Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-04-104

PANEL:	**Ms Laura Diamond, Chairperson** **Ms Leona Barrett** **Mr. Paul Johnston**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Bob Tyre or the Claimant Adviser Office;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Dean Scaletta.**
HEARING DATE:	**September 15, 16 & 17, 2008**
ISSUE(S):	**Whether the Appellant's Personal Injury Protection Plan benefits were properly terminated as of March 2, 2003 under Section 160 of The Manitoba Public Insurance Corporation Act**
RELEVANT SECTIONS:	**Section 160 of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

Reasons For Decision

The Appellant was injured in a motor vehicle accident on November 26, 1994. At the time of the accident the Appellant was employed as [text deleted] in the [Text deleted]. Following the motor vehicle accident, the Appellant was diagnosed with a variety of injuries and psychological conditions. She was in receipt of Personal Injury Protection Plan ('PIPP') benefits, including Income Replacement Indemnity ('IRI') benefits.

In a letter dated February 17, 2003, the Appellant's case manager confirmed an earlier telephone conversation informing her that as a result of surveillance information, along with behavioural descriptions from medical reports during the same period, MPIC no longer believed that the motor vehicle accident was responsible for her claimed inability to return to gainful employment. MPIC agreed to continue with her IRI benefits only up until March 2, 2003, to allow the Appellant time to get her finances in order.

The Appellant sought an Internal Review of this decision. On May 30, 2003, an Internal Review Officer for MPIC advised the Appellant that the decision to terminate her benefits under the PIPP was based upon Section 160 of the MPIC Act which permits MPIC to refuse or terminate the payment of compensation for individuals who knowingly provide false or inaccurate information to the Corporation. The Internal Review Officer reviewed surveillance videotape information regarding the Appellant, as well as the medical information on her file. He reviewed the comparison of the symptoms complained of by the Appellant with the surveillance evidence and the "divergent and conflicting clinical picture" of her status.

The Internal Review Officer agreed with the case manager that there was repeated observation of inconsistencies and potential over reporting of symptoms. The Internal Review Officer found that the validity and accuracy of the Appellant's representation of symptoms had been disproved by the investigation, which justified invoking Section 160 of the MPIC Act to terminate the Appellant's benefits.

The Appellant wrote to the Commission on July 21, 2003 indicating her intention to appeal the decision of May 30, 2003. However, she wrote to the Commission again on September 2, 2003

indicating that she was not able to continue with the appeal, and withdrawing it. She then filed another Notice of Appeal on June 3, 2004, beyond the 90-day period provided in Section 174 of the MPIC Act in order to file an application to appeal MPIC's decision.

The Commission conducted a Pre-Hearing for the purpose of determining whether the Appellant had provided a reasonable explanation for failing to file her appeal in the 90-day time limit.

The Commission held hearings on September 14, 2004, February 6, 2006, May 5, 2006, and June 8, 2006 and concluded, by decision dated July 14, 2006 that the Appellant had established, on a balance of probabilities, that when she discontinued her appeal in the month of September 2003 this was not due to a change of heart, but due to a post-traumatic stress disorder. The Commission also found that in that condition she was chronically depressed, confused, emotionally distraught, suffering from blackouts, memory loss, anxiety, a loss of self-confidence, and had become dysfunctional and unable to cope with life and, as a result, discontinued her appeal. The Commission found that there were exceptional circumstances of a compelling nature which rendered it appropriate for the Commission to exercise its discretion to extend the time to permit the Appellant to appeal the Internal Review decision to the Commission.

It is from this decision of the Internal Review Officer that the Appellant has now appealed.

Evidence and Submission for the Appellant

The panel heard testimony from the Appellant as well as from her daughter, [text deleted], and her friend and neighbour, [text deleted].

The witnesses testified that prior to the motor vehicle accident the Appellant had been a busy, organized and active single mother. She worked full time at a job which demanded a high level of responsibility and was extremely involved with ensuring that her children stayed active in school and extracurricular activities. She was involved in volunteering at her church, was very organized both at work and at home, and was described as intelligent, self-reliant, assertive, and functioning at a high level at the time of the motor vehicle accident.

Her previous health issues, prior to the motor vehicle accident, were limited to some issues with her stomach, but she was generally a busy and healthy individual involved in an active family life.

The Appellant's injuries in the motor vehicle accident were described and included fractured ribs, a blow to her chest, a concussion (including semi-consciousness) as well as lacerations to her forehead. She also suffered from a loss of smell and hearing, and possible memory loss.

The witnesses testified regarding the resulting change in the Appellant's behaviour. She began to miss appointments, became averse to driving, would forget if she paid bills and would even forget that she was cooking something, leading to several burned meals. She had difficulties with her balance and was extremely uncomfortable in any social situation.

The Appellant described the assistance she received from [text deleted], a rehabilitation consultant provided by MPIC, as well as by her children, and by her boyfriend at the time. At one point, she moved with her boyfriend to [text deleted], and continued with treatment, seeing a psychiatrist in that province for treatment. Following her breakup with her boyfriend, she returned to Manitoba, and was hospitalized for a period, due to depression.

The Appellant described her difficulties with becoming more independent again. She described the treatment that she received with her psychologist, [Appellant's psychologist #1], which included assignments to be performed by her such as leaving the house, going shopping, riding a bike or cutting the grass. She indicated that she was working towards improving her level of function, although she was still on a lot of prescribed medication at the time, taking up to seventeen (17) pills a day in order to function.

On cross-examination by counsel for MPIC, the Appellant viewed videotape surveillance of her activities. She was viewed engaging in activities like riding a bike in busy traffic, riding a bike while smoking a cigarette, going on long walks in [text deleted] with friends and family, walking by herself, unaided, in a busy urban section of [text deleted], and in airports, moving luggage, carrying golf clubs, and waiting in lines.

When asked why she did not display any symptoms or discomfort in the videotape evidence which was viewed, the Appellant explained that, although in some cases she could not remember doing these things, in other cases she had the support of friends and family and so did not display anxiety. She also indicated that the medication she was on assisted her to do these things, and also assisted her when she travelled to [text deleted] with a friend in 2003, and was able to organize her passport and all the things she would need for her trip.

The representative for the Appellant submitted that the Appellant suffered significant injuries in the motor vehicle accident, which included a head injury, leading to psychological problems such as difficulties with her memory, confusion, lack of confidence and social phobia. Soon after the motor vehicle accident, her physical injuries were more severe, but as the years

progressed, she no longer needed to use a cane at the time, particularly outside of the winter months. She became able to ride a bicycle. She worked steadily to overcome her anxieties and social phobias regarding leaving the house and her safe environment, and travelling.

The representative noted that the Appellant didn't suffer all her symptoms every day. She felt different things at different times, depending on what was happening in her life. MPIC had done extensive video surveillance, and it should be taken in context. The Appellant had not tried to hide the fact of her travels from MPIC, but rather had openly detailed her movements for them. She was working on overcoming her difficulties, with assistance from family and friends, and that is what was viewed on the videotapes.

The Appellant's representative reviewed the medical evidence, and emphasized the reports from her treating caregiver, [Appellant's psychologist #1], who knew the Appellant best and provided a much better picture of her condition than reports from [MPIC's doctor], MPIC's health care consultant, who had never examined the Appellant.

He submitted that there was no medical information indicating that the Appellant had returned to her pre-accident level of functioning. MPIC had not provided clear and cogent evidence that the Appellant was in violation of Section 160(a) of the MPIC Act, and it was noted that the case manager did not raise Section 160(a) of the MPIC Act in his letter dated February 17, 2003. It was submitted that the Appellant's appeal should be allowed and that her IRI and any other relevant benefits should be reinstated.

Evidence and Submission for MPIC

The panel heard evidence from [MPIC's doctor], the Medical Director for MPIC. [MPIC's doctor] had reviewed both medical reports on the Appellant's file and the videotaped surveillance evidence provided by MPIC's investigators. He had also provided reports to the Appellant's file reviewing this information.

At the hearing, [MPIC's doctor] was asked to comment both on the written reports, which set out the Appellant's symptoms and complaints, and to view the videotaped evidence. [MPIC's doctor] indicated that he had first reviewed the medical information on file, before viewing any videotapes, to see what the clinicians were describing and what the Appellant's complaints were. He then reviewed the videos to see if there was consistency with what was described.

The written material on file made references to anxiety, panic attacks and agoraphobia. The description of the Appellant's condition indicated a severe problem, with difficulty going out in any circumstances and only some improvement a couple of years later.

In contrast, [MPIC's doctor] indicated that his observations of the videotape evidence showed no external manifestations of such psychological problems. The Appellant appeared relaxed, and was even smiling, in unfamiliar situations such as hotels and airports, and in densely populated areas. Although evidence presented by [Appellant's psychologist #1] had indicated that the Appellant was housebound at times and unable to interact in the greater marketplace of life, the videos which [MPIC's doctor] observed indicated that she was able to engage in the public marketplace of life in various situations.

[MPIC's doctor] testified that the Appellant, in travelling alone in certain situations, had also exhibited behaviour which was not consistent with any significant cognitive difficulty. She appeared to be able to make numerous executive decisions involved with travelling alone.

The behaviour shown in the videotapes appeared to be consistent with the Appellant's ability to work. She seemed to be able to use transportation to get to her destination. She also exhibited the cognitive skills needed to perform her tasks. Nothing in the videos indicated that she would be a risk to herself or her co-workers, or that working would adversely change the natural history of her condition.

[MPIC's doctor] reviewed several of the videotapes at the hearing. He indicated that the Appellant, in doing such activities as shoveling topsoil, riding a bike, handling luggage, and walking looked physically quite normal.

There was no evidence of the Appellant using a cane and she was walking normally, with no balance issues, although there were reports on the file of the Appellant requiring the use of a walker or cane.

[MPIC's doctor] also indicated that the videos did not disclose evidence of the Appellant suffering negative effects from any anti-anxiety medication she may have been taking, as there was no appearance of sedation, somnolence or blunted affect.

From a psychological perspective, in such situations as a crowded [text deleted] airport, [text deleted], ferry terminals, walking on a busy street or bike riding on [text deleted], the Appellant had a calm external appearance, a normal affect without anxiety, and no external manifestations

of agoraphobia, even in a situation of profound stimulus. In situations which could be considered to have fairly potent stimulus to an individual with severe agoraphobia, the Appellant seemed to tolerate the exposure fairly well, from an external perspective.

[MPIC's doctor] also reviewed the medical reports on file from other psychiatrists and psychologists, such as [independent forensic psychiatrist], [Appellant's neuropsychologist], [Appellant's psychologist #1], and [Appellant's neurologist #1], a neurologist.
He noted that [independent forensic psychiatrist's] report dated April 2, 1998 was quite forceful. He used language which doctors do not use recklessly. He described the Appellant as a malingerer, a term which a forensic psychiatrist such as [independent forensic psychiatrist] would have a good understanding of. He described borderline personality traits, but blamed these upon her family of origin, indicating that the source was not the motor vehicle accident. [Independent forensic psychiatrist] found with a high degree of certainty that the Appellant was not a credible narrator regarding her statements of illness, and that she was not totally disabled.

[Appellant's neurologist #1] described the Appellant's complaints when investigating the Appellant's claims of black outs due to possible seizures, and her smell and hearing complaints. Significant structural damage to her brain had been ruled out. [Appellant's neurologist #1] described "overlay" which indicated that her difficulties were volitional or a psychological manifestation of her problems, without an organic basis. He indicated that panic attacks, hysteria or malingering were also possible.

[MPIC's doctor] also reviewed reports from [Appellant's neuropsychologist], a neuropsychologist, who performed an evaluation of the Appellant. [Appellant's neuropsychologist] found that the Appellant's tests were profoundly invalid and noted that they

were the most invalid he had seen in his career. As a result, he had requested four (4) other neurologists to consider them. [MPIC's doctor] concluded that this meant that the Appellant could not be considered to have a bona fide brain injury. Her scoring results indicated that she was probably answering incorrectly, and [Appellant's neuropsychologist] concluded that the Appellant was malingering or intentionally feigning difficulties.

[MPIC's doctor] emphasized the importance of accurate self-reporting of symptoms in the diagnosis and treatment of conditions such as agoraphobia and social phobias.

Counsel for MPIC submitted that to knowingly provide false or inaccurate information is a fundamental breach of a claimant's obligation to deal in good faith with the insurer. That is the reason why the preamble to Section 160 of the MPIC Act provides for the extreme remedy of a complete termination of benefits in cases where information being provided by the claimant is demonstrably false or inaccurate. Unlike several other provisions of that section, Section 160(a) is not prefaced with the phrase "without valid reason" as there can be no excuse for knowingly providing the insurer with false or inaccurate information in the course of an ongoing claim.

In the Appellant's case, counsel submitted that although the Appellant was well aware of the particulars of the videotape surveillance, no explanation (even if one were relevant), with respect to the stark discrepancies between her representations to MPIC and others concerning her level of function, and her activities as shown on the videotapes, had been provided.

Counsel provided the panel with a detailed review of the evidence, including highlights from notes on the indexed file, findings and observations of [MPIC's doctor], highlights of the Appellant's chart notes from her general practitioner ([Appellant's doctor #1] of [text deleted]), summaries of the neurological reports and test results, highlights of videotape surveillance, and

records from the Appellant's MPIC file expressing concerns about the bona fide nature of her claim.

On cross-examination, passages from many of these reports from the indexed file were put to the Appellant, along with excerpts from the surveillance evidence which contrasted the answers she had given to her case manager.

For example, although the video surveillance and private investigator reports from November 16, 17, 20, 21, 22 and 27, 2000 indicated that the Appellant was seen walking with no sign of any walking aids or canes, the Appellant's case manager made notes, following conversations with the Appellant on November 20, 21 and 22, which indicated:

> "… [S]till uses a cane … When not using a cane, she has to hang on to someone to stabilise (sic) and avoid falling. I asked her directly whether she could walk any distance without the use of any aids or hanging on to someone and she denied claiming she always uses a cane. I asked her whether she just had to hang on to someone's hand when walking. She said 'No'. She had to physically grab onto the other person's arm and walk slightly behind that individual."
> . . .
> I asked her whether her doctors or chiropractor or physiotherapist has ever instructed her on home exercise or other activities which she could do within the home or outside the home that she has continued to do to help with the endurance and strengthening of her back and neck and other physical difficulties that she is experiencing. She vaguely talked about exercising that she was shown how to do but she is not doing them, denied being able to do any activities such as going for walks or riding a bike as examples.

Counsel contrasted the Appellant's answers to questions regarding her reported inability to ride a bicycle, with the clear videotape surveillance evidence of her rides.

Again, in early March of 2002, the Appellant indicated to her case manager that she could not walk without assistance, while she was observed by a private investigator on January 19, and February 9, 2002 walking alone, normally and without a cane or any other form of assistance.

Counsel also referred to the Appellant's evidence before the Commission in May of 2006, when the Commission heard evidence leading to its decision to exercise its discretion to allow the Appellant to extend the time to file an appeal to her Internal Review decision. At that time the Commission heard evidence from the Appellant, her daughter and her neighbour. They described the Appellant's dire personal and financial circumstances in mid-September of 2003 and her inability to function at even the most basic level at that time. Counsel referred to the decision of the panel of the Commission dated July 14, 2006 regarding the Appellant's evidence that she was at that time in the throes of an episode of severe and disabling post-traumatic stress disorder, was financially destitute, was compelled (by circumstances) to live in the basement of the home occupied by her daughter and son-in-law, rarely left the basement during this period, needed a great deal of support and assistance, and was dysfunctional and unable without assistance to carry out her routine daily activities.

However, counsel noted that it was during this same time period that the Appellant flew alone to [text deleted] to meet up with a friend who took her to [text deleted] for two (2) weeks. During that time period the Appellant completed all of the necessary steps to obtain a passport, planned and packed for the trip, and was able to travel to [text deleted].

Counsel noted that the Appellant had also asserted that she suffered from permanent brain damage and loss of memory. However, she was, during the hearing, able to give her direct evidence and to respond to questions on cross-examination without referring to notes or to many documents. She also gave a detailed description of her medication regime between 1995 and 2003, without any reference to notes or documents to refresh her memory.

Counsel for MPIC also placed great emphasis on a number of psychiatric and medical reports which concluded that the Appellant was not suffering from a condition as a result of the accident and that she was "malingering".

He reviewed an independent psychiatric report (prepared for a different insurer) by [independent forensic psychiatrist] in 1997. [Independent forensic psychiatrist] had concluded that the Appellant was carrying on a "charade" and that she was "malingering".

In November of 2002, [MPIC's doctor], then the Director of Medical Services for MPIC, conducted an exhaustive review of the material on file and concluded that there was not a probable genuine psychological condition directly related to the motor vehicle accident which the Appellant was suffering from. He also noted that:

> "There is reasonable psychiatric and psychological opinion on file that this claimant is malingering, and/or feigning much of her clinical presentation. Much of her clinical presentation is based on self-report, and when there is a question as to the [veracity] of self-report, one must look to other evidence to confirm or deny the self-report. The videotape in this case, would indicate that the claimant's self-report is inaccurate, and could not be relied upon to establish the diagnoses of anxiety, panic attacks, agoraphobia, or depression."

In spite of the Appellant's claims to be suffering from seizures and blackouts, no neurological problems were detected in spite of fifteen (15) assessments and test results generated between November 1994 and January 1999.

Reports from [Appellant's neurologist #2], a neurologist, [Appellant's neuropsychologist], a neuropsychologist, and [Appellant's psychologist #2], a psychologist, did not find the Appellant had a psychological condition as a result of the motor vehicle accident, or that she was suffering from seizures as a result. In addition, [Appellant's neuropsychologist] clearly noted that the

Appellant's measurements on testing were not valid, and that the Appellant was intentionally feigning difficulty.

Counsel submitted that the decision to terminate the Appellant's PIPP benefits in March 2003 was amply supported by the evidence. Whatever the source of the Appellant's ongoing difficulties might have been, it was not a result of the motor vehicle accident of November 1994. Although the case manager's decision referred to the evidence establishing that the motor vehicle accident was no longer responsible for the Appellant's inability to work, the Internal Review decision under appeal clearly found that the Appellant had provided false information to the corporation in that regard. The Commission, he submitted, should find that the Appellant, without valid reason, had knowingly provided false and inaccurate information to the insurer. As a result, the termination of her benefits was reasonable, the decision of the Internal Review Officer should be upheld, and her appeal should be dismissed.

Discussion

Corporation may refuse or terminate compensation

160 The corporation may refuse to pay compensation to a person or may reduce the amount of an indemnity or suspend or terminate the indemnity, where the person

(a) knowingly provides false or inaccurate information to the corporation;

MPIC's Internal Review Officer found that the Appellant had knowingly provided false or inaccurate information to the Corporation and that her benefits should be terminated under Section 160 of the MPIC Act.

The onus is on the Appellant to show, on a balance of probabilities, that the Internal Review Officer was not correct in this assessment.

The panel has reviewed the evidence contained in the Appellant's indexed file as well as the oral testimony presented at the hearing, along with videotaped evidence. We have also considered the submissions of counsel for the Appellant and for MPIC and have concluded that the Internal Review Officer was correct in his decision of May 30, 2003.

The case manager's decision of February 17, 2003 set out the diagnosis which had been forwarded to MPIC by a variety of health care professionals.

DIAGNOSIS	**FIRST DIAGNOSIS**	**HEALTH CARE PROVIDER**
Driving Anxiety	1995	[Appellant's neuropsychologist], [Appellant's psychologist #2]
Social Phobia	1995	[Appellant's neuropsychologist], [Appellant's psychologist #1], [Appellant's psychiatrist #1]
Panic Disorder with Agoraphobia	1995	[Appellant's psychiatrist #2], [Appellant's neuropsychologist], [Appellant's psychiatrist #3], [Appellant's psychologist #1], [Appellant's psychologist #2]
Multiple Somatic Complaints/Blackouts	1995	[Appellant's doctor #2], [Appellant's doctor #3], [Appellant's doctor #4]
Depressed Affect/Suicidal Ideation	1995	[Appellant's psychiatrist #2], [Appellant's psychiatrist #3]
Minimal Brain Injury	1996	[Appellant's doctor #5]
No Malingering	1996	[Appellant's doctor #5]
Major Depression	1997	[Appellant's psychologist #1], [Appellant's psychiatrist #1],
Borderline Personality Disorder	1997 (Childhood Onset)	[Appellant's psychiatrist #3], [Appellant's psychologist #2]
Borderline/Dependent Personality Traits	1997	[independent forensic psychiatrist]
Malingering	1997	[independent forensic psychiatrist]
No Mood, Anxiety, Psychotic Disorder	1997	[independent forensic psychiatrist]
Post Traumatic Stress Disorder	1997	[Appellant's psychiatrist #1], [Appellant's doctor #6]
Psychiatric Condition	1998	[Appellant's doctor #4]
Bulimia	2000	[Appellant's psychologist #2]

The case manager also set out the repeated observations of inconsistencies and potential overreporting of symptoms noted by caregivers.

DATE	PROVIDER	SYMPTOMS	INCONSISTENCY
1995	[Appellant's audiologist]	Hearing Loss	Audiology Report – "out of keeping with her ability to hear conversational speech"
1995	[Appellant's neuropsychologist]	Cognitive	Inconsistent with severity of injury
1995	[Appellant's neuropsychologist]	Cognitive	All cognitive findings on second assessment worse than first
1996	[Appellant's doctor #5]	Physical	Inconsistent physical findings
1996	[Appellant's neuropsychologist]	Cognitive	Third Assessment – "reflects psychological factors"
1997	[independent forensic psychiatrist]	Psychosocial	Embellishment, of a conscious nature obvious symptom endorsement while subtle symptoms not endorsed
1998	[text deleted]	Cognitive	No recall of meeting with writer despite working with him for the past two years
1998	[Appellant's neurologist #1]	Physical	"some degree of overlay" noted
2000	[Appellant's neuropsychologist]	Cognitive	Fourth assessment remains invalid – "unable to confirm that [the Appellant] has identifiable cognitive deficits secondary to the motor vehicle accident"
2000	[Appellant's psychologist #2]	Psychological	Exaggeration on psychological questionnaires

He then went on to contrast specific reports of symptoms made by the Appellant between 1998 and 2002, with the Appellant's behaviour and surveillance tapes during that same period.

SYMPTOM REPORT

June 1998 – [Appellant's psychologist #1]

● Considerable improvement
● Anxiety and depression continue to cause difficulty at times
● Falls and blackouts
● Unsteadiness when walking
● More able to trust people, ask friends and family for appropriate help
● Able to walk to [Text deleted] alone, not going inside alone yet
● Arranged supporters to go to CPP meeting with her - went through with it even though they did not arrive as planned
● Mood much more positive most of the time, some periods over previous months of low mood when slept more, avoided social contact
● Much more able to tolerate interactions

SURVEILLANCE

June - July 1998 - Winnipeg

● yard work
- brings garbage can to curb, returns garbage can
- walk with friend and child
- yard work - shovels topsoil, sweeping, raking in yard - video over 2 days 23 June, 2 July
- persons in area do not appear to distract or alarm [the Appellant],
- no significant anxiety notes during observation
- 10 days surveillance, 4 days observed activity

Sept - October 1998 - Winnipeg

with people, has arranged get togethers, able to consider being more assertive, made new friends in the community

November 1998 – [Appellant's doctor #4]

● Anxious mood, agoraphobia, fear of driving
● Problems with short-term memory, has to keep lists and journals of what she does
● Disoriented to time (date and year)

December 1998 – [text deleted]

● "social situations continue to be quite challenging and there are many things she has difficulty doing because of discomfort in social situations. For example, she reports it is still very difficult for her to go into a coffee shop with a friend and it is difficult for her to go into a store alone and purchase grocery or clothing items"

May 1999 – [Appellant's psychologist #1]

● working at regular homework assignments involving activity outside of the home and contacts with friends and family.
● able to walk to [Text deleted] unaccompanied
● "going out to a restaurant or coffee shop - even with family or friends continues to be quite difficult for her"
● continues to have difficulty with low mood at times and at these times she may withdraw from her normal activities - working on not withdrawing
● reasonable to begin planning for volunteer work
● walking alone out of home on street
● bicycle ride alone 7 kms, 30 mins +
● rides in areas of moderate traffic, east and west on [text deleted], crosses lanes, no apparent anxiety (several facial close-ups, riding smoothly and rhythmically) - rides on roadway on [text del] (not consistent with high anxiety), rides on sidewalk at and of ride
● 6 days surveillance, 2 days observed activity

June 1999

- mowing lawn; sitting in front lawn reading
- cab to [text deleted] building, accompanied by son
- shopping in drug store with usual pedestrian traffic
- no significant observed anxiety,
- 5 days surveillance, 3 days no observed activity

July 1999

- 3 days surveillance, 3 days no observed activity

January 2000 – [Appellant's rehab consultant]

● three volunteer sessions as of this report

March 13, 2000 – [the Appellant] Letter 2

● "am able to leave my home and go for short walks, and not get lost for the first time this past year
● cognitive issues: "I forget what doing or where I am, all the time
● "I now know I cannot be alone because of the forgetfulness, accidents, and blackouts and getting lost"
● "I walk better, my balance is not as bad, but still use the cane at times"
● "no hearing in my left year"
"I feel so out of control with my life and get very confused and anxious and this turn into severe depression and difficult to come out of my home"

June 2000 – [Appellant's rehab consultant]

● Reviewed trip to [text deleted] "trip was enjoyable overall, however that she experienced frequent panic attacks, most notably when large numbers of people and when crossing bridges on foot. She further advised that her boyfriend [text deleted] and/or his daughters accompanied her on almost all outings, and that this support made it possible for [the Appellant] to function in the unfamiliar environments". She reportedly "hid in ([text deleted] daughter's) house for the most part and used a controlled breathing technique when in public. She further stated that her anxiety was less noticeable when she was either engaged in some form of activity or concentrating on other people
● appears that she was able to function adequately with support when tasks were simple and of a relatively short duration. Some question regarding her ability to initiate and implement strategies for anxiety reduction in unfamiliar circumstances and

March - April 2000

- [text deleted]: surveillance of cab to bank then to airport accompanied by son in airport, walking in corridors, smoking room; moderate numbers of other people
- [text deleted]: leaves home; buysbread passenger in 4 x 4

- [text del]AIRPORT: accompanied by man and son, walks slowly through busy terminal, smiling at one point, waits in line at cafeteria, purchases beverages, has coffee in terminal restaurant. In terminal for approx 90 minutes, further 45 minutes + in gate area waiting for boarding (no video of this entire event - description only No apparent acute anxiety
- RETURN TO [text deleted]: accompanied by son, speaks to commissionaire and smiles, arms folded across chest while waiting for luggage, looking around frequently, waits 5 minutes for luggage then heads to front door smoking, returns to obtain luggage 5 minutes later and leaves

environments

July 2000 – [Appellant's psychologist #1]

● "[the Appellant] reports significant anxiety symptoms with unfamiliar people or anything more than a small group. She also describes anxiety when she travels away from the safety of her home - anticipatory anxiety.
● "With her work on treatment over the last years, her "safe zone" has gradually increased in size although she continues to be much more limited than the average person in her ability to participate in everyday activities such as travelling around her neighbourhood, shopping and visiting with family and friends."
● "In preparation for this move, [the Appellant] took two trips to visit this fellow - one to his home in [text deleted] and one to his daughter's wedding in [text deleted]. These trips were very difficulty for her and she experienced a great deal of difficulty before hand with anxiety and depression but in the end the experiences were more positive than
● "pattern of symptoms described over the period of time I have been working with [the Appellant] would fit with diagnoses of social phobia, panic disorder with agoraphobia, fears about driving and traveling, and intermittent major depression. Her pattern of gradual improvements fits with what I have seen in the past with individuals with these problems"
● "she is not even approaching a situation where she could engage in part-time or full-time employment. The volunteer task was a very basic one and just getting to and staying in this situation for one or two hours was a challenge for her. At this point it is not clear that even with assistance [the Appellant] will be able to handle competitive employment

July 2000 – [Appellant's psychologist #2]

● presented in waiting room as quite anxious, accompanied by [text deleted], but came into office quite easily, appeared

May - June 2000

● [text deleted] AIRPORT: Waiting for luggage, looking around, no apparent acute anxiety - waits for luggage 10 + minutes, exits terminal waits for bus approx 25 minutes, smoking others waiting with her, appears to speak to several fellow passengers, smiles, appears to be in no acute anxiety.
● [text deleted]: Description of activity details walking alone to restaurant, ordering food and drinks with no apparent difficult. Video of her speaking with unidentified male outside hotel for 5 minutes, laughing and smiling. Description details cab ride to downtown [text deleted]. Video of shopping in [text deleted] alone approx 1 hour based on descr. - no apparent acute anxiety observed. Then enters "low rent area" of [text deleted], observed to enter "several pawn shops and very rough bars and pubs".
She returns to hotel

● TRAVEL TO [text deleted]: Description of travel to [text deleted] Airport, then to [text deleted] Ferry Terminal, again in passenger waiting area, accompanied, on ferry, meeting others after departing ferry.
● [text deleted]: Accompanied trip to shopping centre, video of accompanied trip to downtown [text deleted]. Video of unaccompanied bicycle ride (1 hour), accompanied trip downtown (2.2 km), accompanied trip to downtown and beach, unaccompanied trip to three pubs
- away from residence over 4 hours

to "put on" anxiety behaviours as preparing to leave
● stated that she "always" feels paranoid in public
● reported that she "apparently handled relatively well" a recent trip to [text deleted] - conflicts with [text deleted] report that she needed frequent support
● tendency to exaggerate symptoms

August 2000 – [Appellant's psychologist #1]

● when first seen "she had very serious problems with major depression, social phobia, driving phobia, and a variety of medical problems"
● difficult to engage in psychological treatment due to poor concentration and memory
● currently described as "very limited in her ability to use public transportation and to be away from home alone
● currently She "has found it difficult to meet new people so the prospect of meeting many new people is challenging for her'. "Group situations are especially difficult for her and she feels that she copes better on a one-to-one basis or in very small groups:

November 2000

[text deleted] SURVEILLANCE: Activity On 1 or 2 days of surveillance, airport

[text deleted] SURVEILLANCE: airport Activity, unaccompanied, waiting for luggage. Unaccompanied cab ride to [text deleted], trip to Bakery, cab ride three consecutive days (unknown destination - subject lost) - chiropractor, physician. Air activity

January 18, 2002 - February 9, 2002

● seen walking briskly without any difficulty or need to use a cane
● seen at airport with no difficulty and moving freely amongst the crowd
● seem limping only in [text deleted] airport but not minutes later out in the airport parking lot nor any evidence of limping when leaving [text deleted] 5 to 6 hours previous

February 26, 2001 – [the Appellant's] Letter 2

● Apparently does not know the cause
of blackouts
● $45000 in debt
● "unable to retain the [text deleted] language"
● ongoing blackouts/falls
● forgetfulness - uses notes
● "I can't seem to manage"
● "I can't survive alone any longer"
● "[text deleted] taken on a big part of
raising [text deleted] "

January 18, 2002 - February 9, 2002

● continues with same complaints
which restrict her social and
employment functioning

The Internal Review Officer placed a good deal of reliance upon the observations of [MPIC's doctor] in his review of the indexed file, which included reports from the Appellant's caregivers. He quoted extensively from [MPIC's doctor's] memorandum of November 25, 2002:

> [MPIC's doctor] indicated that a large number of your atypical "symptoms" had yet to be quantified and until that was done their relationship to the accident could not be established. [MPIC's doctor's] concerns (which echo those of other experts who have provided reports in your file) are evident when he stated at page 8 of his Inter-Departmental Memorandum:
>
> > "Of significant concern in this file, is a relatively frank opinion of [independent forensic psychiatrist], which is echoed by [Appellant's neuropsychologist], and [Appellant's neurologist #1], that this claimant is either malingering, or to a lesser extent, magnifying her impairment. This would be consistent with the observed videotape. Given that psychological impediments have been the most significant alleged impairment for this claimant, it is difficult to conclude that there has been a genuine psychological impairment from the beginning. The evidence from [Appellant's psychologist #1], based on the claimant's report to him, does not appear to be reflective of the claimant's true function, calling into question, the veracity of her self-report.
>
> In discussing "Conditions Unrelated to the Collision in Question" [MPIC's doctor] points out that you had a significant "tumultuous psychosocial and psychodynamic" pre-accident history which includes the diagnosis of borderline personality disorder and depression with suicidal attempts. As to the lack of relationship to the motor vehicle accident, [MPIC's doctor's] analysis was as follows (at page 8):

> "One can conclude that on the balance of probability, the patient's tumultuous psychosocial and psychodynamic milieu prompted the borderline personality trait or disorder, the anxiety, and the depression in her life, which has been associated with suicidal attempts. While the patient may have had a closed mild head injury, there does not appear clear, consistent, or cogent evidence that she has been left with ongoing manifestations of a brain injury. The February 2000 letter of [Appellant's neuropsychologist] indicates that the patient's tests were profoundly invalid, and [Appellant's neuropsychologist] opined that he was not able to confirm that [the Appellant] had an identifiable cognitive secondary to her motor vehicle accident. [Appellant's psychiatrist #3] states that the patient's anxiety and depression were due to her personality disorder, and not as a consequence of the collision in question. [Independent forensic psychologist] believed the patient was likely malingering and that her symptoms were consciously or fraudulently generated for secondary gain. Weighing the two potential causes this patient's pre-accident psychosocial and psychodynamic milieu appears to be the more probably cause of her current anxiety, depression, and potential suicidality. The collision in question does not appear to be the probable cause of this".

[MPIC's doctor] went on to discuss and dismiss the suggestion that the accident led to a significant and permanent increase in your psychological symptoms. Finally, [MPIC's doctor] concluded his Inter-Departmental Memorandum by stating:

> "In my opinion, on the balance of probability, one cannot conclude that there is a probable genuine psychological condition, which is directly related to the collision in question. As of 1997, [Appellant's psychiatrist #3] stated this claimant had significant psychological problems, which probable (sic) date back to childhood and childhood events. The diagnosis of a borderline personality disorder with self-mutilation would be consistent with this type of developmental abnormality. There is reasonable psychiatric and psychological opinion on file that this claimant is malingering, and/or feigning much of her clinical presentation. Much of her clinical presentation is based on self-report, and when there is a question as to the veracity of self-report, one must look to other evidence to confirm or deny the self-report. The videotape in this case, would indicate that the claimant's self-report is inaccurate, and could not be relied upon to establish diagnoses of anxiety, panic attacks agoraphobia or depression. While the claimant may be experiencing these problems, the evidence on file would make it difficult to conclude that they were the direct consequence of the collision in question or leading to genuine impairment. There is ample evidence to the contrary".

It was submitted by the Appellant's representative that MPIC must provide clear and cogent evidence in order to establish that the Appellant had knowingly provided false information. In

his view, the fact that the Appellant's symptoms could vary over time and go up and down over the years, does not indicate that the Appellant did not suffer from these symptoms. Nor did the lack of visible external signs on the videotape evidence mean that the Appellant did not suffer from internal anxiety and difficulty and rely upon medication and the assistance of other people to attempt to function more normally.

Indeed this is what the Appellant did assert, to some degree at least, in her testimony.

However, the panel did not find the evidence of the Appellant to be credible. Many inconsistencies arose between her reports to her case managers, to her caregivers, and to the Commission in 2006, and the evidence viewed in the videotape surveillance and at the appeal hearing. In general, the Appellant's evidence, including her demeanor and explanations for questions posed to her by counsel for MPIC on cross-examination, did not lead the panel to find that she was a credible witness. The Appellant, who at times claimed that she could not recall anything and had not looked at the file in several years, was at other times able to accurately cite exact details, symptoms and/or quantities of medication. She was not able to explain the varieties and inconsistencies which arose between her evidence, her reports to caregivers and the videotaped evidence and medical reports presented.

The panel has given greater weight to the opinions of [independent forensic psychiatrist], [Appellant's neuropsychologist], [Appellant's neurologist #1], [Appellant's psychiatrist #3], and finally [MPIC's doctor]. Although we recognize that the Appellant's position was supported by reports from her psychologist, [Appellant's psychologist #1], we note that [Appellant's psychologist #1] did not review or comment upon the videotape evidence.

[Independent forensic psychiatrist], in his report of April 2, 1997, noted that the Appellant has personality difficulties which were likely well established by her early adolescence. He indicated that she was "deliberately grossly embellishing symptomology, leading this writer to conclude she is malingering". His view was that the vast majority of her embellishing behaviour was due to malingering and that she had consciously and fraudulently generated the symptomology for secondary gain reasons. He stated:

> In my opinion, [the Appellant] is not a credible narrator of fact in regards to symptoms of alleged mental or physical illness. This statement is made with high certainty. . . In my opinion [the Appellant] is most likely not totally disabled from any occupation . . . though she wishes to be perceived as totally disabled . . . In my opinion, [the Appellant] is not generally interested in returning to the workforce, however this is a lifestyle choice and not a result of a medical, psychiatric or psychological disorder. . . .

[Appellant's psychiatrist #3] reported on February 3, 1997 that the Appellant had a clear personality disorder with an element of somatization. He reported again on January 3, 1997 that he was unable to recognize a specific psychiatric reason why the Appellant could not work.

[Appellant's neuropsychologist] attempted to assess the Appellant on a few occasions. He noted, on December 31, 1996, that the Appellant's:

> "level of impairment cannot be attributed solely to organic deficits, since even patients emerging from coma, who are in-patients, are generally functioning at a higher level on objective testing. Qualitatively (her) responses are atypical of the majority of individuals with organic injuries . . . "

On July 31, 1995, [Appellant's neuropsychologist] found that all the Appellant's functions were actually clinically worse than they had been three (3) months ago, with levels of performance generally at a "severe" degree. He did not regard these as a valid measure of her day to day functioning. He indicated that "the level of performance that she is operating at is equivalent to in-patients I have in the hospital." He found her testing to be invalid.

Although the Appellant saw several neurologists in attempting to assist her with her complaints of blackouts, dizziness, imbalance, headaches and other symptoms, all documented normal neurologic examinations. [Appellant's neurologist #1], consultant neurologist, reported on January 18, 1999. He stated:

> I thought that the history and physical examination were suggestive of some degree of overlay. In terms of the differential, I thought that high up were entities such as panic attacks as well as vasovagal syncope. I thought that hysteria or malingering were also possibilities, and noted that these had been raised previously . . .

[MPIC's doctor] reviewed all of these reports, among others, as well as the videotaped evidence of the Appellant's activities. He concluded that the Appellant was able to encounter situations with other people with no external manifestations of agoraphobia, panic or anxiety and that her observed behaviour was not consistent with her self-reports of limitation in engaging in social contacts or of significant cognitive deficiencies. There did not appear to be evidence that she had been left with ongoing manifestations of a brain injury and he noted that, since [Appellant's neuropsychologist] had concluded that the Appellant's tests were profoundly invalid, caregivers were not able to confirm an identifiable cognitive deficit secondary to the motor vehicle accident. In fact, he noted that [Appellant's psychiatrist #3] had felt the patient's anxiety and depression were due to her pre-accident personality disorder and not as a consequence of the accident.

In [MPIC's doctor's] view the opinions of [independent forensic psychologist], [Appellant's neuropsychologist] and [Appellant's neurologist #1] to the effect that the Appellant was either malingering or magnifying her impairment were consistent with the observed videotape. He concluded:

> . . . There is reasonable psychiatric and psychological opinion on file that this claimant is malingering, and/or feigning much of her clinical presentation. Much of her clinical presentation is based on self-report, and when there is a question as to the veracity of self-report, one must look to other evidence to confirm or deny the self-report. The videotape in this case, would indicate that the claimant's self-report is inaccurate, and cannot be relied upon to establish diagnoses of anxiety, panic attacks, agoraphobia or depression. While the claimant may be experiencing these problems, the evidence on file would make it difficult to conclude that they were the direct consequence of the collision in question or leading to genuine impairment. There is ample evidence to the contrary.

We agree with the findings of the Internal Review Officer that the Appellant's complaints of symptoms to her caregivers and to MPIC conflict with and are inconsistent with the evidence obtained through video surveillance, as well as with the findings and opinions of medical experts. Given our finding of the Appellant's lack of credibility, as well as her failure to advance further evidence to dispute the findings of the medical experts referred to above, the panel finds that the Appellant has failed to meet the onus upon her of showing, on a balance of probabilities, that the Internal Review Officer erred in concluding that in spite of her complaints, the Appellant did not continue to suffer symptoms resulting from the motor vehicle accident, and that her benefits should be terminated as a result of her knowingly providing false information to the insurer.

Accordingly, the decision of the Internal Review Officer dated May 30, 2003 is hereby upheld. The Appellant's appeal is dismissed.

Dated at Winnipeg this 10th day of November, 2008.

LAURA DIAMOND

LEONA BARRETT

PAUL JOHNSTON