Social Security Tribunal of Canada | Tribunal de la sécurité sociale du Canada

Citation: *S. T. v. Minister of Employment and Social Development*, 2016 SSTGDIS 60

Tribunal File Number: GP-15-186

BETWEEN:

S. T.

Appellant

and

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

Respondent

SOCIAL SECURITY TRIBUNAL DECISION

General Division – Income Security Section

DECISION BY: Jeffrey Steinberg

HEARD ON: July 11, 2016

DATE OF DECISION: August 12, 2016

Canada

REASONS AND DECISION

PERSONS IN ATTENDANCE

S. T., the Appellant

Derry Rangin, the Appellant's legal representative

Raheleh Niroomand, licensed paralegal (observer)

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on April 30, 2014. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Social Security Tribunal (Tribunal).

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

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

b) This method of proceeding respects the requirement under the Social Security Tribunal Regulations to proceed as informally and quickly as circumstances, fairness and natural justice permit.

THE LAW

[3] 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).

[4] 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.

[5] 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

[6] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2013.

[7] 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 date of the MQP.

Preliminary Matter

[8] On July 4, 2016, the Tribunal received the Respondent's Addendum Submission dated June 29, 2016 (GD-9). It was received outside of the Filing and Response periods and the Appellant did not receive a copy prior to the hearing date. The Member advised the Appellant's legal representative that he was accepting GD-9 into evidence and provided the Appellant the option of adjourning the hearing in order to receive and review a copy of GD-9. Alternatively, the Member was prepared to summarize the contents of GD-9 and permit the Appellant's legal representative the opportunity to provide oral submissions in response. The Appellant's legal representative agreed to the latter option and the Tribunal Member summarized the contents of GD-9 into the record.

EVIDENCE

Documentary Evidence

[9] In the CPP Questionnaire dated April 23, 2014, the Appellant stated she completed Grade 13, has a 3 year BA and a one year B. Ed. She worked between September 1, 2004 and January 22, 2013 as a teacher. She stopped working due to post traumatic stress disorder (PTSD). She could no longer work as of February 2013 due to PTSD. She explained the origins of her PTSD. Recent events (a school shooting) have triggered her symptoms. She has become anxious and physically sick as well as emotional. She has bowel movements to excess if triggered by places and objects associated with PTSD. At times, she has difficulty following conversations and speaking in chronological order due to memory issues. Her short and long term memory is poor. She has limited concentration. Her sleep is sporadic and broken, sometimes due to nightmares. Every sound seems to wake her up. When panic sets in affecting work, it becomes unmanageable and she gets light headed due to irregular breathing. Driving a car, she needs to stop every 15 minutes to take a break: the level of required concentration gives her headaches and makes her nauseous. She does not use public transportation due to problems with anxiety and crowds of people. She is prescribed Paroxetine 30 mg and Olanzapine 2.5 mg. She also receives psychotherapy. Despite her efforts to recover/alleviate her PTSD, the symptoms have been repeatedly triggered. They have become progressively worse, particularly when exposed to the workplace. If she makes it to the workplace, she begins to panic, the anxiety becomes unmanageable and she begins to vomit, experience frequent bowel elimination, lightheadedness and extreme emotional upset (crying). Efforts to calm down, changes to medication and counselling have been unsuccessful.

[10] In the CPP Medical Report dated April 22, 2014, Dr. Teehan, psychologist, reports he has known the Appellant for 15 years. He started treating her for her main medical condition in April 1999. He diagnosed PTSD. He stated that as a police officer, the Appellant was involved in a shooting that went badly. Subsequently, she was guarding the scene alone. Later, she was not helped by the police department. Serious PTSD left her unable to work and with ongoing significant difficulties functioning in her everyday life. She has been prescribed Mylan-Paroxetine daily for the past 9 years and Olanzapine (anti-psychotic medication as needed) for

periods of decompensation. She sees her family doctor as tolerated and when needed. The prognosis is poor. She tries every day to overcome the effects of PTSD, however progress is minimal. Persistent symptoms of increased arousal, avoidance of triggering stimuli and a re-experiencing of traumatic events including work environments, have resulted in serious destabilization and regression.

[11] In her September 12, 2014 Reconsideration request, the Appellant disputed the Respondent's assertion she has been taking the same medication for 9 years which supports stability of her symptoms. She stated she was enclosing a copy of a pharmacy printout of all medications since 2007. According to the Appellant, this shows significant medication changes to her PTSD while under Dr. Michael's care. A different SSRI was prescribed in 2008 after she came into his care because her anxiety was getting worse. Another increase in medication is documented in 2010: Paroxetine 20 to 30 mg. In February 2013, after she could no longer work, her anxiety became exceedingly high. She was given Co-Olanzapine, an anti-psychotic. It was to be taken with Paroxetine. The Appellant also disputed the Respondent's assertion there was no indication of any deterioration in her condition when she stopped working in January 2013. She states that shortly after she stopped working, she spoke with Dr. Teehan, her psychologist, and enclosed a note from him dated February 2013. She also saw Dr. Michael, who had been aware she was under the care of a psychologist. The Appellant takes issue with the Respondent's assertion: "There is no indication you have required referral to a psychiatrist." She states Dr. Michael was already aware she was under the care of a specialist, which explains why she was not given another referral. The Appellant further takes issue with the Respondent's assertion she should be able to do some type of work. She states that after being diagnosed with PTSD, she had to leave the police service for many reasons, e.g. workplace harassment, death threats from co-workers, etc. She struggled to obtain a teaching degree and began a new profession. She fought hard for a new start but despite her best efforts, her PTSD has overtaken her well-being. It has become so severe she cannot function in any workplace because it triggers anxiety associated with the trauma she experienced as a police officer. She cannot hold any sustainable and gainful employment at this point in time and since January 2013.

[12] In her Notice of Appeal, the Appellant states her September 12, 2014 letter was not given sufficient consideration. While she had some history of psychological treatment, it was

only when she stopped working that her condition worsened. Her medications reflect that deterioration.

[13] On May 14, 1999, Dr. Teehan, psychologist, reported on his assessment of the Appellant due to difficulties she was experiencing at work. She would become distraught whenever she had to think about a return to work. During her last shift, she found she was physically ill on patrol. She was upset about events from six months earlier and remarked on how a shooting in which officers fatally shot a man had a strong effect on her. According to Dr. Teehan, feelings of horror, intense fear and helplessness were evident as the Appellant spoke. A few days after the shooting, she had to guard the family residence where the shooting took place. She thought the family was returning to the property to get revenge and to shoot whoever was there. After the shooting, she found herself much less focused and more nervous. She was finding it harder to shut the shooting out of her mind. She vomited during her last shift and was numb. She was avoiding conversations and wanted to stay away from court and the township where the shooting happened out of concern for her safety. She reported feelings of detachment in not wanting to go anywhere with other officers. Although she could fall asleep, she would awaken at the "drop of a pin" and by 3 am regardless of how much energy she expended during the day. She found herself irritable and prone to anger outbursts, less able to concentrate, more hyper vigilant than usual and easy to startle. Since these problems had been occurring longer than a month and were causing significant distress and impairment in social and occupational areas, Dr. Teehan diagnosed chronic PTSD. He stated the Appellant was unable to return to work at present. She required twice weekly individual psychotherapy to help her understand and try to overcome her difficulties. He further stated she was unable to return to police work of any kind at the time. It would be at last 3 months before this could be attempted. Clinical reassessment would first be required. The prognosis was guarded but it was likely that with treatment, the prognosis would become more positive.

[14] On August 13, 1999, Dr. Teehan sent a letter to HR, Durham Regional Police. He stated the Appellant had been having difficulty with a return to work plan because of her PTSD and some changes to the plan. She was finding herself overly reactive, especially dealing with tense situations and use of force. The Appellant reported that working the night shift significantly interfered with her ability to sleep when not on duty. According to Dr. Teehan, working the night

shift aggravated the Appellant's psychological condition. She could not work the night shift at present.

[15] On May 25, 2002, Dr. Teehan advised the Appellant he supported her plan to attend teacher's college that fall. He noted it was very difficult for her to overcome the PTSD she developed in response to the shooting and the alleged pattern of provocative sexual and authoritative harassment by fellow officers.

[16] On February 28, 2013, Dr. Teehan reported the Appellant suffered from a very serious PTSD exacerbated by overwhelming anxieties associated with long term and recent events that made continuing work impossible. Despite attempts to take medications, she had been frightened again by a serious medication reaction that led to an understandable aversion to experimenting further at that time. Shocking news of shootings in a school bus only elevated her levels of anxiety that remained active just below the surface calm that years of training helped her to mask. She required six months of rest and time with her children to recover her feelings of hopefulness and resilience and financial counselling and support until she felt she had recovered.

[17] On July 22, 2014, Dr. Michael reported there was no medical history for the Appellant prior to Dr. Teehan's 1999 diagnosis of anxiety due to PTSD. According to Dr. Michael, Dr. Teehan diagnosed and consulted with the Appellant on a regular basis. Dr. Michael stated he saw the Appellant for prescription renewals only. He had not made any examination findings relating to PTSD. He stated these are better addressed by Dr. Teehan. He noted the Appellant had been under his care for the past 14 years. He was not aware whether she had seen a psychiatrist or attended group therapy.

[18] On September 7, 2014, Dr. Teehan described a workplace incident during a night watch in 1998 which was traumatic for the Appellant and caused her to become overwhelmed psychologically with fear and panic. Following the incident, which involved guarding a property alone for hours after a shooting by police that resulted in the death of the property owner, the Appellant showed clear signs of PTSD including intrusive recollections of the incident. Often she thought there could be a recurrence of the shooting on other calls. Going to calls, she would often vomit in the car and cycle between overwhelming panic and feeling numb. She would avoid thoughts, feelings and conversations about the incident. However, other officers continued

to discuss the subject. She lost interest in her surroundings, became estranged from fellow officers, continued to feel numb, was irritable with herself and others and found she experienced lack of loving feelings. She developed heightened reactivity to stimuli, irritability and avoidance, hyper vigilance, suspicion of others and heightened startle response. She would often become lightheaded, have bowel problems, vomit, sweat profusely, find herself shaking with fear, burst out crying and feel a strong need to flee. She could not focus, showed poor concentration and had difficulty with memory. During the first year since the shooting, she was more ill than usual. In April 1999, she showed seriously compromised psychological functioning under pressure with a poor level of mental health consistent with a psychotic level of functioning. She was transferred out of her division, became physically ill from the stress and had to go home. According to the Appellant, her new superior indicated he did not believe what she told the department and he treated her in a denigrating and degrading manner. Fellow officers did not back her up. One officer made sexual demands and threated that the group would murder her if she refused his demands. When she decided to get help from her police association, she was told "to get a grip" and was dismissed. She hired legal counsel to protect her rights. Immediately afterwards, individual superiors in the department began what she described as a series of provocative activities aimed at violating her human rights, intimidating and terrorizing her. She found she became very sick every time she was in a police station. She suffers from repeated panic attacks. She is still afraid during night time and is unable to watch anything involving violent crimes or guns on television. She is also unable to remain calm when she is in a position of responsibility that is under the scrutiny of a superior and even thinking about this situation brings the symptoms on full force. She is unable to travel back to X or anywhere there has been a traumatic encounter without having a severe panic attack. When she sees a police officer or cruiser, it takes all her resolve to avoid falling apart and even then, sometimes, she will break down crying and shaking. She cannot manage in crowded situations. She feels trapped and needs to get away. She avoids large stores and venues unless she has a choice. She cannot manage altercations or confrontations. She has had to distance herself from a number of relationships because the specter of rejection has been setting her catastrophic anxiety reactions into full swing. She became Dr. Teehan's patient in April 1999 and was diagnosed with severe PTSD after the shooting. Her serious condition was exacerbated with subsequent provocative turmoil that followed with other officers and superiors. Over the next two year and half year period, she

took medication, attended weekly therapy and tried to recover. However ongoing disputes with the Department only exacerbated her symptoms and deepened her despair, depression and emotional suffering. These symptoms have persevered since the shooting. Despite a number of trials on different medications, changing her profession, etc., her function has deteriorated to the point she can no longer work at any occupation despite her significant efforts over many years to change her life and regain control over her thinking, impulses and anxieties. She has difficulty sleeping, is paranoid and has problems concentrating and thinking clearly. She remains both emotionally labile and subject to emotional collapse under the influence of even mild stressors. She suffers from the chronic mental illness of PTSD and after almost 15 years, her level of functioning is poor. Dr. Teehan stated he was not aware of any other treatment that was likely to change the Appellant's clinical profile substantially. There was no chance of her being able to return to any employment. Her PTSD would continue to interfere with her best efforts and no significant change could be expected even with work modification.

[19] On November 6, 2014, Dr. Mehta, psychiatry, saw the Appellant on an emergency consultation. He stated she was a 41 year old ex-police officer. She self-referred to the Emergency Room (ER) reporting she had been stopped by the police a few weeks earlier for not having a valid sticker on her car. This triggered her PTSD, anxiety and lack of sleep. She came to the ER for assistance. She denied any plan to harm herself or others. She reported having a history of PTSD which was work related. She had never been admitted to a psychiatric hospital or seen a psychiatrist. She was on Celexa 30 mg and previously on Paxil. She was also prescribed Olanzapine increased to 5 mg. She reported this was not helping her. It was making her anxious and a bit drowsy. She reported she was still having sleep difficulties. Dr. Mehta recommended she take a single medication (taper off Celexa and stop Olanzapine right away) and stated he would start her on Seroquel 25 mg nightly daily. He explained the main stay of PTSD therapy is psychological therapy. He stated she would be followed up by the urgent clinic crisis team workers. He indicated he would discharge the Appellant from the ER and noted she would benefit from seeing a psychiatrist on a regular basis.

[20] On November 12, 2014, Dr. Mehta reported he again reviewed the Appellant in the ER. He stated she denied any plan to harm herself. She had complained of a rash from Seroquel with poor appetite. He noted she was still taking Celexa, which he had asked her to wean off of

slowly. Given her report of a rash, he advised her to stop Seroquel and discharged her from the ER. He prescribed Trazadone 50 mg and gave her a script for 30 days. He noted she reported that her family doctor increased her Quetiapine from 25 mg to 50 mg. Dr. Mehta stated he understood a psychiatric referral was being initiated.

[21] On February 10, 2015, Dr. Paramsothy, psychiatrist, reported on his January 5, 2015 consultation of the Appellant. He stated she is a 42 year old separated lady presently unemployed as a teacher since January 2013 with two children, ages 9 and 10, with underlying symptoms of major depressive illness with panic features and PTSD. She is presently on Trazodone 75 mg. The depressive symptoms manifest as depressed mood with fatigue, high levels of anxiety of panic proportion, no suicidal thoughts, being uptight, tense most of the time, poor attention and concentration span, loss of interest in activities, social withdrawal and a sense of feeling hopeless and worthless. The psychological stressor precipitating and perpetuating her depressive illness with PTSD was a 1998 incident in which, while working as a police officer, she guarded a property at night while alone after a police shooting that resulted in the death of the property owner. The family was known to be violent and threatening. Being on guard and responsible for protecting the crime scene alone was traumatic as she could see very little in the dark. With fear of reprisals, she became quite overwhelmed with fear and panic. This resulted in her having to go on leave of absence and later quitting the force after a period of being criticized, isolated and looked upon by her fellow officers. She was previously on Celexa, Paxil and Effexor. On mental status, she was a tearful depressed lady with anxiety of panic proportion, was not suicidal, had diminished attention and concentration span and adequate insight. Dr. Paramsothy prescribed Pristiq 40 mg along with Clonazepam. He stated supportive psychotherapy was provided and that she was being referred to the Urgent Clinic and Brief Therapy. A Patient Health Questionnaire (PHQ-9) indicated a score of 20 suggestive of severe depression. He concluded stating: “This lady is not fit for employment at present”.

[22] On October 23, 2015, Dr. Paramsothy stated that the Appellant suffers from major depressive illness with panic features and PTSD. The psycho social stressor which precipitated and perpetrated her depressive illness was a traumatic incident on December 28, 1998 while she was working as a police office and was guarding property at night that resulted in the death of the property owner. She was overwhelmed being on guard alone. Fear of reprisals became quite

real. She was presently on Trazodone with low mood, high levels of anxiety of panic proportion, marked fatigue, poor attention and concentration span, withdrawal and sense of hopelessness and worthlessness. She was previously on several antidepressants with only partial response. She was presently on Cymbalta 60 mg and continued to improve in her mood. Her energy level, self-esteem and motivation continued to be low. She was compliant with treatment and motivated to return to work.

[23] On November 19, 2015, Dr. Paramsothy clarified that the Appellant was presently on Cymbalta 60 mg daily and Lorazepam 1 mg sublingual on a PRN basis which she had not been using regularly in lieu of improved mood. She was compliant with her treatment modalities. She remained disabled and was not fit for any employment. She was not on Trazadone.

[24] On May 25, 2016, Dr. Paramsothy reported the Appellant was initially seen on January 5, 2015 and had been reviewed on a regular basis. She suffers from major depressive illness with panic features and PTSD. Her psychiatric illnesses are severe and prolonged and have interfered with her ability to sustain meaningful employment and quality of life. She has difficulty traveling to places outside of X due to her panic symptoms and continuing PTDS symptoms of hypervigilance and hypersensitivity.

Oral Testimony

[25] Her mental condition began subsequent to a shooting incident in 1998. She had no previous episodes involving a mental condition before 2008.

[26] After the shooting incident, she stayed home for approximately two months. She then went on light duties and never returned to the road.

[27] While off work for two months, she used her vacation pay. WSIB (Workplace Safety and Insurance Board) covered her therapy.

[28] She started working at the front desk on light duties. She was threatened and harassed by her supervisors and other workers. She was then transferred to the Children's Safety Village, where she taught children road safety. She was not bullied or intimidated at that location.

[29] She left the police force in August 2002. She had been given an opportunity to train as a teacher and the police force offered to pay for the retraining.

[30] She first took a break to recover from her trauma and received a one year deferral from teacher's college. She started teacher's college in 2003 and graduated in June 2004. During her studies, she received some accommodation. She entered the program as an identified student with a psychological disorder, i.e., PTSD. She was allowed to do some correspondence courses as she was uneasy being around people at the time.

[31] She felt better in 2004. She felt that her efforts to get back to work had succeeded. She felt hopeful and that she would be able to cope. She was happy with her progress.

[32] She did supply teaching for nine years and worked for two school boards. She worked between 2-3 days per week. She did this until January 2013.

[33] In January 2013, she had panic attacks and missed days at school. She was throwing up and having uncontrollable stomach issues. Her symptoms were triggered by a shooting at Sandy Hook in which children were killed. It triggered her anxiety because it was gun related. The shooting was all over the news and it was hard to get away from it.

[34] During the two year period before she went off work in January 2013, she started to get depressed. Her marriage was abusive and broke down. She had to file for bankruptcy. Also, one of her children was diagnosed with autism.

[35] In January 2013 she was worse than when she stopped working in 2002. In 2002, she could still move around and was able to function a lot better than she can now. She was not depressed then and did not have to deal with bankruptcy, her son's diagnosis or her spouse's abusiveness, which have made things a lot worse. Her therapist thinks that when she relapsed, a lot of things "boiled over" and came back even stronger.

[36] She saw Dr. Teehan shortly after she stopped working in 2013. He used to be her psychologist and was aware of her history. WSIB previously paid for his treatment. In 2013, she had to pay for his treatment out of her own pocket, i.e., $200.00 per session. She saw him only

once as she could not afford to see him regularly. Also, she could not travel to see him as she was stuck in her house.

[37] Her family physician understood she was in the care of Dr. Teehan. Also, getting a psychiatrist takes a long time in X. She was hopeful her condition would improve however it remained the same. Dr. Michael referred her to see a psychiatrist. She believes this was in the spring in 2014 as she was not getting better even though she had tried different medications.

[38] Her doctors at the medical clinic became frustrated and suggested she go to the hospital where she could see a psychiatrist and get prescribed different medication.

[39] At the hospital, they tried to change her medications. She had some bad side effects consisting of suicidal thoughts. Her medications were changed one week later.

[40] She was referred to see Dr. Paramsothy. Although her appointment was scheduled for May 2015, she got in to see him on a cancellation in January.

[41] Dr. Paramsothy changed her medications two or three times.

[42] Her mental condition is the same today as it was in January 2013. She still feels overwhelmed and cannot think or concentrate the way she used to. She has a very hard time handling authority and judgment even if it is fair, based on what happened in the police force. She does not like confrontation. She cries at the smallest things. Her mood is low. She has debilitating fear. She wants to go out and do exposure therapy however panic sets in. She avoids triggers such as television and reading certain things. She stays in her house all the time and has to get people to do things for her and her children. Her friends and ex-spouse take her children places. Her children do not understand why she is afraid all the time. She experiences panic attacks and flashbacks and is sensitive to light and sound.

[43] The Tribunal had some questions for the Appellant.

[44] After she stopped working as a supply teacher in January 2013, she did not qualify for short or long term disability or benefits to pay for counselling.

[45] She saw Dr. Teehan in 2013 and had to pay for his services out of her own pocket. She subsequently spoke with him over the phone and requested that he provide a report.

[46] In 2013, Dr. Teehan recommended she seek counselling through OHIP or elsewhere as he knew she could not afford his services. He recommended some free counselling courses, attendance at the Women's Centre and various outpatient programs. However she could not get out of the house and there was little she could do without calling someone. She focused on getting her medication dealt with as she was having a lot of problems.

[47] She does not recall if she had a bad reaction to Olanzapine at or around the time she saw Dr. Teehan in February 2013. Part of her PTSD symptoms involves memory loss.

[48] At the time she saw Dr. Mehta in November 2014, he referred her to the Urgent Clinic crisis team. There was no follow up. However, in January 2015, Dr. Paramsothy referred her to the outpatient unit at Southlake. Due to a waiting list, she did not get in until May 2015. They provided approximately four sessions however she was not stable enough to continue with her one-on-one CBT (cognitive behavioural therapy) with a dialectical behavioral therapist. She had issues with her medications and did not have the required coping skills. She was constantly breaking into tears and the therapist was worried about her underlying trauma. She told Dr. Paramsothy what happened. In November 2015, she was put in touch with the Trauma Centre in Sharon. She started treatment there in 2016. They are trying to stabilize her following which she will receive EMDR (Eye Movement Desensitization and Reprocessing) therapy. She attends the Trauma Centre twice monthly and sees a team of care providers including a trauma therapist. She receives CBT therapy.

[49] She still sees Dr. Paramsothy approximately once monthly. He reviews her medications and asks how she is doing.

[50] She is not certain if she was first referred to see Dr. Paramsothy in the spring of 2014. She does not agree with the Respondent that the referral was first made in November 2014 after she saw Dr. Mehta. She recalls Dr. Michael making the referral at an earlier point in time.

[51] In December 2013, she was living with her two children who were approximately ages 9 and 8.

[52] She would ask people to get groceries for her and her children.

[53] She could perform chores inside the house, however they would take longer to complete because she gets tired quickly. Sometimes, she does not get out of bed for days and has to have a friend come over.

[54] In December 2013, she could dress and groom herself.

[55] If she has an appointment, a friend will drive her. At times, she will tell them to turn around if she is having a panic attack.

[56] When she attends the Trauma Center or has an appointment with Dr. Paramsothy, she gets someone to drive her. If she does exposure therapy, she gets someone to go with her. She does not go out by herself. If she hears an ambulance or the police, it acts as a trigger.

[57] Her father has been sick and is dying of cancer. She cannot travel to see him. It would be too much for her to deal with.

[58] She does not travel and has lost a lot of her friends. Her children ask her why she cannot take them places. She is housebound most of the time. She cannot go too far from the house or she experiences panic.

[59] Friends take her to do her banking.

[60] Since she last worked, there is no other job she could perform. She cannot leave her house. She tried so hard in the past and went into teaching.

[61] She currently takes Cymbalta and Lorazepam.

[62] The Trauma Center and Dr. Paramsothy will continue to see her. [63] She is currently age 43.

[64] She remains awake all night.

[65] During a typical day, she wakes up, gets the children ready for school and then goes back to sleep. She then gets up and wanders around a bit. At times, she sits in the dark as a lot of

things act as triggers. She may talk on the phone with her friends for support. She does not like light coming into the room. At night, she cannot sleep. She cries which makes her angry at herself. Her children see it. They will remember that their mother could not cope. She thinks she will have to get counselling for them too.

SUBMISSIONS

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

a) She was being treated by her psychologist, Dr. Teehan at her MQP. In his February 28, 2013 report, he stated she suffers from a very serious PTSD exacerbated by overwhelming anxieties associated with long term and recent events that have made continuing work impossible at present.

b) Her condition has not changed and has stayed the same preventing her from performing any type of gainful employment. The fact her medications have not changed does not mean her symptoms were not treated. It means they are being maintained. The fact she is taking medication consistently does not mean she is capable of returning to gainful employment.

c) Her PTSD has been the cause of her inability to continue working. Although her MQP is 2013 and the onus is on her to provide medical information, she was not completely familiar with the rules. Also, she suffered from severe memory loss, insomnia, lack of focus and panic attacks. Her concern was to receive treatment. While there seems to be a lack of medical documents in 2013, there are many medical reports in 2014 which discuss her condition in 2013 which would meet the MQP timeline. The medical documents in 2014 should be given as much importance as those from 2013 as they refer to the same disabling condition.

d) In his February 10, 2015 report, Dr. Paramsothy, psychiatrist, noted she had major depressive illness with panic features and PTSD. He indicated she was not capable of returning to any gainful employment and referred her to an Urgent Care clinic. His diagnosis is the same as that of Dr. Teehan who was treating her at the MQP.

e) The Respondent has not considered the September 7, 2014 report of Dr. Teehan. It discusses her condition at the time she stopped working which was within the MQP timeline. He commented on her severe depression and described her symptoms. In his opinion, there was no chance of her being able to return to any employment.

f) Although she was assessed by Dr. Paramsothy after the MQP, it is not for lack of trying. Her family doctor was responsible for this referral and the wait time was very long. In the meantime, she was treated and monitored by Dr. Teehan. Dr. Paramsothy continued her treatment once he assumed her care. He treated her for the same condition Dr. Teehan treated within the MQP.

g) The Respondent did not comment on Dr. Paramsothy's November 19, 2015 report. He clarified an error in dosage and stated she remained disabled and was not fit for any employment.

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

a) The Respondent acknowledges the initial medical report submitted by Dr. Teehan. He reports a diagnosis of PTSD for the past 15 years. Although he reports a poor prognosis, he does not report any hospitalizations, further investigations or referrals to psychiatry at that time. She has been maintained on the same psychiatric medication for several years, implying her condition was effectively treated and managed.

b) Although diagnosed with severe PTSD in 1999, she attended teacher's college in the fall of 2002 after she stopped working as a police officer and obtained her teaching degree. She worked as a teacher for 8 years until her symptoms were exacerbated by recent events. While the psychologist reported in February 2013 that she required 6 months off work to reset and spend time with her children, her medication did not change in the following 15 months, nor did she require crisis intervention or a psychiatric referral until late 2014, almost a year after her MQP.

c) She was seen in consultation in the emergency room in November 2014 for symptoms of anxiety related to PTSD after being stopped by a police officer for not having a valid

sticker on her car. While medication adjustments were made and psychiatric consultation was considered at this time, this is almost a half year after the MQP. It is irrelevant that her condition deteriorated after the MQP.

d) In January 2015, she was assessed by Dr. Paramsothy for symptoms of depression and PTSD. He reported she was not presently fit for employment. He did not describe severe examination findings that would disable her from all suitable work.

e) Her condition has been maintained for the past 15 years under the care of her psychologist, with her family doctor prescribing predominantly one psychiatric medication from 2010 until August 2014. The evidence does not support a severe worsening in her condition that would be uncontrollable or untreatable with appropriate treatment.

f) Additional medical information between January 2014 and November 2015 post-dates the MQP and does not support a severe psychiatric condition at the MQP and continuously thereafter. Dr. Paramsothy assessed her well after the MQP and indicated that Cymbalta, which she had been on since August 2015, continued to improve her mood. It was noted she was compliant with treatment and was motivated to return to work.

g) If the Appellant's condition was severe, there would be medical evidence to support her disability at the MQP. Her psychiatric medication had not changed in 15 months while she was seen by Dr. Teehan. It would be reasonable to expect that Dr. Teehan would have recommended psychiatric consultation and a medical review had her condition been severe.

h) Her medical condition was not continuously severe as she attended teacher's college in 2002 and worked as a teacher between September 2004 and January 2013. Her PTSD was managed by her family doctor. While she stopped teaching due to a triggering of her symptoms related to the school shooting, the medical evidence does not support symptoms of such severity that she would be incapable of alternate work at the MQP and continuously thereafter.

i) Although the Appellant's legal representative states that the Appellant was not seen by a psychiatrist until after the MQP because the family doctor was responsible for the referral and the wait time to see Dr. Paramsothy was very long, Dr. Mehta assessed the Appellant in November 2014 for a triggering of her post-traumatic stress symptoms after she was stopped by a police officer for a routine traffic violation. Dr. Mehta reported the Appellant felt she would benefit from seeing a psychiatrist and stated he would leave consideration for a psychiatric referral to Dr. Michael. When she was seen in the emergency department 6 days later due to a rash, Dr. Mehta documented that a psychiatric referral was being considered as per his previous recommendation. The medical evidence supports a finding that the appointment with Dr. Paramsothy in January 2015 (just 3 months after the recommendation) was more than a year after the MQP. While Dr. Mehta made medical adjustments and explained that the mainstay of PTSD therapy is psychological, he did not describe mental status examination findings or symptoms supporting a severe mental health condition.

ANALYSIS

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

Severe

[69] The Tribunal is satisfied based on the medical record and the Appellant's testimony that she suffers from PTSD which renders her incapable regularly of pursuing any substantially gainful occupation.

[70] The medical record clearly sets out that the Appellant suffered a triggering event in the late 1990s while working as a police officer, which resulted in a significant and functionally disabling PTSD.

[71] Although the Appellant eventually recovered function which allowed her to return to school, obtain her B. Ed, and work as a teacher between September 2004 and January 22, 2013, the Tribunal is satisfied she suffered a recurrence of PTSD following news of a school shooting in the media. Dr. Teehan, a qualified psychologist, who has treated the Appellant extensively and

is familiar with her case, reported in February 2013 that the Appellant suffers from a very serious PTSD exacerbated by overwhelming anxiety associated with long term and recent events that have made continuing work impossible at present. Although he stated she required six months of rest and time with her children to recover her feelings of hopefulness and resilience, the medical record does not support a finding that the Appellant's condition sufficiently recovered to enable her to return to work.

[72] On April 22 2014, only four months after the MQP, Dr. Teehan reported that the prognosis was poor. He stated the Appellant had tried every day to overcome the effects of PTSD however progress was minimal. Persistent symptoms of increased arousal, avoidance of triggering stimuli and a re-experiencing of traumatic events including work environments, resulted in serious destabilization and regression.

[73] In his September 7, 2014 report, Dr. Teehan stated he was not aware of any treatment that was likely to change the Appellant's clinical profile substantially and that there was no chance of her being able to return to any employment.

[74] As further evidence of the Appellant's ongoing impairment since the recurrence of her PTSD in early 2013, Dr. Mehta, psychiatrist, reported in November 2014 that the Appellant attended the Emergency Room that day after she reporting having been stopped by the police a few weeks earlier for not having a valid sticker on her car. Significantly although Dr. Mehta noted the Appellant's past medication therapy and recommended some changes, he also explained that the mainstay of PTSD therapy is psychological therapy, which the Tribunal notes the Appellant was unable to afford with Dr. Taheen following her recurrence of symptoms.

[75] As further evidence of the Appellant's serious and significant functional impairment arising from her PTSD, Dr. Paramsothy, psychiatrist, reported in his February 2015 assessment that the Appellant has depressive illness with PTSD. She had anxiety of panic proportion and diminished attention and concentration. He stated she was not fit for employment at present. The Tribunal views Dr. Paramsothy' s report as evidencing not a deterioration of the Appellant's psychological status post-MQP, but rather her ongoing disability since she stopped working in January 2013.

[76] The Tribunal is satisfied that the medical record and the Appellant's credible and unchallenged testimony substantiate the existence of a significant functionally disabling mental impairment as of January 2013 at which time the Appellant was no longer able to work as a school teacher resulting from the recurrence of her PTSD. Her disability has remained severe as defined in the CPP at the MQP and the Tribunal is satisfied it will remain so for an indeterminate period of time thereafter.

Prolonged

[77] The Tribunal is satisfied, on balance, that the Appellant's PTSD is prolonged. It dates back to 1999 and is long continued. Her PTSD recurred in early 2013 after remitting for many years. Despite returning to see Dr. Teehan, psychologist, on one occasion and more recently Dr. Paramsothy, psychiatrist, the Appellant continues to manifest functionally disabling symptoms.

[78] With ongoing CBT at the Trauma Centre and psychiatric care provided by Dr. Paramsothy, the Appellant's symptoms may eventually abate and allow her once again to return to the workforce. However, at this point and for the indeterminate future, the Tribunal is satisfied the Appellant will continue to suffer from functionally disabling symptoms which render her incapable regularly of pursuing any substantially gainful occupation.

CONCLUSION

[79] The Tribunal finds that the Appellant had a severe and prolonged disability in January 2013. According to section 69 of the CPP, payments start four months after the date of disability. Payments start as of May 2013.

[80] The Appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security