Automobile Injury Appeal Commission

Province of Saskatchewan

Citation: *A.A. v. Saskatchewan Government Insurance*, 2007 SKAIA 046

Date: 20070326

File: 129 of 2004

BETWEEN

A.A., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances*:*
Jonathan M. Goby, for the Applicant
Tamara M. Harasen, for the Respondent

Before: **Beverly Cleveland, Chair**
Carolyn Jones, Commission Member
Al Knippel, Commission Member

THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION

Heard at Regina, Saskatchewan
April 20, 2006

DECISION

[1] The Appellant, A.A., was injured in a motor vehicle accident on January 18, 1997. He suffered injuries in the accident and applied to Saskatchewan Government Insurance ("SGI") for and received benefits under the no-fault provisions in Part VIII of *The Automobile Accident Insurance Act* ("the *Act"*).

[2] By letter dated May 28, 2004, SGI advised the Appellant that benefits for medications, therapy and special equipment would be terminated, because SGI had concluded that the Appellant's on-going care was not related to injuries caused by the vehicle accident. The Appellant disagreed and appealed the decision.

FACTS AND BACKGROUND

[3] On January 18, 1997, the Appellant was driving alone in a snowstorm. A semi-trailer passed him and caused a white out and a buffet of wind. The Appellant lost his bearings, lost control and went into the ditch. The vehicle rolled, though no one is certain how many times. Emergency vehicles attended and found the Appellant pinned in the vehicle. It took as much as an hour to free him.

[4] The Appellant was transported to hospital by ambulance. At hospital, he was found to be alert, conscious and orientated. After x-rays and examination, he was found to have suffered soft tissue injuries only. He was hospitalized for three days, during which he was treated with analgesics and rest. He was discharged to his home on January 21, 1997.

[5] At the time of discharge, Dr. Tsoi requested a physiotherapy assessment for the Appellant. The physiotherapy assessment records injury to his neck, left shoulder and back and a diagnosis of cervical strain. The physiotherapist noted that the Appellant had a history

of neck[1] and low back pain and suggested that this had been aggravated by the vehicle accident. The physiotherapist indicated that the Appellant had been treated with heat and acupuncture and progressed to active exercise. He was, by the date of discharge from physiotherapy, apparently attending weekly hydrotherapy exercise classes.

[6] The next report of significance provided to the Commission is the Appellant's Secondary Assessment Report regarding an assessment on September 5, 1997. His primary physical complaint at that time was regarding pain in his neck and the tops of his shoulders. Otherwise, and most significantly to this decision, he complained of difficulty sleeping, flashbacks, nightmares, increased nervousness when driving and increased episodes of dizziness.

[7] The Secondary Assessment Team concluded that the Appellant was recovering from his whiplash associated disorder (WAD). It was concerned, however, by what it saw as underlying problems that might prolong his recovery and that the team thought required further investigation. In regard to his non-physical symptoms, they recommended:

- Referral to a neurologist regarding short tem memory loss and other indicated difficulties;

- A psychological consultation in regard to a possibility that the Appellant suffered post-traumatic stress disorder (PTSD), particularly in light of his report of nightmares and flashbacks

[8] A tertiary assessment was conducted on November 30 and December 1, 1998. A team comprised of a physician, physiotherapist, occupational therapist, exercise therapist, psychologist and a nurse examined the Appellant to review his medial management, confirm his diagnosis, assess his then current status and make recommendations regarding on-going treatment and management.

[9] At the assessment, the Appellant complained of a stiff neck and shoulders, headaches, trouble with balance, nightmares and other sleep difficulties, and forgetfulness.

[1] See paragraph [28]. We agree with Dr. Sibley's analysis and conclusion that this notation is incorrect and

While he was uncertain when the forgetfulness had begun, he was certain that the nightmares started after the vehicle accident and that they were not diminishing.

[10] Testing and examination seem to have confirmed the Appellant's subjective complaints. The team reported that, although physical and functional examinations were conducted, the assessment focused on cognition. He was found to have cognitive deficits ranging from mild to severe in regard to temporal awareness, safety and judgment, visual memory, auditory recall, money and math skills. His memory was decreased. However, deficits were not found in attention span, following directions, immediate memory or in foresight and planning. The team expressed concern that the Appellant receive further investigation and appropriate treatment regarding his cognitive deficits.

[11] From a medical perspective, the team suggested that the Appellant might have been suffering the effects of a head injury, an intercranial-space occupying lesion[2] or Alzheimer's disease. From a psychosocial perspective, his flashbacks and images were found to meet the criteria necessary to PTSD. The team was unable to conclude whether or not the Appellant was, in addition, suffering depression or a mood disorder. A number of his concerns were found to be consistent with a closed head injury, post-concussion syndrome (PCS) or both.

[12] Given their differential diagnosis and corresponding uncertainty, the team recommended:

- An urgent referral for an MRI of his head;
- An urgent referral to a neurologist;
- A referral to a neuropsychologist;
- Physical rehabilitation, although not until after the neurological and neuropsychological consultations and a cardiovascular investigation were completed;
- Psychological counseling, following completion of medical and neuropsychological investigations; and
- Family counseling.

[13] The MRI, taken in Minot on January 8, 1999, was normal.

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that there was no prior history of neck pain.

[14] The Appellant was examined by Dr. Capp, a consultant in Physical Medicine and Rehabilitation on February 9, 1999. Dr. Capp reported that the Appellant certainly had problems with concentration, recent memory and, to a lesser degree, with abstract reasoning. As to physical injuries, Dr. Capp found restrictions in the Appellant's neck movement and recommended a period of therapy.

[15] Dr. Veloso, a neurologist, examined the Appellant on February 25, 1999. Believing that the Appellant had suffered head and neck injuries in the vehicle accident and after reviewing the Appellant's reported symptoms – headaches, neck pain, forgetfulness, nightmares, insomnia and poor memory – Dr. Veloso opined that the symptoms were consistent with post-concussion syndrome.

[16] Next, the Appellant had a neuropsychological examination at Wascana Rehabilitation Centre (Wascana) on May 13, 1999. Dr. Landry, who conducted the examination, concluded that the Appellant demonstrated cognitive impairments in the majority of the areas that had been assessed. He said that the medical records did not suggest that the Appellant had suffered a significant traumatic brain injury, but the cognitive impairments demonstrated were too severe to have been caused only by a more minor concussion type of injury. This suggested to him that the Appellant's depression, mood disorder, anxiety disorder with nightmares, sleep disorder, fatigue, pain and headaches might be complicating factors. Dr. Landry cautioned against concluding that the listed complaints were not neurologically-based only because the MRI results had been normal.

[17] Dr. Landry recommended that the Appellant be followed by a neurologist and that MRI scans be repeated. With regard to rehabilitation, he recommended that the Appellant be referred to a psychotherapist and to the Acquired Brain Injury Outreach program.

[18] On February 26, 1999, the Appellant saw Dr. Alfano for the recommended neuropsychological evaluation. In his report dated June 7, 1999, Dr. Alfano stated that the Appellant's report of memory loss for events prior to and including the accident and his

[2] A CT scan taken March 12, 2000 after the Appellant's admission to the Regina General Hospital Psychiatric

report that he had memory loss and confusion for a few days afterward were consistent with his having suffered a concussion at the time of the accident.

[19] Much as Dr. Landry had reported, Dr. Alfano found notable deficits in cognitive functioning, especially regarding attention, concentration, speeded mental processing, and new learning and memory. He opined that the objective neurological findings indicated significant deficits in cognitive functioning that were of the kinds consistent with traumatic brain injury. He also concluded that the Appellant's report of persistent nightmares related to the accident was consistent with PTSD.

[20] Dr. Alfano recommended that the Appellant reduce his volunteer commitments, particularly those that involved critical decision-making. He recommended a referral to a psychiatrist for further evaluation and treatment of possible PTSD. He did not believe that the cognitive limitations were likely to diminish and, presumably for that reason, did not make recommendations respecting treatment for those. Instead, he recommended a referral to the Acquired Brain Injury Outreach Team for psychosocial support and monitoring.

[21] The Appellant was admitted to the Wascana Functional Rehabilitation Program (FRP) on October 4, 1999. His admission, which appears to be subsequent to an admission assessment[3], was for WAD, closed head injury (query post-concussion syndrome) and PTSD, all considered related to the vehicle accident. His pre-existing injuries arising from a 1984 workplace incident were also noted.

[22] Wascana recorded findings relating to tenderness, restricted range of motion and decreased strength in the Appellant's neck and shoulder, as well as decreased strength in his arms. As to psychosocial matters, Wascana noted the Appellant's on-going concerns about sleep dysfunction, nightmares, cognitive confusion and memory deficit. He was referred to a psychiatrist in regard to his sleep dysfunction and nightmares. After about eight weeks of treatment, the Appellant was discharged from the FRP due to his admission to hospital, which will be detailed below.

Unit showed no space occupying lesion and no other acute intracranial abnormality.

[23] On September 28, 2000, the Appellant was admitted to [name] Hospital in [City] on the instruction of his psychiatrist, Dr. Rajabi. After three days there, he was transferred to the [City] Mental Health Centre for further assessment. He remained at the Centre until October 27, 2000.

[24] Dr. Rajabi-Asl's Discharge Report indicates that during his hospitalization, all of the Appellant's medications had been withdrawn with a view to determining which were effective and whether alternate medicines might be helpful. In addition, Dr. Rajabi-Asl held daily psychotherapy sessions with the Appellant. Dr. Rajabi-Asl strongly agreed with the previous diagnosis of PTSD for the Appellant; he said the case was complex as multiple incidents contributed to his condition - the WCB accident, his divorce, the vehicle accident and "numerous other factors". The Appellant was reported to be responding well to treatment.

[25] Given the complexity of the case and concerns about the extent of SGI's responsibility, SGI referred the Appellant for an Independent Medical Examination (IME). This was done by Dr. Sibley, a rheumatologist at Royal University Hospital in Saskatoon, on March 2, 2001.

[26] His report, dated December 10, 2001, states that the Appellant complained of constant headaches, numbness and pain in certain digits, right foot pain and leg pain. As regarded non-physical aspects, the Appellant reported insomnia, impaired memory, irritability and mood swings.

[27] Dr. Sibley divided his opinion based on his view of responsibility. He concluded that SGI was responsible for the Appellant's PTSD, while recognizing that there are very likely other contributors. He noted that whatever his pre-MVA stressors, the Appellant had been coping fairly well prior to the vehicle accident but not afterward. He included insomnia, nightmares, depression and anxiety among the symptoms that he thought related to PTSD.

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[3] If there is a separate assessment report, the Commission was not provided a copy.

[28] Dr. Sibley concluded that, in all of the WCB and SGI medical records, there was only one reference to neck pain prior to the vehicle accident and he concluded that this entry was in error. He therefore concluded that the Appellant's neck complaints were entirely caused in the 1997 vehicle accident.

[29] Dr. Sibley specifically concluded that the Appellant did not suffer PCS at all. He recognized that various practitioners had put the diagnosis forward and that it had been indicated in various neuropsychological tests. However, Dr. Sibley thought the cognitive impairments observed were too great to be caused by a mild head injury. He thought that they could be explained by reference to childhood turmoil, family problems, PTSD, multiple medications and mechanical neck pain with headaches.

[30] Dr. Sibley concluded that the chronic foot and ankle pain and chronic mid and low back pain were directly related to the Appellant's work injury and remained the responsibility of WCB.

[31] Finally, Dr. Sibley noted that possible heart disease, Parkinson's disease, right shoulder pain and gastrointestinal symptoms could not be attributed to either the work accident or the vehicle accident. He further expressed concerns that certain of the Appellant's medications might be ineffective or of too little effect to justify their continuation. He was also cautioned that it was not in the interests of any of the Appellant, SGI or WCB to assign every problem the Appellant experienced to these accidents.

[32] A second report from Dr. Veloso dated March 13, 2002, provided his opinion that the Appellant's history and physical findings were consistent with PCS, associated with mild Parkinsonism that was likely drug-induced. With the exception of the reference to Parkinsonism, this report suggests the same conclusion as Dr. Veloso reached when he examined the Appellant on February 25, 1999.

[33] As the Appellant's symptoms continued and new conditions were diagnosed, SGI thought it appropriate to review his file and consider its responsibilities to the Appellant. Dr. Alexander, a physician consulting to SGI, provided his opinion in a letter dated

December 9, 2002. Dr. Alexander consulted one of the Appellant's physicians and sought further reports. In the meantime, Dr. Alexander concluded that "the treatment of the Appellant's insomnia, and nighttime problems is perhaps part of the Post-traumatic Stress Disorder, and thus SGI would be responsible." On this basis, SGI paid for certain equipment that had been prescribed in respect of sleep apnea that had been diagnosed in the Appellant.

[34] By letter dated May 10, 2003, Dr. Buwembo advised that he had seen the Appellant in March 2000 regarding his neck injury. Dr. Buwembo found mild cervical myelopathy and recommended surgery but the Appellant was reluctant to take that avenue. On examining the Appellant again on May 7, 2003, Dr. Buwembo found that the condition had deteriorated in that the Appellant was by then experiencing weakness in his left arm and unsteadiness and weakness in his legs. Pending a repeat MRI to confirm the diagnosis, Dr. Buwembo intended to again discuss surgery with the Appellant.

[35] Many further investigations were undertaken at Regina General Hospital after the Appellant's admission for depression in early January 2004. These included an MRI of the brain and a neurolite brain scan. While the results of the latter were normal, the former showed "moderate diffuse cortical atrophy and nonspecific focus of T2 signal in the right temporal white matter"

[36] Another of those examinations was by Dr. Buwembo. He found that the Appellant's neurological status was unchanged from what was observed in March 2000. Dr. Buwembo recommended continued observation with follow-up.

[37] Dr. Messer, the Appellant's treating psychiatrist, discharged him from hospital on February 23, 2004. In his Discharge Summary, Dr. Messer indicated that he found "multiple cormorbidities in a chronically traumatized individual with severe depression". He diagnosed:

- PTSD which was by then chronic;

- Depressive disorder with paranoid ideation and suicidal ideation. He opined that the vehicle accident had reactivated past stressors "from which he had recovered";
- Cognitive impairment including clear memory problems;
- Chronic pain with cervical myelopathy that was progressive and problematic;
- Brain problems with cerebral atrophy; and
- Sleep apnea.

Dr. Messer thought the conditions were progressive and the prognosis was poor.

[38] On further review, Dr. Alexander provided letters dated May 25, 2004 and November 2, 2004. In the first of these letters, Dr. Alexander concluded that "there do not appear to be problems which are directly related to the MVA which are in need of care."

[39] In the second letter, Dr. Alexander reviewed the files in some detail and concluded that "the MVA is not the sole and only provocative item in producing the problems which present." He noted Dr. Messer's opinions set out in the Discharge Report but also that Dr. Messer had not been consulted until March 2000. He observed that the Appellant's situation was complicated by circumstances of his history and suggested that it might be necessary to co-ordinate the suggestions in Dr. Sibley's report with Dr. Messer's more recent observations. He did not expressly state his opinion as to SGI's on-going responsibility to the Appellant, if any.

[40] Dr. Messer provided a document titled "Certificate of Medical Opinion" dated December 19, 2005. In this document, Dr. Messer opined that the Appellant had recovered from his pre-1997 injuries and was functioning well prior to the 1997 vehicle accident. He stated that, "[a]ll of the Appellant's current problems and issues are directly or indirectly related to injuries and trauma which sustained in the 1997 motor vehicle accident", including PTSD with depressive disorder, cognitive problems that affected cognition and functioning, and "aggravation of his medical status".

[41] Given Dr. Messer's Certificate, SGI referred the matter for further review by a medical consultant. Dr. Alport provided his review and opinion on April 13, 2006. Dr. Alport was firmly of the view that Dr. Messer was wrong is ascribing the Appellant's

conditions entirely to the vehicle accident and that, in fact, there was no clear link between the vehicle accident and the PTSD or that the Appellant's symptoms, as reported, could be related to a very minor brain injury. Indeed, Dr. Alport was not satisfied that any brain injury occurred at all. He was also not satisfied that the Appellant had PTSD at April 2006 or, if he had PTSD in 2000, that it was related to the vehicle accident. He concluded that if the PTSD was related to the vehicle accident, the accident was only a contributor and not a major cause of it.

[42] Based on Dr. Alexander's and Dr. Alport's opinions, SGI provided a decision letter to the Appellant on May 28, 2004 that stated that SGI was "no longer responsible for medications, therapy or special equipment such as the invoice from Vital Aire."

Personal Circumstances

[43] Certain of the Appellant's personal circumstances are considered relevant in the analysis of his current condition and its relationship to the 1997 vehicle accident. A brief summary of relevant aspects follows.

[44] The Appellant has had a number of traumatic incidents in his life. It is recorded that he was born in Yugoslavia and, at the age of five, was separated from his parents and was then homeless with his younger brother. Eventually, he stayed at an army camp where, still at about the age of five, he was accidentally shot in the leg. After that, he was placed in an orphanage.

[45] Eventually, the Appellant completed high school and six years of trade school and mechanical engineering studies.

[46] After moving to Canada in 1968, the Appellant was employed as an industrial mechanic and in 1984 was seriously injured in a workplace accident when he fell 60 – 80 feet from a ladder. He suffered multiple fractures to his feet, ankles and back and significant injury to his pelvis. He received Workers' Compensation Board (WCB) benefits

in respect of the accident and eventually, WCB disability pension because the permanent impact of his injuries left him unable to return to work.

[47] Nonetheless, he was active in community work and was a member of the Board of Directors of [name] Hospital in [City], a member of the [Town] Lodge Trust Committee, Chairperson at the [Village] Senior Citizen's Centre, a member of the [Village] Curling Club Board, a councilor for the Village, and a representative on the Financial Distribution at the [Village] Culture and Recreation Centre. He also completed a number of classes at the University of Regina.

[48] The Appellant married after coming to Canada but that union, unfortunately, ended in divorce in about the mid-1980s. The Appellant established a relationship with P.O. in 1987 and they have lived as man and wife since 1991. The couple raised P.O.'s grandson from the time he was a baby; he was about seven years old in 1997 when the Appellant had the vehicle accident. In addition, the couple tried to support the Appellant's adult son who had personal problems and made unreasonable and sometimes stressful demands on them.

[49] By February 4, 1999, the Appellant reported to Dr. Capp, a consultant in Physical Medicine and Rehabilitation, that he was not doing as much community work as he had previously but he retained some positions. He advised that his wife was by then doing more of the financial management as he was no longer as accurate as he had been. He also had to write notes to himself as reminders. He needed help dressing.

[50] He reported similarly to Dr. Alfano on February 26, 1999 that he was having difficulty meeting his responsibilities in his volunteer positions due to poor memory and concentration. Dr. Alfano, as noted above, recommended that he reduce the number of his volunteer commitments.

[51] On admission to FRP on October 4, 1999, the Appellant reported that he was still able to manage some household tasks like washing dishes and preparing simple meals, but he was reliant on his wife's frequent phone calls throughout the day to remind him about

these tasks. He said that his relationship with his wife was becoming difficult because of his inability to contribute to household management and maintenance.

[52] Eventually, as his condition progressed, the Appellant mental and physical illnesses increasingly prevented him from enjoying and participating in activities of family and life. Documentary evidence and testimony of the Appellant's wife indicates that the Appellant has discontinued all of his volunteer and community work and that he has surrendered all but the simplest aspects of home tasks, management and maintenance for her attention.

STANDARD OF REVIEW

[53] SGI's decision letter in this case is ambiguous in stating:

> Based on the information presently available the consultant advises SGI is no longer responsible for medication, therapy or special equipment such as the invoice from Vital Aire. Therefore reimbursement for the medication receipts and the receipt from Vital Aire will not be reimbursed.

[54] It is unclear whether SGI intended by this letter to refuse only reimbursement of specific invoices that the Appellant had submitted or whether it is intended to indicate that SGI had concluded it was not responsible for any of the Appellant's ongoing conditions and that benefits were entirely terminated.

[55] We believe the letter was intended as a termination of all benefits. The letter is not worded to be restricted to the specific receipts mentioned but to medication, therapy and special equipment "like" those mentioned. In addition, a copy of Dr. Alport's opinion was appended and this opinion appears to conclude that the vehicle accident was not the cause of the Appellant's PTSD or cognitive problems or, if it was, not in a significant way.

[56] When SGI terminates benefits by reason of a purported lack of causation, it makes a decision involving benefits to which, if causation is proven, a claimant is entitled. In

accordance with the Court of Appeal decision in *Allary* v. *Saskatchewan Government Insurance*[4], therefore, our standard of review is correctness.

ONUS OF PROOF

[57] In *Collis* v. *Saskatchewan Government Insurance*[5], the Saskatchewan Court of Queen's Bench considered the question of who held the onus of proof in appeals under the no-fault provisions of the Act. Justice Wimmer stated[6]:

> Cases dealing with disability insurance contracts hold that the insured has the onus of establishing that he or she is disabled within the meaning of the policy and, having done so, the onus shifts to the insurer to prove that benefits are not, or are no longer, payable. Also, the fact that the insurer at one time accepted the claim may weigh the balance in favour of the insured.

[58] The question before us is whether the Appellant has established that he was disabled within the meaning of the "policy". (The policy, for purposes of this decision, is the Act itself.) If he has not done so, the matter ends but if he has, the onus will shift to SGI.

[59] In this case, the Appellant was diagnosed with various conditions, including a cervical injury, PTSD, a possible brain injury or PCS, cognitive impairment and other purportedly related conditions over a period of years after the vehicle accident. Until December 9, 2002, when Dr. Alexander suggested that SGI was responsible for only a portion, set at 20%, of responsibility for the Appellant's sleep apnea and its treatment, SGI paid the Appellant all benefits related to all diagnoses, including those for medications, travel and treatment. It was not until May 25, 2004 that SGI suggested it might not be responsible for the Appellant's ongoing difficulties.

[60] Thus, SGI accepted responsibility for the very conditions that it subsequently concluded were not caused, or caused significantly, by the vehicle accident. As such, the Appellant has met the burden set out in *Collis* to prove that he was disabled in the vehicle accident and the onus is then shifted to SGI to prove, on a balance of probabilities, that he is no longer entitled to benefits.

[4] 2006 SKCA 89 (CanLII)

CAUSATION

[61] In the course of his testimony, Dr. Messer strongly urged the Commission to resist separating the Appellant's injuries and circumstances and attempting to find specific causes among them. He said that each plays on and from the others and that it is impossible to attribute some to the vehicle accident and others to other causes; one must look at it as a connected whole.

[62] In applying the law and legislation, we are required to do exactly what Dr. Messer urged against. However, the law of causation is not so narrow as to require the kind of restricted application Dr. Messer perhaps presumed.

[63] In *Athey* v. *Leonati*[7], the Supreme Court of Canada considered questions relating to causation. Justice Major said [all references omitted]:

> Causation is established where the plaintiff proves to the civil standard on a balance of probabilities that the defendant caused or contributed to the injury.
>
> The general, but not conclusive, test for causation is the "but for" test, which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant.
>
> The "but for" test is unworkable in some circumstances, so the courts have recognized that causation is established where the defendant's negligence "materially contributed" to the occurrence of the injury. A contributing factor is material if it falls outside the *de minimis* range.

[64] Perhaps most significant, Justice Major said this:

> It is not now necessary, nor has it ever been, for the plaintiff to establish that the defendant's negligence was the <u>sole cause</u> of the injury. There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring. . . . As long as a defendant is <u>part</u> of the cause of an injury, the defendant is liable, even though his act alone is not enough to create the injury. [Emphasis in the original.]

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[5] 1998 CanLII 13463, 165 Sask. R. 108
[6] paragraph [5]
[7] [1966] 3 S.C.R. 458

[65] In respect of certain of the Appellant's conditions – PTSD and cognitive impairment – it has been suggested that the Appellant had a pre-accident condition that was exacerbated or exaggerated by the impact of the vehicle accident. This assertion raises the concepts of the thin and crumbling skull. These were explained by Justice Major as follows:

> The "crumbling skull" doctrine is an awkward label for a fairly simple idea. It is named after the well-known "thin skull" rule, which makes the tortfeasor liable for the plaintiff's injuries even if the injuries are unexpectedly severe owing to a pre-existing condition. The tortfeasor must take his or her victim as the tortfeasor finds the victim, and is therefore liable even though the plaintiff's losses are more dramatic than they would be for the average person.
>
> The so-called "crumbling skull" rule simply recognizes that the pre-existing condition was inherent in the plaintiff's "original position". The defendant need not put the person in a position better than his or her original position. The defendant is liable for the injuries caused, even if they are extreme, but need not compensate the plaintiff for any debilitating effects of the pre-existing condition which the plaintiff would have experienced anyway.

[66] We will apply these principles in the discussion following. For ease of explanation, we will discuss each aspect of the Appellant's condition separately below.

POST-TRAUMATIC STRESS DISORDER

[67] Documentary evidence before us shows that PTSD was first suggested as possible and meriting investigation at the Appellant's secondary assessment on September 5, 1997. At that time, he had reported nightmares and trouble sleeping, flashbacks, increased episodes of dizziness, nervousness when driving and forgetfulness. The team thought these symptoms might suggest PTSD, although they did not diagnose the condition.

[68] At the tertiary assessment late in 1998, the team diagnosed PTSD. It is unclear whether and what action was taken in this respect as the focus of investigations for a significant period of time was on the Appellant's cognitive disabilities and possible PCS. Nonetheless, PTSD was confirmed when the Appellant was admitted to the [City] Mental Health Centre in September 2000 and the diagnosis has been maintained consistently thereafter. With the exception of Dr. Alport, it does not appear that any health care provider has challenged the diagnosis.

[69] The fact is that Dr. Messer and Dr. Rajabi-Asl, who provided extensive treatment to the Appellant before, during and after an extended hospital stay, have diagnosed PTSD. We are fully satisfied that the Appellant suffers PTSD with depressive disorder, as Dr. Messer testified.

[70] As to causation, Dr. Messer and Dr. Rajabi-Asl have both concluded, enthusiastically, that the Appellant's current PTSD was brought on by the vehicle accident. None of the health care providers who considered the matter suggested otherwise until, perhaps, Dr. Alexander's letter of May 2004 and certainly Dr. Alport's letter of April 13, 2006.

[71] In that letter, Dr. Alport detailed a number of concerns. He admitted that he is not an expert on the matter but understood that nightmares associated with PSTD generally related to the traumatic incident, whereas he found no reference to the Appellant's complaining of nightmares relating to the vehicle accident. However, we note references to nightmares about the accident in both the tertiary report and in Dr. Alfano's report.

[72] Dr. Alport questioned whether a vehicle accident-related case of PTSD would cause flashbacks of incidents unrelated to the vehicle accident. He was also troubled by the length of time after the accident until concerns that led to the PTSD diagnosis were raised. Indeed, SGI, through counsel, suggested that the timing in the onset of symptoms was a major consideration in SGI's decision to terminate the Appellant's benefits.

[73] However, the expert health care providers who concluded that the Appellant suffered PTSD must be presumed to have taken these matters into consideration in reaching their conclusions. From this, we can infer that neither flashbacks of non-vehicle accident incidents nor a lapse of time before symptoms were reported necessarily suggest against a diagnosis of PTSD arising from the 1997 vehicle accident.

[74] Clearly, there were other significant stressors in the Appellant's life at the time of and following the vehicle accident. Drs. Sibley and Messer both recognized this fact but

nonetheless concluded, in Dr. Messer's case, that the PSTD was caused by the vehicle accident and, in Dr. Sibley's case, that it was the most likely cause.

[75] Relying on the expert opinions of Drs. Sibley, Messer and Rajabi-Asl, we are satisfied that the Appellant's PTSD was caused or contributed to in a materially and significant way by the January 1997 vehicle accident. In accordance with *Athey* v. *Leonati*, therefore, SGI is responsible to the Appellant for all benefits respecting his PTSD.

Pre-Accident Condition

[76] Little evidence has been provided as to the Appellant's condition prior to the accident. We know and accept that he continued to suffer impairment as a consequence of the 1984 workplace injury. The Appellant's wife testified that he was "quite functional" though this was stated, we believe, in the context of how he managed physically.

[77] She testified that the Appellant changed after the vehicle accident. Before it, she said, he was "one of the happiest guys around" but afterward, he was very emotional and couldn't handle stress. She said he was angry and difficult to deal with. She says he disrespected her and accused her of things she hadn't done. She spoke especially of his sleeping problems – he would jerk and kick. While dreaming, he became delusional and thought people were after them. In that state, he once pushed her.

[78] In his testimony, Dr. Messer made reference to the Appellant's condition prior to the vehicle accident. In passing references that were not explored by counsel, he said that the Appellant had brain dysfunction and forgetfulness before and after the vehicle accident. He said past stressors were "reactivated" by the accident; in this respect, we understand that Dr. Messer was referring to pre-vehicle accident traumas in the Appellant's life. Dr. Messer stated that prior to the vehicle accident, the Appellant was functioning in "what had become his life" but that he was not functioning as he had prior to the 1984 work injury.

[79] We have difficulty with this part of Dr. Messer's evidence. No evidence was presented as to the source of this information, while we are aware that Dr. Messer did not

meet or treat the Appellant until March 2000. It may be that this evidence is speculative as to how the Appellant might have been expected to manage given earlier trauma and the 1984 work injury; we simply do not know.

[80] Dr. Sibley reported that there was "some indication of psychological disorder following, but not likely caused by, his 1984 work injury". Dr. Sibley did not provide further details regarding this comment and we have no evidence of the likelihood, nature or severity of the possible disorder.

[81] On the other hand, the Appellant stated that he had not seen a psychiatrist prior to the 1997 vehicle accident and there is no evidence whatsoever that the Appellant suffered any psychological, psychiatric or emotional condition in any aspect of the significance of that which is now documented.

[82] Prior to the accident, the Appellant was an active participant in many community organizations, including responsibilities respecting the management of funds for some. According to his reports to caregivers and the Appellant's wife's testimony, he engaged in leisure pursuits such as fishing and activities with his grandson. He was apparently communicative and content. The Appellant's wife's evidence, overall, was that he managed reasonably well with his limitations. Dr. Messer similarly described his behaviour at that time as reasonable.

[83] It would appear, to use Dr. Messer's words, that the Appellant was vulnerable at the time of the accident. According to Dr. Messer, the Appellant's life held many challenges but he was managing them. It is common knowledge that not everyone will develop PTSD after a vehicle accident, even a serious one, but for the Appellant it was one stress too many. Were it not for his traumatic childhood or stresses in his family life or his prior work injury or all of them, he might not have developed the condition. In this sense, he was a person with a thin skull who, as was stated in *Athey*, suffered losses more dramatic than an average person would have suffered. This, of course, does not change SGI's obligation to him in respect of the PTSD.

[84] Whatever his pre-accident condition, there is absolutely no evidence that the Appellant’s condition was progressing, that it would have progressed or how and over what time it would have progressed. The Appellant was not, to use the unfortunate legal expression, a crumbling skull in that we are not satisfied that all or any part of his current condition would have occurred eventually irrespective of the vehicle accident.

POST-CONCUSSION SYNDROME/COGNITIVE IMPAIRMENT

[85] There has been some disagreement among the health care professionals as to whether the Appellant suffered post-concussion syndrome as a result of the vehicle accident. The tertiary assessment team, Dr. Alfano and Dr. Veloso all opined that the Appellant’s symptoms were consistent with PCS.

[86] Dr. Messer testified at some length and with great passion that the Appellant had suffered a concussion in the vehicle accident. He said that it is not uncommon that symptoms of PCS are minor but progressive and not identified as brain injury until months after an accident. Like Dr. Landry had cautioned in his report, Dr. Messer testified that one must not rely on MRI results in such cases, as it is common to diagnose this illness long before objective signs show in CAT scans and other tests. He suggested that this is what had happened in the Appellant’s case.

[87] On the other hand, Dr. Landry noted that the brain injury, if any, was too mild to explain all of the cognitive deficits that the Appellant demonstrated. Dr. Sibley shared Dr. Landry’s view and further opined that the cognitive deficits could be explained by reference to historic personal trauma, family problems, PTSD, multiple medications and mechanical neck pain with headaches. Dr. Alexander advised that with PCS, one would expect symptoms to plateau or improve, whereas the Appellant’s symptoms became progressively worse.

[88] Dr. Alport noted that at the time of his admission to hospital, the Appellant was observed to be alert, conscious and oriented. Aside from a doctor’s notation indicating

questionable loss of consciousness, Dr. Alport says – correctly – there was no indication at all that any brain injury or concussion had occurred.

[89] The Appellant's statements in this respect are not helpful. While he indicated at his secondary assessment, tertiary assessment and to Dr. Veloso that he was dazed or knocked out in the accident, he is reported to have told Dr. Alfano that he was unsure whether he had lost consciousness or not. Given this inconsistency and the fact that the Appellant has also consistently said that he has amnesia regarding the time from the beginning of the roll until he awoke in hospital, we do not think the Appellant's information on this matter can be considered reliable.

[90] We are not satisfied that the Appellant suffered PCS in the vehicle accident of November 1997. While intending no disrespect to those practitioners who opined that he did, we agree with SGI's submission that those opinions were based directly or indirectly on the history recounted by the Appellant that he was rendered unconscious in the accident, or on previous conclusions that he had suffered a concussion. While we are not convinced that he did not, neither are we satisfied that he did.

[91] It is clear, however, that the Appellant suffered significant cognitive impairment following the accident. Memory loss and other impairments were reported by the Appellant at his secondary assessment in September 1997 and again at his tertiary assessment in November 1998. Multiple impairments were diagnosed, following objective testing, by Drs. Landry and Alfano in 1999. We understand that there is no dispute that the Appellant suffers significant cognitive impairment but SGI is of the view that these are not a result of the accident as there was no brain injury caused in the accident.

[92] We have concluded that a brain injury was not proven but we are not convinced that that disposes of the matter. While we are curious what the practitioners who thought there had been a concussion might have opined had history disclosed that the Appellant had not been rendered unconscious in the accident, we are without those opinions. Instead, we must consider only the opinions of those medical professionals who did not relate the Appellant's cognitive deficit to brain injury or PCS; these are the opinions of Drs. Landry and Sibley.

While neither entirely eliminated the possibility of a brain injury in the accident, both concluded that any brain injury suffered would have been too mild to explain the extent of the cognitive impairment indicated.

[93] Dr. Sibley suggested that there were other explanations for the cognitive impairments including, “English second language, childhood turmoil, current family problems with son and grandson, PTSD, polypharmacy, and mechanical neck pain with headaches”. Dr. Landry suggested that a minor concussion might exacerbate other medical or neurological illnesses in older people. Or, an existing neurological problem combined with the Appellant’s psychiatric problems, pain and headache complaints might combine to prevent improvement in his condition. In response to a specific question whether the vehicle accident contributed to the cognitive deficits, Dr. Landry did not offer an express opinion but he did indirectly, we think, suggest that there was a contribution by responding that the Appellant did not experience significant cognitive difficulties prior to the accident.

[94] We accept Dr. Messer’s evidence that, contrary to Dr. Alport’s suggestion, the Appellant’s cognitive impairment is not early symptoms of dementia. In reverse, however, Dr. Messer testified that cognitive impairment and distress can lead to depression that, in turn, can lead to dementing changes.

[95] Instead, Dr. Messer testified that the field of psychiatry has acquired a better knowledge of the effects of stress and that it is now accepted that chronic stress can affect brain-derived neurotropic factor and can cause cognitive problems.

[96] We are impressed by these opinions as they are consistent and provide a rational explanation for the development and progression of the Appellant’s cognitive impairment. Otherwise, we would be forced to the conclusion that these were wholly coincidental, a conclusion which strains common sense[8].

[8] In Athey v. Leonati, Justice Major stated that causation didn’t have to be determined with scientific precision. He referred to Justice Sopinka’s approval of Lord Salmon’s words in *Alphacell Ltd.* v. *Woodward*, [1972] 2 All E.R. 475 when he said causation is “essentially a practical question of fact which can best be answered by ordinary common sense.”

[97] It is the opinion of Drs. Sibley and Messer, which we accept, that the Appellant's PTSD, multiple medications and neck pain and headaches – all of which were directly caused in the 1997 vehicle accident – may have been material causes of the Appellant's cognitive disability.

[98] We are satisfied that they were. In this regard, we note that the other three possible causes set out by Dr. Sibley all existed prior to the accident, yet the Appellant did not have this cognitive disability, either in degree or number of aspects. It follows, therefore, that injuries caused in the vehicle accident, in turn, were a material cause of the Appellant's current cognitive impairment.

[99] As the 1997 vehicle accident was a material cause of the cognitive impairment, SGI is responsible to provide no-fault benefits respecting that injury.

PARKINSON'S TREMOR

[100] In the course of his post-accident treatment, the Appellant was treated for Parkinson's tremor. It is unclear whether he has been diagnosed with Parkinson's disease *per se* or only a tremor described as a "Parkinson's tremor".

[101] Dr. Matti, a psychiatrist, advised SGI in November 2000 that Dr. Veloso had prescribed a medication for Parkinson's disease. However, Dr. Veloso reported the condition as "mild Parkinsonism, likely drug induced". Dr. Sibley, while concluding that the Parkinson's disease was not within SGI's responsibility, noted that the condition can be trauma-related or that the term may be used simply to describe a tremor.

[102] Dr. Sridhar, who diagnosed and treated the Appellant's sleep disorder, stated that Parkinson's disease is associated with rapid eye movement behaviour disorder, a condition that the Appellant exhibited. It is unclear, however, whether Dr. Sridhar meant that people with Parkinson's disease sometimes develop the rapid eye movement disorder or the reverse.

[103] While it appears possible that the vehicle accident is a material cause of the Appellant's "Parkinsonism", the evidence is insufficient to establish this. That being the case, SGI is not responsible to provide no-fault coverage in respect of that condition unless information clarifying the nature of the diagnosis and its cause is subsequently provided.

SLEEP APNEA

[104] Commencing in February 2000, the Appellant attended the Sleep Clinic at Regina General Hospital where he was treated by Dr. Sridhar in regard to his nightmares. While observation at the time of his initial visit showed no sleep apnea, the condition was reported at his June 17, 2002 visit. A CPAP machine was prescribed and its use eliminated the apnea events. Eventually, Dr. Sridhar diagnosed Rapid Eye Movement behaviour disorder in the Appellant and this posed a difficulty - the treatment for the REM disorder exacerbated the apnea. However, Dr. Sridhar reported that the CPAP controlled the apnea, even in that circumstance.

[105] In response to a question as to whether the apnea was related to the vehicle accident, Dr. Sridhar was unable to be certain. However, he said that the condition was not significant when it was diagnosed in 2002 so it was unlikely to have been significant in 1997. We understand his letter as suggesting that since the Appellant did not have the disorder in 1997 but did in 2002, it might be related to the vehicle accident.

[106] If this understanding is correct, the fact that the condition developed post-accident alone is not sufficient to establish a causal connection. If the understanding is incorrect, the evidence presented does not appear to address a causal connection at all.

[107] In a later document, Dr. Sridhar says that PTSD and recurrent dreams might be related to the apnea condition. This bare statement of a possibility does not establish a causal connection.

[108] As such, SGI is not responsible to provide coverage in respect of the sleep apnea.

CERVICAL INJURY

[109] Upon admission to hospital and subsequently, the Appellant was diagnosed with a whiplash injury to his cervical spine. Complaints respecting injury to the neck and shoulders were consistent from the Appellant's early visits to the physiotherapist, through his secondary and tertiary assessments, FRP, visits to Dr. Capp and eventually to Dr. Buwembo. Dr. Buwembo identified cervical myelopathy and, at least initially, recommended surgery.

[110] There is no suggestion in any of the evidence before us that the Appellant had any cervical condition or complaint prior to the vehicle accident in 1997. Indeed, Dr. Sibley reviewed medical records more extensive than those before us and similarly found no evidence of prior neck complaints. He concluded that the neck injury was caused directly in the vehicle accident. We agree.

[111] We are satisfied that SGI was and remains responsible to provide all benefits that are or may be indicated in regard to the Appellant's neck and shoulder injuries. In this regard, we note especially Dr. Buwembo's recommendation for cervical surgery and the possibility that it will proceed in the future.

CONCLUSION

[112] For the reasons given above, SGI's decision letter of May 28, 2004 is set aside in so far as it purported to terminate benefits relating to PTSD, cognitive impairment and cervical injury and the Appellant's entitlement to all related benefits is reinstated.

[113] SGI is ordered to pay the Appellant all relevant benefits regarding his PTSD, cognitive impairment and cervical injury effective May 28, 2004 together with pre-judgment interest where appropriate.

[114] The decision letter of May 28, 2004 is confirmed respecting the termination of benefits for Parkinson's symptoms or disease and sleep apnea.

COSTS

[115] As the Appellant has been partly successful in his appeal, he is entitled to his reasonable expenses and costs calculated on double Column 3 of the Queen's Bench Tariff of Costs subject to the cap of $2,500.00 pursuant to s. 193(11) of the Act and s. 96 of the *Personal Injury Benefit Regulations* (Regulations). He is also entitled to be reimbursed for any practitioner's reports as per s. 169 of the Act and 76(1) of the Regulations subject to the cap set out therein.

[116] In addition, the Appellant shall be refunded his appeal fee.

Dated at Regina, Saskatchewan, on March 26, 2007.

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Beverly Cleveland, Chair

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Carolyn Jones, Commission Member

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Al Knippel, Commission Member