absence of any prejudice to the Respondent, which reviewed and provided submissions on its contents.

Contents of GT3

[13] On November 5, 2014, the legal representative filed an earlier written submission with enclosures consisting of medical reports and clinical notes. (GT3). Throughout the submission, the legal representative summarized or quoted from various medical documents which were purportedly contained under various Tabs. However, the submission did not include any Tabs and did not appear to contain many of the reports quoted from or summarized in the submission.

[14] On December 17, 2014, the Tribunal sent the legal representative a letter which stated the following:

> For ease of facility on the part of the Tribunal and parties in locating the referenced materials throughout the Written Submission, the Tribunal requests that the legal representative provide the GT page numbers at which the various documents referenced in the Appellant's Written Submissions are found.
>
> Please provide the requested information by January 2, 2015.

[15] The legal representative did not provide the Tribunal with the requested information on or before the January 2, 2015 deadline. As previously noted, he failed to attend the January 6, 2015 hearing and requested an adjournment, which the Tribunal granted with a revised Filing

Period. He also failed to provide the requested information on or before the revised Filing Period.

[16] At the onset of the hearing, the Tribunal asked the legal representative to identify the precise GT page number location of every report he referenced and quoted from in the body of his submission. The Tribunal explained to the legal representative that his quotations from or summaries of reports not filed into evidence do not constitute evidence.

[17] The Tribunal spent approximately one and one-half hours reviewing the contents of GT3 with the legal representative while he attempted to identify and locate those reports he summarized and quoted from in his submission. The legal representative was repeatedly unable to locate numerous reports relied upon in his submission, which were never actually attached as enclosures to his submission and filed with the Tribunal.

[18] In conclusion on this point, given the legal representative's failure to file into evidence reports he relied upon in his submission, despite being provided ample opportunity to do so, the Tribunal's chronology of medical reports set out below does not include reference to those reports since they were not before the Tribunal.

THE LAW

[19] 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.

[20] 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).

[21] 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.

[22] 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

[23] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2011. However, the Appellant must be found to be disabled no later than November 30, 2011, the month prior to the month she started to receive her CPP Retirement pension.

[24] In this case, the Tribunal must decide if it is more likely than not that the Appellant had a severe and prolonged disability no later than November 30, 2011.

EVIDENCE

Documents

[25] In her Questionnaire dated February 24, 2011 for CPP Disability Benefits, the Appellant stated she stopped working on August 3, 2007 due to a motor vehicle accident (MVA). She experiences back pain, severe pain in her left leg, hypertension, severe allergies and asthma. She is limited in standing, walking, lifting and carrying. She is prescribed Oxycocet, Tylenol, Aleve, Adalat and nasal spray.

[26] The Appellant was born in 1950 and completed Grade 12. She attended Centennial College part-time. She obtained a certificate as a Health Care Aid. She worked between June 1986 and Aug 2007 as a Personal Support Worker (PSW).

[27] According to the Appellant's submission, she also held a part -time job working for O'Neil Center as a PSW for 17 years. She worked 67 hours every two weeks.

[28] In the CPP Medical Report dated December 17, 2010, Dr. Richards, family physician, diagnosed: i) OA - both knees right greater than left; ii) WAD (whiplash associated disorder) injured neck and back; iii) Spondylosis (lumbar spine and neck); iv) hypertension; v) asthma; and vi) multiple environmental allergies and drug allergies. Dr. Richards noted that the Appellant had right knee arthroscopy in November 2010. She stated the prognosis was guarded to poor.

[29] According to an August 4, 2007 Ambulance Call report, the Appellant was involved in an MVA. She complained of abrasion to her chest and left arm. An Emergency Record report of the same date referred to a burning sensation to the chest and burns to arms and chest noted.

[30] On September 14, 2007, Dr. Richards completed a Disability Certificate. She described WAD II neck and chest contusion. She indicated the Appellant was unable to perform the essential tasks of her employment at the time of accident but could return to work on modified hours and/or duties and estimated a time of early October 2007.

[31] On October 15, 2007, Dr. Deakon, orthopedic surgeon, examined the Appellant and stated:

> In summary, Ms. A. P. was involved in a high energy front end off-set impact on August 4, 2007. At that time she suffered a Whiplash Associated Disorder Grade II and lumbar myofascial strain. She has no evidence of neurological compromise in her upper or lower extremities. She is making a reasonable recovery from these injuries but has not yet reached maximal medical recovery. She continues to demonstrate some limitations of her cervical spine movement which are asymmetrical. She also has limited extension of her lumbar spine. I believe that Ms. A. P. is capable of returning to her full time employment on modified activities**.** A Functional Abilities Evaluation given valid effort is put forth would be of benefit in determining restrictions upon her return to her pre-accident employment activities. Ms. A. P. experiences ongoing difficulty with some of her housekeeping activities. I think she requires assistance for heavier

tasks and suggest this be quantified with an In-Home Occupational Therapy Assessment.

[32] According to a September 12, 2008 clinical note of Dr. Bodenstein, psychologist, the Appellant was not back at work as there was no accommodation. She had problems with her neck, back and knee and had bad allergies, which was why she could not take a lot of medications and shots. According to a September 19, 2008 clinical note, the Appellant would think about going back to work as she could not "last otherwise". She required a release from her doctor saying she was "ok" to return to work. An October 10, 2008 clinical note referred to her knee bothering her a lot.

[33] An October 15, 2008 MRI of the right knee revealed a suspected tear of the lateral meniscus. An October 8, 2008 cervical spine MRI revealed mild to moderate degenerative cervical spondylosis from C3-C7 and mild bilateral foraminal narrowing. A December 17, 2008 motor and sensory study was normal.

[34] In a November 28, 2008 clinical note, Dr. Bodenstein referred to the Appellant as being in pain and feeling so stiff she could not get out of bed. She was anxious because of her finances. She indicated her employer did not want to take her back at work including even modified duties because of liability reasons. According to a December 12, 2008 clinical note, the Appellant reported being extremely stressed because of creditors disturbing her. She indicated she was in a lot of pain. According to a January 2, 2009 clinical note, the Appellant was described as having difficulties and a lot of anxiety. She reported wanting to return to work but not being able to do so because no one was willing to insure her and take responsibility for her situation including light duties.

[35] On December 17, 2008, Dr. Chaiton, Dept of Clinical Neurophysiology, reported that the Appellant's motor and sensory studies were normal. A full recruitment and no neurogenic changes were seen in the muscle groups sampled.

[36] On January 8, 2009, Dr. Tountas, orthopedic surgeon, reported diffuse soreness of the right knee. Apart from the MRI showing degenerative change of the lateral meniscus, plain radiographs revealed chondral calcinosis with some early arthritic change to the lateral

compartment of the right knee. Dr. Tountas injected the knee with Depo-Medro. On January 21, 2009, he reported that the Appellant felt a little better with the injections.

[37] According to Dr. Bodenstein's February 19, 2009 clinical note, the Appellant had a Cortisone shot and started treatment. She also had a problem with a vein in the leg which was hit. She was feeling upset and pressured.

[38] A multidisplinary insurer's examination was completed in March 2009. It consisted of a physiatry (Dr. Boulias – February 27, 2009), psychology (Dr. Mackay C. Psych – March 2, 2009 not filed with the Tribunal) and orthopedic (Dr. Auguste – March 5, 2009) examination.

[39] According to Dr. Auguste, orthopaedic surgeon, the Appellant was involved in an earlier MVA in 1989 and suffered a right knee injury. Despite occasional achiness, she was able to work and carry out her activities. In August 2007, she was involved in another MVA. A few weeks later, she complained of left-sided neck pain, anterior chest wall pain, low back pain, right leg pain, right elbow pain and arm pain. She attended physiotherapy and chiropractic and did not return to work since the MVA due to the heavy nature of her work as a PSW. Dr. Auguste stated the Appellant presented with residual neck pain and ongoing right knee complaints. The Appellant reported that the majority of her injuries resolved with the exception of neck and right knee pain, which seemed to be getting worse, According to Dr. Auguste, the Appellant had impairment in prolonged walking, prolonged standing and heavy lifting as a result of her right knee injury and WAD II cervical strain/sprain. She had pain, hyptertonicity and stiffness in the left trapezius and left paraspinal cervical muscles despite full range of motion and an intact neurovascular examination of the upper extremities. She also had a meniscus tear of the right knee. Dr. Auguste stated she understood the Appellant had a cortisone injection which provided partial relief but remained apprehensive about weigh bearing, carrying and lifting. Dr. Auguste did not believe the Appellant had yet reached maximum medical recovery. She described significant improvement in the neck symptoms but indicated the Appellant might require surgery for the meniscal tear. She suggested knee arthroscopy for lateral meniscectomy and ongoing massage, electrical stimulation and chiropractic for the WAD II cervical strain/sprain**.** She noted the Appellant had returned to her previous daily activities including housekeeping and home maintenance in addition to social activities. Dr. Auguste stated she did not believe the Appellant

was capable of performing her pre-accident employment. Given her knee condition, she could not perform heavy lifting/carrying. However, if she were offered modifications including no transfer of patients, pacing, load-splitting and frequent breaks, she could return to modified pre-accident employment.

[40] According to Dr. Boulias, physiatrist, who completed the physiatry component of the multidisciplinary insurer's examination in February 2009, the Appellant sustained soft tissue injuries to her cervical and lumbar spine following the MVA and developed lateral epicondylitis on the right. She also had spondylosis of the cervical spine, neck pain and meniscal tear of the right knee for which she required orthopedic treatment. Dr. Boulias stated the Appellant would have difficulty with her pre-accident employment given her internal derangement of the right knee. With respect to her lumbar spine, the she did not have an impairment that would render her substantially unable to perform the PSW job. She was also not substantially unable to perform her housekeeping tasks.

[41] According to a March 20, 2009 clinical note of Dr. Bodenstein, the Appellant was upset and anxious. According to a March 27, 2009 clinical note, she was depressed and confused and wanted to return to work. However she was not cleared by her doctor to do so. In an April 16, 2009 report, she indicated she had a lot of pain and felt extremely stressed. According to an April 24, 2009 clinical note, the Appellant looked a little better, her neck was better and her knee was better due to cortisone shots. She felt better and was considering a return to work. According to a June 12, 2009 clinical note, the Appellant indicated she had terrible pain when she was assessed. She stated that pain and the unresolved issue of surgery stopped her from returning to remunerative employment. On June 26, 2009, the Appellant reported doing better but that she still had pain in her knee and stomach. On July 8, 2009, she reported she had an appointment with a pain clinic. She indicated her knee had become worse and she could not put pressure on it. She was not taking cortisone shots.

[42] According to a May 29, 2009 IE Social Work Assessment Paper Review, the Appellant was facing a number of psychosocial stresses in the aftermath of the MVA. The assessor recommended that a social worker/psychologist be provided to the Appellant.

[43] On October 26, 2009, Dr. Best, neurologist, completed an Independent Neurological Assessment. He stated the Appellant had current complaints of neck pain present every day aggravated by neck movement, low back pain which was midline and "achy" in character with aggravating factors consisting of sitting and lifting, right knee pain, and nocturnal urgency. According to Dr. Best, the clinical examination was unremarkable from a neurological perspective. He diagnosed cervical sprain/strain, lumbar sprain/strain and right knee injury. According to Dr. Best the Appellant's difficulties were related to myofascial sprain/strain in the spine at both cervical and lumbar levels and orthopedic complaint involving the right knee. The examination was unremarkable from a neurological perspective. He noted that objectively, he did not find evidence to support any diagnosis which is not surprising as "one normally does not have objective evidence where myofascial sprain or strain are concerned." He stated her subjective complaints were consistent with the diagnosis and objective findings. He concluded there was no neurological basis for any disability resulting from the MVA to cause her to suffer substantial inability to perform the essential tasks of her previous job.

[44] According to a January 27, 2010 clinical note of Dr. Richards, the Appellant was approved for physiotherapy for the neck and back. Her right knee pain was reduced. A February 14, 2010 noted referred to swollen feet.

[45] On February 25, 2010, Dr. Hagen, surgeon, saw the Appellant concerning her gastrointestinal issues. He suspected irritable bowel syndrome and recommended a high fiber diet.

[46] According to a July 4, 2010 clinical note of Dr. Bodenstein, the Appellant was still in pain and could hardly walk sometimes. She was worried she might have lost her job as she never received clearance to return to work.

[47] A July 13, 2010 MRI of the spine revealed spondylosis. No significant disc herniation or definite nerve root impingement was identified. A July 20, 2010 right knee MRI confirmed a tear of the meniscus. An August 11, 2010 whole body bone scan was normal.

[48] According to a July 15, 2010 clinical note of Dr. Bodenstein, the Appellant had difficulties with her feet. She had an upcoming bone scan as preparation for possible knee

surgery. On July 21, 2010, she tried to get her doctor to give permission to return to work however the doctor refused. She was suffering pain in the back and left leg and sometimes could not stand or walk.

[49] According to an August 10, 2010 clinical note, Dr. Richards noted a complaint of musculoskeletal pain. In an August 16, 2010 clinical note, she indicated the Appellant complained of left anterior chest well.

[50] According to an August 11, 2010 clinical note of Dr. Bodenstein, the Appellant was dismissed from work. She had pain in her leg off and on. She was going to see a specialist about surgery. She was a little less depressed than before but was still worried.

[51] On August 23, 2010, Dr. Handelsman, rheumatology, diagnosed mild OA involving the lateral joint compartment of the right knee with a possible element of referred non-radicular pain involving the lower extremities arising from the low back. The Appellant indicated she could walk for about half an hour. She stated if she sits for an hour and gets up, there is pain that is diffuse involving the lower extremities. She indicated she was not currently taking any regular medication for knee pain. On examination, she walked with a normal gait, transferred well and had full cervical and lumbar spine movement. According to Dr. Handelsman, the Appellant had mild OA involving the lateral joint compartment of her right knee although there may have been an element of referred, non-radicular pain involving the lower extremities, arising from the low back. He recommended exercise and maintenance of an ideal body weight and Acetaminophen.

[52] On August 30, 2010, Dr. Tountas, orthopedic surgeon, reported that the recent back MRI revealed degenerative changes but no surgically treatable pathology. The knee MRI revealed tears of the medial and lateral menisci. He stated the Appellant had symptoms of a mechanical problem in the right knee and he arranged arthroscopic debridement.

[53] On September 20, 2010, Dr. Bodenstein, clinical psychological, and Dr. Solomon, C. Psych. Assoc, completed a psychological progress report/new treatment plan, noting their request for an extension of treatment was based on the fact the Appellant was about to undergo surgery in March 2011 for her accident related injuries and was experiencing significant surgery related anxiety as well as anxiety about her job. On the Beck Depression Inventory, she scored in the

severe range for depression. On the Beck Hopelessness Scale, she scored in the moderate level for hopelessness. On the Beck Anxiety Inventory, she fell in the severe range for anxiety. Given her observed and reported benefits from psychological treatment, high motivation to return to previous levels of function and persisting distress, Drs. Bodenstein and Solomon recommended additional treatment. The goal of therapy was to provide support and cognitive behavioral to help the Appellant reduce her level of depression and anxiety and increase her level of function without exacerbating her pain.

[54] On October 25 2010, Dr. Prutis saw the Appellant for neck, low back and right knee pain, which was interfering with her daily activities and sleep. She diagnosed exacerbation of chronic neck and low back pain secondary to MVA. She recommended acupuncture, physiotherapy and chronic pain management. She stated the Appellant was unable to work.

[55] On November 18, 2010, the Appellant underwent arthroscopy and debridement of the right knee.

[56] According to a December 3, 2010 clinical note of Dr. Bodenstein, the Appellant had surgery. She could not drive for a while. She was reinstated at work but was having a lot of problems. She had no idea whether she could be accommodated. On December 17, 2010, she reported still being in pain due to her knee. She had more pain than before. On December 24, 2010, she described being in even more pain. Her doctor felt she was unable to work anymore. She found herself limping often which was not the case before.

[57] According to a January 31, 2011 clinical note, Dr. Tountas stated the Appellant continued to experience pain in her right knee which was arthroscoped.

[58] On February 2, 2011, Dr. Bodenstein administered various tests. According to the Beck Depression Inventory –II test, the Appellant scored in the severe range for depression. On the P3 Results, she scored in the Above Average range on the Depression Scale, suggesting chronic fatigue, sadness, listlessness and appetite and sleep disturbance associated with pain. She scored in the Average range on the Anxiety Scale and Above Average on the Somatization Scale. According to Dr. Bodenstein: "(The Appellant) still suffers from Adjustment disorder with depression and anxiety, chronic. This diagnosis appears to concur with all the psychological

assessments that Ms. A. P. underwent (more than 8, most of them IEs). It should also be emphasized that all psychological reports recommended that psychotherapy be continued."

[59] According to a March 29, 2011 clinical note, Dr. Richards described chronic pain and reported that the Appellant was unable to work as a PSW indefinitely

[60] On May 19, 2011, Dr. Bodenstein issued a Psychological Discharge Report. Dr. Bodenstein stated: "(The Appellant) continued to show high motivation to return to work as, she still suffered a lot from the lack of income, which doubled with her pain and her worry for the future, further deepened her depression and anxiety. (The Appellant) felt that the surgery is actually now causing her more pain than she used to suffer before". According to Dr. Bodenstein, toward the end of the treatment plan, the Appellant appeared slightly more optimistic with slightly improved mood. She expressed the wish to stop psychotherapy.

[61] According to a December 12, 2011 clinical note, Dr. Richards reported neck and back pain which increased with long sitting and standing of 30-60 minutes. GT3-29

[62] According to a January 21, 2012 Toronto Heart Cardiology Associates Report, the Appellant developed a change in the pattern of her chronic epigastric or chest discomfort. It was more associated with physical activity. She was also complaining of right leg symptoms.

Oral Testimony

[63] She worked at O'Neil Center (retirement home) between 1990 and 2007. She also worked at Case Verde between 1986 and 2007. She stopped both jobs in which she worked as a PSW due to the MVA. After the MVA, Dr. Richards and Dr. Prutis did not clear her to return to work. Without a letter to that effect, she could not return to her nursing job.

[64] She used to do some cake decorating in her spare time for family and friends.

[65] She fell the previous Sunday when her knee/hip gave out and broke her finger. She cannot do weight bearing and lifting.

[66] Before she worked as a PSW, she did some babysitting and housekeeping work.

[67] She completed Grade 12 in Canada and Jamaica. She also studied Health Care Aid at Centennial College and obtained her certificate as a PSW at a private institute.

[68] After she stopped working, she never returned to work. The doctor gave her a note to go back to work but the workplace said no. They did not offer light duty work and she could not perform weigh bearing activity. PSW work is heavy duty work and she had to be on her feet. If the workplace had offered light work consisting of carrying out activities with residents or paperwork, she would have tried that. Perhaps they did not offer it as she cannot sit or walk for a long time.

[69] She had knee surgery in November 2010. Initially, the results were okay, however after a few months she could not walk well. There has been some discussion about a complete knee replacement in the future.

[70] At times she can walk a distance. Other times she has too much pain. Getting up from a seated position can be a problem. She can currently walk on average between 15 minutes to one half-hour. She does not use a cane.

[71] She was never on short or long-term disability benefits. She took early CPP retirement.

[72] She has some hypertension. The other day it was not stable. It can fluctuate. It was high the other day but came down later in the day.

[73] She has asthma and takes puffers. Smoking can make it worse although she does not smoke.

[74] She made the decision to stop attending psychotherapy in or around May 2011. It took two hours to get there and she had to pay two different fares. She found psychotherapy partially helpful. She has never resumed psychological counselling since then.

[75] She can sit continuously for a period of time but with discomfort. She specified approximately one-half hour or so. She sees Dr. Nisran, a walk-in clinic doctor, who has temporarily replaced her family doctor. However, she does not see any specialists for her back condition. Dr. Nisran gave her a prescription for physiotherapy but she does not have money to pay for it. She believes she received the prescription about one year ago.

[76] She cannot recall if she ever went to a pain clinic. She recalls attending a sleep clinic.

[77] In terms of Dr. Handelman's report that she was not taking any regular medication for knee pain, she stated she ends up in the hospital with an allergic reaction if she takes pain medication. For example, Naproxen caused her to go to the hospital. She can take over the counter Tylenol 500 but nothing with Codeine.

[78] Her daughter drove her to the hearing. She has a valid driver's license. She has not driven in approximately 3 years.

[79] In November 2011, she was living in a two- story house with her son - approximately age 30 - and tenants. At the time, her neighbor, son and daughters would take her shopping or pick up her groceries. She could pick up a few light items. She could make her own meals but would receive some help. She could dress, shower and bathe herself but would require assistance with her bra. She could do light laundry but her neighbor and another girl would help fold the bed linens and place them in the machine.

[80] In terms of Dr. Auguste assertion in August 2009 that she returned to her regular activities including home maintenance, the Appellant testified she did not recall having that discussion.

[81] She currently takes Adalat 60 mg 1x daily; Advair (Puffer) 2 puffs daily; and Tylenol 500 two pills 3x daily for her back, knee and lower hip. She has been on Tylenol 500 since the accident on and off. Since 2014, she has been taking it continuously. She also recalls attending a pain clinic sometime last year and believes it is where physiotherapy is provided. However, she is not sure whether the pain clinic is a naturopathic clinic she attends.

[82] She goes on the computer at home to skype. She may stay on for about 10-15 minute. She is not a "computer person".

[83] She used to travel before the MVA. She travelled to Jamaica in 2010 following her aunt's death and to Colorado in 2011 where she stayed with her son following her knee surgery.

[84] At times, if she is not in pain, she has good sleep. On average, she sleeps 3-5 hours nightly. She uses CPAP. Her sleep can vary.

[85] Since the MVA, she does not believe there is any job she could do. Her doctor did not clear her to return to work. If she had clearance, she cannot say whether she could have performed a lighter job as she did not attempt such work.

[86] She considered retraining sometime in 2012 and went to an agency. The person she saw stated she could not recommend retraining and that no workplace would take on that responsibility. The Appellant did not mention this to her legal representative or file any report from the retraining agency with the Tribunal.

SUBMISSIONS

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

a) She suffers from a variety of medical conditions (see GT3-4) and requires Cortisone, Ventolin and Advair.

b) Following the MVA, she has discomfort over the left shoulder, base of neck and low back pain. She also sustained injury to her chest. She developed problems of knee pain, myofascial injury in the spine, shoulder pain, depression and anxiety.

c) She cannot perform her work as a PSW or other work in which she made cakes for order. Worsening of her health conditions has rendered her incapable of continuing to engage in any kind of gainful employment.

d) Based on diagnostic tests and the medical record, it is clear she is incapable of performing any kind of modified or full-time duties in the work force. Her ailments render her incapable of gainful employment. These include fibromyalgia, left shoulder pain, depression and anxiety, numbness in the body and severe pain. She states she cannot use her left shoulder or arm due to pain and numbness. She drops things from her left hand and experiences chest pain often.

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

a) She reported limitations in her activities of daily living but could walk one-half hour and sit for one hour and was not taking regular pain medication.

b) Her whole body scan was normal. The MRI of her cervical spine showed mild to moderate degenerative changes with no evidence of nerve root compression. The MRI of the lumbar spine did not reveal any significant disc herniation or nerve root impingement. Dr. Best, neurology, concluded she sustained myofascial strains/sprains and that there was no neurological basis for disability. Dr. Richards completed a form for the insurance company a month after the MVA suggesting a return or modified duties. Dr. Deakon, orthopedic specialist, reported in October 2007 that she walked with a normal gait. Although she had some limitations in range of movement of her cervical and lumbar spine, there was no underling orthopedic pathology. He suggested modified work.

c) She has right knee pathology (torn meniscus). While Dr. Boulias stated her right knee issues would pose difficulty as a PSW, he did not rule out all types of work. Dr. Auguste, orthopedic surgeon, suggested a return to modified duties.

d) Her right knee pathology, while limiting, would not preclude lighter more sedentary work.

e) The specialist indicated she was able to return to work with restrictions.

f) She earned $8,742.00 several years after she claimed she was prevented from working.

ANALYSIS

[89] The Appellant must prove on a balance of probabilities that she had a severe disability on or before November 30, 2011.

Severe

[90] The Tribunal is not satisfied the Appellant's hypertension, asthma, multiple environmental allergies or IBS, considered alone or in combination, reached the level of severity as defined in the CPP on or before the MQP. There is a dearth of medical evidence concerning these conditions, their severity and the attempts to treat them which would allow the Tribunal to conclude they were severe and prolonged on or before November 30, 2011.

[91] The Tribunal is satisfied, however, that the Appellant was incapable regularly of performing her previous job as a PSW on or before the MQP and continuously thereafter based on her knee condition. It would further prevent her regularly from pursuing any job which requires ambulation, heavy lifting and carrying.

[92] The more difficult question confronting the Tribunal is whether the Appellant was incapable regularly of performing any substantially gainful occupation, including lighter sedentary work on or before November 30, 2011.

[93] In March 2009, Dr. Auguste, orthopaedic specialist, opined that if the Appellant were offered workplace modifications, which included not transferring patients from bed to chair or chair to toilet, pacing, load-splitting and frequent breaks to rest her right knee, she could return to modified work. The Tribunal notes that Dr. Auguste appears to have removed the physical aspects of the Appellant's PSW job which centrally involved lifting and carrying. This is consistent with the Tribunal's finding that the Appellant would be incapable regularly of pursuing her previous physical job. However, Dr. Auguste's recommendations do not foreclose consideration of lighter sedentary work.

[94] In February 2009, Dr. Boulias, physiatrist, reported that the Appellant would have difficulties with her pre-accident job given the internal derangement of the right knee. However, he did not comment one way or another about sedentary work. The Tribunal finds it reasonable to infer that Dr. Boulias was not ruling out sedentary or modified work which would accommodate the Appellant's knee right condition.

[95] The Tribunal also notes that Dr. Richards, family physician, did not herself express an opinion on employability in the December 2010 Medical Report. However, in her March 29, 2011 clinical note, she described chronic pain and reported that the Appellant was unable to work as a PSW indefinitely. Significantly, she did not rule out lighter work approximately eight months prior to November 30, 2011, the last possible date of onset of disability given the start date of the Appellant's retirement pension.

[96] On October 25, 2010. Dr. Prutis, physical medicine and rehabilitation, indicated that ongoing pain interfered with the Appellant's daily activities and sleep. Dr. Prutis' impression was that of exacerbation of chronic neck, low back pain and right knee meniscus tear. Dr. Prutis recommended chronic pain management and physiotherapy and stated that the Appellant was unable to work. The Tribunal finds it significant that Dr. Prutis did not clarify whether she was referring to the Appellant's previous work when she stated the Appellant was unable to work or whether she was referring to all work including light or sedentary work. Also, she did not clarify whether, in her opinion, the Appellant was temporarily unable to work or was unable to work for the foreseeable and distant future. Given this lack of clarity and the import of Dr. Richards', Dr. Auguste's and Dr. Boulias' reports, which the Tribunal finds leaves the door open to a consideration of lighter work, the Tribunal is not satisfied on the strength of Dr. Prutis' report alone that the Appellant was severely disabled on or before November 30, 2011.

[97] Although Dr. Prutis recommended pain management, the Tribunal has not been presented with evidence that the Appellant followed up with Dr. Prutis or underwent chronic pain management such as referral to a chronic pain clinic. As such, the Tribunal is not satisfied that the Appellant has taken all reasonable measures to pursue recommended treatment or that her symptoms could not be managed with proper pain management oversight.

[98] The Tribunal is not persuaded that the Appellant's right knee condition rendered her incapable regularly of pursuing light sedentary work or from seeking retraining for work within her physical restrictions. The Tribunal finds she retained residual capacity to perform light sedentary work or to pursue retraining for work within her physical restrictions which did not involve ambulation and heavy carrying.

[99] The Tribunal has also considered whether the Appellant's psychological condition rendered her severely disabled on or before November 30, 2011.

[100] Dr. Bodenstein reported that the Appellant was under a lot of stress due to her financial situation. A May 2009 Social Work Assessment Paper Review noted the Appellant was facing a number of psychosocial stressors in the aftermath of the MVA. On September 20, 2010, Dr. Bodenstein and Dr. Solomon requested an extension of treatment. They noted she would undergo surgery in March 2011 and was experiencing significant surgery related anxiety as well as anxiety about her job. On February 2, 2011, Dr. Bodenstein administered various tests. According to the Beck Depression Inventory, the Appellant scored in the severe range for depression. On the P3 Result's, she scored in the Above Average range on the Depression Scale, suggesting chronic fatigue, sadness, listlessness and appetite and sleep disturbance associated with pain. She scored in the Average range on the Anxiety Scale and Above Average on the Somatization Scale. Dr. Bodenstein and Dr. Solomon indicated the Appellant still suffered from Adjustment Disorder with Depression and Anxiety, chronic. They stated: "This diagnosis appears to concur with all the psychological assessments that (the Appellant) underwent (more than 8, most of them IEs). It should also be emphasized that all psychological reports recommended that psychotherapy be continued". The above report would appear to suggest the Appellant suffered from a severe disability. The question for the Tribunal is whether the disability was both severe and prolonged on or before November 30, 2011.

[101] In their May 2011 Psychological Discharge Report, Drs. Bodenstein and Solomon reported the Appellant appeared more optimistic with slightly improved mood and wished to stop psychotherapy. Although the Appellant testified it was expensive for her to travel to psychotherapy, she also testified she never resumed treatment after she discontinued therapy. She testified she currently does not receive psychological treatment or counselling. She also described her current medications, which do not include anything for depression or anxiety.

[102] On balance, the Tribunal is unable to conclude that the Appellant's depression and/or anxiety were severe and prolonged on or before November 30, 2011. She had discontinued treatment in May 2011 and has not provided evidence she was on medication for depression or counselling in November 2011. She has also not received any psychotherapy or psychiatric

counselling or treatment for depression and/or anxiety since May 2011 and currently does not take medication for these conditions. She did not testify as to any serious and disabling depressive or anxiolytic symptomatology, which would lead the Tribunal to conclude that her psychological disability was severe as defined in the CPP at or around the time of November 30, 2011.

[103] The Tribunal has also considered whether the Appellant's neck pain and low back condition rendered her severely disabled on or before the MQP.

[104] In terms of neck pain, Dr. Auguste reported in her March 2009 reported that the Appellant had full range of cervical motion with end range pain. The Appellant's shoulder range of motion was noted to be 140 deg of forward elevation, 140 deg of abduction, external rotation of 45 deg and internal rotation to L4. Neurological testing of the upper extremities was unremarkable and thoracic and chest examination was unremarkable. According to Dr. Auguste, the Appellant had pain, hypertonicity and stiffness in the left trapezius primarily and region of the left paraspinal cervical muscles, despite full range of motion and intact neurovascular exam to the upper extremities. Although Dr. Auguste set out restrictions involving heavy lifting resulting from the right knee injury and WAD II cervical strain/sprain, she did not specify any restrictions involving sedentary work due to the neck and shoulder conditions. She stated the Appellant did not require any further consultation or investigations with respect to her cervical spine as there was no neureoformainal compromise on the MRI and she found no neurological impairment on examination. She recommended massage, electrical stimulation and chiropractic for three months.

[105] In his February 27, 2009 report, Dr. Boulias, physiatrist, indicated that upon examination, the cervical spine revealed full forward flexion. Extension was decreased by about 25%; lateral flexion was normal; lateral rotation to the right was 90 degrees and to the left 80 degrees. All movements were pain free. Shoulder examination did not demonstrate a painful arc and Neer's test was negative. Forward flexion was to 160 degrees and abduction was to 180 degrees.

[106] In his October 2009 neurology report, Dr. Best reported a normal neurological examination. He stated the Appellant demonstrated good range of neck motion with reasonable extension.

[107] The Tribunal is not satisfied the Appellant's functional restrictions in her neck and shoulder would rule out light sedentary work which did not require overhead work or heavy lifting.

[108] The Tribunal has also considered the Appellant's low back condition. The medical record notes some functional restrictions. For example, Dr. Handelsman, rheumatology, did not challenge the Appellant's statement that after sitting for an hour and getting up, she experiences pain that is diffuse involving the lower extremities. The Tribunal is not satisfied, however, that this restriction would necessarily rule out light or sedentary work. According to Dr. Handelsman, the Appellant had full cervical and lumbar spine movement and full movement of her hips. Significantly, neither Dr. Auguste nor Dr. Boulias ruled out prolonged sitting. On examination, Dr. Boulias reported extension decreased by 25% with some discomfort and forward flexion full to the point she could touch her toes with her fingertips. Lateral flexion was full and she had some discomfort in the mid lumbar spine. Rotation was normal and pain free. Dr. Boulias stated: "With respect to the lumbar spine symptoms, in my opinion she does not have an impairment that would render her substantially unable to perform her job as a Personal Support Worker.

[109] On examination, Dr. Auguste reported that lumbar spinal examination revealed normal lordosis with diffuse tenderness to palpation, and no hypertonicity or any segmental findings or spasm. Mobility testing revealed full flexion and full extension with a decrease in left and right lateral flexion with no report of end range pain.

[110] Although the Appellant testified she can sit continually for one- half hour or so, the Tribunal is not persuaded that the Appellant was unable to perform light sedentary work on or before November 30, 2011. In arriving at this conclusion, the Tribunal has considered i) Dr. Handelsman's August 2010 report in which the Appellant indicated she could sit an hour and would experience diffuse pain in in her lower extremities on getting up; ii) Dr. Handelsman's statement she had full lumbar spine movement; iii) Dr. Best's neurological opinion she had no neurological basis to cause her to suffer substantial inability to perform the essential tasks of her previous job; iv) Dr. Boulias' February 2009 physiatry opinion the Appellant did not have an impairment with respect to her lumbar spine that would render her substantially unable to perform the PSW job – which gives rise to the inference she would be able to perform work of a

lesser physical nature such as sedentary work; and v) Dr. Auguste's March 2009 orthopedic opinion that the Appellant could return to modified pre-accident employment.

[111] Where there is evidence of work capacity, a person must show that effort at obtaining and maintaining employment has been unsuccessful by reason of the person's health condition (*Inclima v. Canada (A.G.)*, 2003 FCA 117).

[112] The Appellant has not satisfied the Tribunal that she pursued employment within her restrictions or was unsuccessful by reason of her health condition. She testified she could not say whether she could do a lighter job such as doing activities with residents or doing paperwork as she never made the attempt. Even if her current work place did not clear her to return to modified work, she still had an obligation to pursue work within her restrictions beyond her previous place of employment.

[113] The severe criterion must also be assessed in a real world context (*Villani* v. *Canada* (*A.G.*), 2001 FCA 248). This means that when deciding whether a person's disability is severe, the Tribunal must keep in mind factors such as age, level of education, language proficiency, and past work and life experience.

[114] The Tribunal has also considered the Appellant's age and past work history. Although she primarily worked as a PSW and was age 61 in November 2011, she completed Grade 12 in Canada and Jamaica, is fluent in English and had attended college for her PSW and Health Care Aid certificates. The Tribunal is unable to conclude that her age and work history alone would rule out light sedentary work or retraining as unrealistic or unachievable.

[115] Although the Appellant testified she recently attended an agency to look into retraining and was told that she was not a realistic prospect, she could provide very little detail about whom she saw and what she was told. The Tribunal does not know what medical reports, if any, the Appellant provided the agency person reviewing her situation, and is unable to provide much weight to the Appellant's hearsay evidence as to what the agency person stated or why they concluded she was not a suitable candidate for retraining. In any event, the Tribunal notes that the Appellant's reported effort to look into retraining was recent, that is to say, well after November 2011, the last possible date of onset of disability. The Tribunal is unable to satisfy

itself that any opinion provided by the agency would be the same if it were proffered in November 2011.

[116] Finally, although the Appellant stated she never returned to work after 2007 or received short or long-term disability benefits, the Tribunal notes she had income in 2011 which she did not explain. The Tribunal notes the Appellant was in receipt of income replacement insurance benefits at some point. For example, the physiatrist examination conducted by Dr. Boulias and orthopaedic examination carried out by Dr. Auguste were multisciplinary insurer examinations carried out at the request of RBC General Insurance Company to review the Appellant's ongoing entitlement to housekeeping/home maintenance and income replacement benefits.

[117] The Tribunal accepts the Appellant's evidence that she did not return to work after the MVA and questions whether the 2011 income was on account of insurance benefits.

[118] The Tribunal also notes that in her March 29, 2011 clinical note, the family physician stated it was almost four years since the Appellant was off work. Also, according to a clinical note entry dated February 2, 2011 (GT7-19), the Appellant was preparing for a settlement. (GT3-32). As well, in February 2011, she was still receiving psychological counselling which appeared to be funded by RBC Insurance. (GT7-7).

[119] On balance, the Tribunal finds that the income reported on the Appellant's Record of Earnings for 2011 was not on account of 2011 employment earnings. In any event, that income does not change the Tribunal's findings, based on the evidence, that the Appellant's disability was not severe as defined in the CPP on or before November 30, 2011.

Prolonged

[120] Having found that the Appellant's disability is not severe, it is not necessary to make a determination on the prolonged criterion.

CONCLUSION

[121] The appeal is dismissed.

Jeffrey Steinberg

Member, General Division - Income Security