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

Citation: *D. P. v. Minister of Employment and Social Development*, 2017 SSTGDIS 13

Tribunal File Number: GP-15-2734

BETWEEN:

D. P.

Appellant

and

Minister of Employment and Social Development

Respondent

SOCIAL SECURITY TRIBUNAL DECISION

General Division – Income Security Section

DECISION BY: Jeffrey Steinberg

HEARD ON: January 25, 2017

DATE OF DECISION: January 26, 2017

REASONS AND DECISION

PERSONS IN ATTENDANCE

D. P., the Appellant

Jayson Swain, the Appellant's legal representative

S. H., spouse (observer)

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on December 24, 2013. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Social Security Tribunal (Tribunal)

[2] This appeal was heard by Videoconference for the following reasons:

a) Videoconferencing is available within a reasonable distance of the area where the Appellant lives

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

c) 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.

EVIDENCE

Documentary Evidence

[8] In his Questionnaire for Canada Pension Plan disability benefits dated December 13, the Appellant wrote he completed Grade 12. He attended college for 9 months for his plumbing license. He was self-employed between January 1, 2004 and December 5, 2011. He stopped working in the business due to incarceration and medical issues. He was the sole proprietor of a plumbing contractor business. He last filed an income tax return on the operation of the business for 2012. He states he could no longer work due to his medical condition as of June 7, 2013. He described HIV/AIDS, high blood pressure and high cholesterol. He stated he always feels tired and exhausted, has little to no energy or endurance, difficulty sleeping, back and knee pain, and side effects from medication. He has stomach and digestive issues, extremely loose bowels and headaches. He cannot sit or stand for more than one hour at a time. He cannot walk

more than a block. It hurts his lower back when trying to lift/carry a heavy item for any distance. Sometimes it hurts when bending to put on socks/shoes. He has constant diarrhea. He has some difficulty performing household maintenance activities. He has difficulty concentrating and focusing on tasks at hand and a lot of difficulty sleeping. He gets winded very easily. He cannot sit to drive a car for more than one hour. He is prescribed Norvir, Truvada, Reyataz, Lorazepam, Wellbutrin, Crestor, Hydrochlorothiazide, Ramipril and Symbicort.

[9] In the CPP Medical Report dated December 13, 2013, Dr. Burns, family physician, reported she knew the Appellant for 14 years. She started treating him for his main medical condition in September 2009. She set out a diagnosis of AIDS and described chronic fatigue secondary to AIDS, depression, insomnia, constant diarrhea and nausea secondary to medications, and increased blood pressure and cholesterol. The Appellant is prescribed Reyataz, Truvada, Norvir, Wellbutrin, Rousuvastatin, Ramipril and Lorazepam. Under Prognosis, she stated he was currently stable on medication. GD2-53

[10] On October 9, 2013, Dr. Khosravani, in the service of Dr. Sharkawy, reported that the Appellant was seen in the Immunodeficiency Clinic. He was supposed to be seen in June and was not seen in July. His other comorbidity was a mood and anxiety disorder. Since his last clinic visit (February 2013) he continued to have fatigue. This appeared to have worsened in the setting of taking some unscheduled medication interruptions. There were episodes for a week or more at a time that he had not been compliant with his medications. He stated he stopped the medications to feel better and reduce his episodes of fatigue. Otherwise, he was well. He had lost some weight and continued to have some issues with anxiety. His weight loss was mostly related not to his mood disorder but his decreased p.o. (oral) intake. He was on Truvada, Atazanavir, Ritonavir, Crestor, Wellbutrin, Lorazepam and Hydrochlorothiazide. Lab investigations from March 2013 showed an undetectable viral load and CD4 count of 443 with a fraction of 34 percent. According to Dr. Sharkawy, it was difficult to assess how the Appellant was doing in terms of HIV. They discussed the negative side effects and treatment effects of stopping medications. The Appellant promised he would be more compliant with medication. Dr. Sharkawy stated he would defer the issue of a disability application as that is

not something the clinic is involved in. They noted that his degree of fatigue was not related to his medications. GD2-55

[11] On September 24, 2014 Dr. Sharkawy, Infectious Diseases, reported he first assessed the Appellant in the Immunodeficiency Clinic at X Western Hospital on January 21, 2010. He had been diagnosed with HIV in December 2009. He presented to his family physician with significantly worsening fatigue over a period of several months and progressively worsening headache. He was also experiencing recurrent skin and soft tissue infections over almost a year due to MRSA, a resistant bacterium, which was incompletely responsive to multiple courses of antibiotic therapy. On original examination, he appeared healthy with normal vital signs but had a notably anxious affect. There was evidence of lymphadenopathy throughout his neck bilaterally. Neurologic exam was grossly normal. Skin exam revealed multiple nodules over his left forearm and multiple similar lesions throughout both groins consistent with small soft tissue abscesses. He was started on antibiotic therapy for resistant skin infection. He was not offered anti-retroviral therapy which was deemed unnecessary based on the level of his CD4 count. On follow up visit in February 2010, he was found to have dyslipidemia. Otherwise, he was clinically largely unchanged. By May 2010, he was complaining of worsening fatigue, declining exercise tolerance, increasing shortness of breath both with and without exertion, increasingly severe headache, and profound sleep disturbances requiring regular sedative medications, including Lorazepam. His CD4 count declined to 344 and his viral load remained relatively stable at 44, 970 copies per ML. Dr. Sharkawy recommended starting HIV medication. The Appellant was prescribed Atripla and offered counselling for better sleep hygiene. By June 2010, he had been taking Atripla regularly and was tolerating it fairly well with some morning lethargy. On further probing, it became clear he was demonstrating significant lack of motivation and depressive symptoms. Much appeared to stem from his inability to accept the diagnosis of HIV. Dr. Sharkawy states he informed the Appellant that it was manageable but noted it would be difficult to convince him of this. The Appellant reported that his blood pressure was becoming difficult to control and that he recently increased his Ramipril from 5 to 10 mg daily. By August 2010, he still complained of significant sleep disturbances and daily severe headache. He also began to experience intermittent loose stools and difficulty with appetite. His viral load had declined to 228 copies per ML and his CD4 count rose to 389. Dr. Sharkawy advised the Appellant that his headaches were most likely

secondary to chronic stress and anxiety. However, due to the possibility that his HIV medication, Atripla, may have contributed to some of his mood/sleep disturbances, Dr. Sharkawy agreed to switch to Truvada with Atazanavir and Ritonavir. In September 2010, the Appellant's mood had improved somewhat and he had stopped his antidepressants. However, he had ongoing headache, sleep disturbance, generalized itching and GI upset. His CD4 count was 376 and viral load confirmed as undetectable. Dr. Sharkawy provided counselling on diet, sleep hygiene and tips to counter stress/anxiety. By December 2010, the Appellant demonstrated significant overall improvement but still complained of ongoing regular headaches, particularly with any form of stress or exertion. His CD4 count had improved to 507 and his viral load was still undetectable. He missed follow up appointments and returned to the clinic in June 2011. He had been started on new antidepressants/anxiolytics including Cipralex. He was still taking Lorazepam nightly to maintain sleep. He disclosed "legal trouble" and concern he would likely be charged and imprisoned. Dr. Sharkawy noted this weighted heavily on the Appellant's mind and caused a great deal of stress. The Appellant demonstrated markedly reduced energy levels, more generalized itching and difficulty sleeping. He had elevated lipids which also appeared to heighten his anxiety. He was prescribed Crestor. His CD4 count had declined to 290 but his viral load remained undetectable. By November 2011, it was confirmed he was charged with a serious criminal offence and placed on 24 hour house arrest. He was more anxious then ever seen before. He complained of low libido and decreased energy. His testosterone levels were low. His CD4 count was stable at 368 and viral load remained undetectable. Testosterone replacement therapy was deferred until his long term status regarding incarceration could be clarified. This caused stress. He did not return to the clinic until July 2012 (he advised he had been incarcerated since December 2011). He maintained his HIV medications and new medications had been prescribed for anxiety and depression. In October 2013, he advised he was finally released from incarceration in July 2012 but had great difficulty complying with his medications due to a number of residual stressors. He admitted to missing medications for 1-2 weeks at a time and started to lose weight due to worsening appetite. He was last seen on March 19, 2014. He demonstrated improved mood status and better control of anxiety. He attributed much of this to being granted ODSP for drug coverage. He continued to complain of chronic fatigue and headaches. His CD4 count was stable at 446 and his viral load remained undetectable. He missed his June 25, 2014 appointment. Dr.

Sharkawy wrote: “In summary, it is my professional opinion that the pattern of chronic anxiety, headaches, sleep disturbances and extreme difficulty with stress management in the context of chronic HIV disease and now a criminal offense history render (the Appellant) a very poor candidate for meaningful gainful employment of any kind on a consistent basis. When he has demonstrated brief periods of improvement with respect to his overall stress and anxiety levels, they do not appear to be sustainable for more than a few months at a time based on my experience with him over the past four years. It is therefore my firm belief that he will likely be on permanent disability on an indefinite basis”. GD2-41

Oral Testimony

[12] He is age 44.

[13] He graduated high school and is a licensed plumber, licensed scuba diver, licensed rigger, licensed well technician and submersible pump installer.

[14] He applied for CPP disability because he finds it difficult to work or maintain work. He has HIV, chronic depression, chronic fatigue, and his medications cause severe side-effects. He was diagnosed in September 2009 with HIV. At that time, he was self-employed as a general contractor. He is a licensed plumber and would do new construction, renovations, service calls, etc. He continued to work until he was incarcerated in December 2011. Since 2009, his work hours progressively decreased from 60-70 hours a week to 20 hours a week. Just prior to being incarcerated, he would go to work some days; other days, he could not. Some weeks he could not work at all. His overall earnings in 2011 dropped in relation to his earnings in prior years. He is convinced he had to reduce his hours due to HIV, which causes severe fatigue, severe muscle pain and insomnia. He also has a history of back problems, bad knees and ankles. He was involved in a motor vehicle accident at age 16, which affected his shoulder. His shoulder went out a lot more since the infection. His immune system is depleted and he tends to get sick a lot. He could not be valuable to his customers if he was not dependable.

[15] He was put on Atripla in 2010 which caused many daily side effects such as diarrhea, headaches, decreased appetite, sweating, insomnia, muscle and joint pain, etc. The doctors put him on other medications. However, he had other side effects such as nausea, upset stomach,

dizziness and trouble concentrating. He would get easily winded with no endurance, muscle pains/aches and headaches all the time. He would experience some side effects on a daily basis. Most days, he found it difficult to get out of bed. The medications enhanced his depression. Given his history of depression, just being told he was HIV caused his depression to skyrocket. He lost customers and friends due to the infection. He did not want to do anything or face the world. He did not want to go outside. He was first diagnosed with depression and ADD when he was a child. He has suffered from depression on and off since then.

[16] He was incarcerated in December 2011 for 18 months. He was released on July 1, 2013. He was not able to work around the time he was released from prison. During incarceration, he received basic treatment for HIV and depression. He did not eat right or sleep in jail. His back was sore when he left jail. After he was released from jail, his health worse than before he entered jail. Upon release, he attempted to get his customer base back. He retained some customers but was unable to perform his work tasks, e.g., crawling under cottages, doing renovations, climbing ladders (he developed a fear of heights in jail after falling off his bunk bed). It got to the point that physically, he could not do his work anymore. He cannot sit or stand more than one hour, walk any distances or climb/descend steep hills or stairs due to his back, knees and ankles.

[17] He started to do cottage monitoring on a sporadic and very part-time basis toward approximately November/December of 2013. This involved going to vacant cottages to ensure that the water and heat were on. He did this for approximately 5 hours a week. He had difficulty trucking through unplowed roads and would get winded climbing hills to get to various cottages. It got to the point he just wanted to stay in bed shortly after he tried performing cottage maintenance. He went on ODSP (Ontario Disability Support Program) shortly after he was released from jail. He believes it started in December 2013. He remains on ODSP with no review date.

[18] He considered alternative forms of work however he cannot sit for more than one hour at a time or be too far from a bathroom. He has almost constant headaches, gets easily winded, cannot focus and his little to no concentration. From day to day, he does not know whether he will be vomiting or suffer from a pounding head all day long.

[19] Following his release from prison, he has continued to see an HIV specialist and his family doctor. He sees his HIV specialist every six months. He changed from Dr. Sharkawy (TWH) to Dr. Fong (St. Michael's Hospital). He started to see Dr. Fong in or around March 2015. Dr. Burns, family physician, knows his history quite well. He went back on his previous medications however the dosages have continuously been increased.

[20] His symptoms remain in play. Medication enhances the symptoms. He has indigestion, insomnia and is always tired. Dr. Burns prescribed sleeping pills which stop his mind from racing. He still gets only four hours sleep at a time. He has to nap during the day, sometimes 2-3 times a day.

[21] He discussed his future with his doctors. He has a virus for which there is no cure. The doctors are trying to stabilize the disease and help him to cope the best he can. Even though his CD4 levels and viral loads are stable, that does not mean he feels good or that the pain goes away.

[22] He loved working. HIV impacted his social life and hobbies, in which he can no longer participate. He finds it difficult to go out. He tends to get sick a lot. A lot of people do not want him over or to visit. He does not know how he will be from one day to the next. He has no endurance to do his hobbies and gets winded going up a flight of stairs. He finds housecleaning very difficult. Given his difficulties with concentration, he could not guarantee that he would not make mistakes in his previous job, e.g., hooking up the wrong wires, which could be dangerous. He has difficulty focusing on any task. If he reads a book, his mind is elsewhere.

[23] It is difficult to get counselling in X. He asked his family doctor for a psychiatric referral shortly after he got out of prison however X does not have one. The closest one is in X. He has done everything the doctors have suggested. He saw a psychologist for counselling, B. Euler (maximum of six sessions) in 2015. Dr. Burns made the referral. Ms. Euler was going to help him locate a psychiatrist and suggested that he go to X or X. If a referral is made, he would travel to X to see a psychiatrist. Dr. Burns is still actively looking into it.

[24] He is not a complainer. Therefore, he did not complain to his family doctor about his back, knees and ankles. However, he did have MRIs for his ankle and knees. Dr. Sharkawy saw him for his HIV and therefore would not have commented on his back, knees and ankles.

[25] He does not see himself returning to gainful employment. His main symptoms which have impacted upon him are depression, body aches/body falling apart. He worked all his life in hard labour. He misses the social interaction with customers/employees and managing his business. There is work available out there. He wants to do it but is unable to do so. He cannot concentrate or focus long enough to do paperwork or sit long enough. If he goes to the bathroom, he may forget what he was doing or he may have to nap because he cannot stay awake. He may also get a headache which requires him to block out the light.

[26] At the MQP date, he would get headaches every couple of days. They might last for 3 hours. There were no specific triggers. He had poor and sporadic sleep. He was not able to cope with stress. If faced with stress in the workplace, he would cry, give up, panic and not complete his tasks. He still had diarrhea and might have to go to the bathroom at least once every couple of hours. On a scale of 1-10 with 1 being no energy, he would rate his energy level at 2. All such symptoms continue to this day. During an average day, he will decide whether he wants to get out of bed. His days are unpredictable. He might start off the day feeling okay and then get nauseous or have to go back to bed. He cannot plan anything.

[27] He believes that his fatigue relates to his HIV. Dr. Sharkawy explained to him that his body is fighting a virus with all of its energy. Therefore, he will feel worn out all the time.

SUBMISSIONS

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

a) Dr. Sharkawy would not mention the knees/back as he saw the Appellant for HIV. The family doctor focused on AIDS as the main condition. Independent of the problems with his knees/back, the issues related to HIV are serious and numerous.

b) He had depression prior to HIV which is now exacerbated by HIV. His condition is chronic, severe and prolonged. His work was tapering off prior to his incarceration in

2011. Therefore, incarceration was not the main reason he stopped working. He has been on ODSP since December 2013. This would be an appropriate CPP disability onset date.

c) He tried to do cottage monitoring but was unable to do so.

d) He cannot do sedentary work. He has fatigue and his available for work is unpredictable.

e) Dr. Sharkawy is supportive of the Appellant's case.

f) He meets the definition of severe and prolonged in the CPP.

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

a) His application was received on December 24, 2013. He was 41 with Grade 12 and certification as a plumber. His reason for stopping work was related to incarceration and medical issues. He last worked as a self-employed plumbing contractor from January 2004 to December 2011 when the business shut down. He applied for CPP disability with HIV/AIDs. He felt he could no longer work as of June 2013.

b) In his Questionnaire, he states he was limited with sitting, standing and driving for one hour, household maintenance, lifting/bending due to back pain, concentration and sleep. Treatment consisted of medication. Dr. Burns confirmed that he was diagnosed with AIDs with associated chronic fatigue, depression, insomnia, diarrhea and nausea. He indicated the Appellant was stable on his current medication regimen. The fact he is stable on his current medication regimen is considered a successful outcome when it comes to HIV/AIDS as blood values determine the treatment regimen and response to treatment.

c) The Respondent received an update from Dr. Sharkawy. Given the stability of the CD4 count and viral load since at least November 2011 and lack of follow up since, it is reasonable to conclude that he continues to be stable with his disease (anything to the contrary requires review, blood work and medication adjustments).

d) According to the Internal Medicine specialist and family physician, the disease has been stable for some time and undetectable in terms of viral load, which is indicative of the efficiency of treatment. He has not returned to his HIV specialist for follow up since March 2014, which confirms that his HIV is inactive. Since he has been stable and there is no medical barrier to seeking/obtaining appropriate work activity, he is not disabled by his HIV status. Rather, the date he stopped work is the result of being incarcerated which may pose difficulty in securing certain work; however, this is not an issue relevant to the determination of disability. He does not have a severe and prolonged disability whereby any and all work activity is prohibited.

ANALYSIS

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

Severe

[31] The Tribunal is satisfied based on the consensus of the medical reports and the Appellant's unchallenged testimony that the Appellant was incapable regularly of pursuing any substantially gainful occupation on or before the MQP.

[32] Dr. Burns, family physician, who has known the Appellant for 14 years, testified that the Appellant has chronic fatigue secondary to AIDS, depression, insomnia, constant diarrhea and nausea secondary to medication.

[33] Dr. Sharkawy, infectious disease specialist, described a comorbid mood disorder and anxiety disorder alongside the Appellant's HIV. He provided a detailed report, which chronicled the Appellant's symptoms and difficulty in function and stated in no uncertain terms that in his professional opinion, the Appellant's pattern of chronic anxiety, headaches, sleep disturbances, and extremely difficulty with stress management in the context of HIV disease (and now a criminal defense history) render him a very poor candidate for meaningful gainful employment of any kind on a consistent basis. Dr. Sharkawy further noted that any demonstrated brief periods of improvement with respect to overall stress and anxiety levels, did not appear to be sustainable for more than a few months at a time, based on Dr. Sharkawy' s

experience with the Appellant over a four year period. Therefore, he concluded: "It is therefore my firm belief that he will likely be on permanent disability on an indefinite basis".

[34] The Appellant testified that before he was incarcerated in 2011, his business had already dwindled. Although he was working up to 20 hours a week, he also testified that some days he could go to work, other days he could not. Some weeks he could not work at all. The Tribunal notes that the Appellant had a drop in earnings in 2011 in relation to prior years. Given his incarceration late in the year, i.e., December, his drop in income would be explained by his reduction in overall work hours, which he explained related to how he was feeling at the time. He further testified that he felt worse after he was released from prison in 2013. He testified that he tried doing cottage maintenance work for several months. Apart from difficulty driving on unplowed roads, he would get winded climbing hills to check on cottages. He testified that he did this work for approximately 5 hours a week during the months of November and December 2013. The Tribunal does not find that such work close in time to the MQP constituted evidence of capacity on the Appellant's part regularly to pursue a substantially gainful occupation.

[35] The Appellant testified as to his disabling symptoms at the MQP which continue to this day. These included headaches every couple of days, poor and sporadic sleep, inability to cope with stress, ongoing diarrhea and very low energy. The Tribunal is satisfied that the cumulative impact of these symptoms would prevent the Appellant regularly from pursuing any substantially gainful occupation including sedentary work.

[36] The Appellant testified that his family doctor is trying to find him a psychiatrist. He testified that if one is located, he will attend the appointment. He remains under the active care of his HIV specialist and family doctor.

[37] The Tribunal is satisfied that the Appellant suffered the onset of a severe and prolonged disability at the MQP date given his documented medical symptomatology as set out in the medical record above.

Prolonged

[38] The Tribunal is further satisfied that the Appellant's condition is prolonged. In his detailed September 24, 2014 report, Dr. Sharkawy set out the Appellant's medical history which spanned over four years. He clearly documented a medical condition of long continued and indefinite nature. After chronicling the history he wrote: 'It is therefore my firm belief that he will likely be on permanent disability on an indefinite basis".

CONCLUSION

[39] The Tribunal finds that the Appellant had a severe and prolonged disability for the reasons set out above in December 2013. According to section 69 of the CPP, payments start four months after the date of disability. Payments start as of April 2014.

[40] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security