Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-17-160

PANEL:	**Ms Laura Diamond, Chairperson** **Mr. Guy Joubert** **Ms Sandra Oakley**
APPEARANCES:	**The Appellant, [text deleted], was represented by [text deleted];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Anthony Lafontaine Guerra.**
HEARING DATE:	**November 21, 2019**
ISSUE(S):	**Whether the Appellant's cognitive deficits are as a result of the MVA on November 23, 2015 which would entitle him to PIPP benefits.**
RELEVANT SECTIONS:	**Section 70(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act').**

Reasons For Decision

Background:

The Appellant was involved in a motor vehicle accident (MVA) while working as a delivery driver on November 23, 2015, when his truck was rear ended while he was stopped in a driveway. An ambulance did not attend the scene of the MVA and he did not attend to a hospital immediately following. On March 24, 2016, the Appellant met with his case manager to complete various forms and authorizations. He advised that he had made a claim to the Workers Compensation Board (WCB) in regard to the MVA but his claim had been denied and he wished to file an Application for Compensation with MPIC.

In his application, the Appellant reported a prior history of concussion as well as one prior stroke. He indicated that he had hit his head on the headrest during the MVA and had suffered injuries including neck pain, concussion and a stroke the day after the accident.

The Appellant's case manager investigated and collected a report from the Appellant's family doctor, diagnosing a mild limitation of cervical spine range on November 25, 2015. She also collected information from the [medical centre] dated November 27, 2015 (sic) providing a diagnosis of delirium, likely secondary to alcohol and /or benzodiazepine abuse. She obtained a review from MPIC's Health Care Services team which indicated that the medical information did not support a finding that the Appellant had suffered a stroke or cerebrovascular condition following the collision. The Health Care Services consultant did not find evidence of a concussion or traumatic brain injury and concluded that the medical evidence did not support a collision related impairment which would limit the Appellant from his regular work.

The Appellant's case manager issued a decision dated May 31, 2016 denying entitlement to Personal Injury Protection Plan benefits.

The Appellant sought an internal review of this decision. On March 17, 2017, an Internal Review Officer (IRO) for MPIC issued a decision reviewing his claim. Following a review of the documents and a hearing, the IRO concluded that the Appellant's cognitive deficits were not caused by an automobile or the use of an automobile pursuant to the MPIC Act. There was no medically probable causal relationship between the Appellant's symptoms and the MVA as he had not sustained a concussion or stroke as a result of the MVA. His symptoms were of delirium, likely secondary to alcohol and/or benzodiazepine abuse. The decision of the case manager was upheld.

It is from this decision of the IRO that the Appellant has now appealed.

Issue:

The issue for the Commission was whether the Appellant's cognitive deficits resulted from the MVA of November 23, 2015, entitling him to PIPP benefits.

Disposition:

Upon a review of the documentary evidence, testimony of the witnesses at the hearing and submissions of the parties, the panel has concluded that the Appellant has failed to show, on a balance of probabilities, that his cognitive symptoms were caused by the MVA.

Documentary Evidence:

The Appellant provided a report from his family doctor dated November 25, 2015. The doctor stated:

> He is seen today. Suffered a possible concussion in a motor accident on the 23rd November. He was rear ended while he was stationary. Apart from slight reduction in his movement of the C-spine there is not really any hard physical signs today. He is a very small thin frail gentleman, barely weighing 130 pounds. He certainly has not had or got a severe whiplash injury or a severe lumbar injury. He is discouraged from using strong pain killers or sedatives at the moment.

The Appellant also provided records from the [hospital] dated November 27, 2015. These included assessment and treatment records as well as CT scan and laboratory reports. Further reports from that hospital dated November 28, 2015 included ECG, medication and physician notes.

The [hospital] notes indicated that the Appellant had been feeling cold and his partner stated that his mind had been wandering and he was not making sense. The CT scan report identified:

> … Tiny remote appearing lacunar infarcts…
>
> …
>
> No other intracranial abnormality is identified. …no intracranial hemorrhage, mass, evidence of large vessel infarct or hydrocephalous is identified.

The radiology report reviewing the CT scan identified no aneurysm and no acute intracranial abnormality.

The Appellant was then admitted to [medical centre] in [text deleted] and seen by the neurology service. A discharge summary of December 2, 2015 from [neurologist] reviewed his social history, history presentation, investigations and course in hospital. He was described as having been admitted with a diagnosis of acute confusional state in the setting of a recent and prior rear-end MVA.

His social history indicated that while he denied any illicit drug use, it was "well-known on previous documentation that he abused benzodiazepines." A history of smoking and long history of alcohol abuse in binge episodes was also described.

The MVA of November 23, 2015 was noted along with his wife's reports of abnormal behaviours including poor memory, confusion, erratic driving, increased energy and uncharacteristic personality traits in the days following. The report noted that systems were negative for any focal neurological deficient, there were no constitutional symptoms and other systemic review was unremarkable.

The report stated that CT of the brain and arteries:

> … did not show any acute lesions though there were tiny left corona radiata lacunar infarcts that were remote in nature… an MRI of the brain which again demonstrated diffuse cerebral atrophy but no focal lesions… Importantly, his tox screen was positive for benzodiazepines, which he was not given in hospital. It must be then surmised that he was taking benzodiazepines prior to his being seen at [medical centre], and it should be noted that he does not have any benzodiazepines prescribed him (sic) on his DPIN.

The report noted that the Appellant was back to his baseline cognitive status which remained stable, with his symptoms of confusion resolved and he was discharged home in stable neurologic condition.

A follow-up report from the Appellant's doctor was dated January 13, 2016. That report stated:

> I have a note from the [medical centre] that he was admitted on 30th November discharge 2nd December. Possibly mild stroke although nothing definite was found on imaging but he was admitted in a confusional state thought to be due to benzodiazepines with combination alcohol. They did find some cerebral atrophy to be present and he did have a history of a recent motor accident but no definite acute lesion was seen and he was sent home a few days later. He is aware of the risks of combining these medications.

The Appellant's doctor provided a further report on February 12, 2016, which stated:

> We have a caution on the file that this gentleman was admitted to hospital with a delirious condition probably due to high doses of benzodiazepines and Tylenol 3. I have seen him today. He seems clear, coherent today. He can give an account of himself and is not showing any worrying signs. …we will give him treatment again monthly for the next few months until we see that he does not run into the same problem as before which was a drug-induced delirium. He is cooperative with this and agrees with this.

These reports were reviewed by the WCB. As a result, a decision was issued on February 17, 2016 indicating that WCB was unable to establish a causal relationship between the reported symptoms and the MVA of November 23, 2015. As such, the claim for compensation at WCB was denied.

The Appellant then signed a Notice of Intention to Elect PIPP Benefits, instead of WCB benefits, on March 24, 2016.

On May 18, 2016, MPIC's Health Care Services medical consultant provided an opinion, after reviewing the medical information on file. This report noted an initial physician assessment for confusion and behavioural changes at a local hospital emergency room on November 27, 2015. A differential diagnosis that included stroke was documented, followed by CT scans without signs of acute trauma or ischemic disease and transfer to [medical centre] for neurological assessment and admission. Also noted was the discharge summary with diagnosis of "delirium, likely secondary to alcohol and/or benzodiazepine abuse."

The medical consultant opined that the medical information on file supported a probable diagnosis of Whiplash Associated Disorder (WAD) Type II of the cervical spine. The medical information did not support the presence of acute features traditionally associated with concussion or traumatic brain injury, and evolution of the presentation was not consistent with concussion.

> "Similarly, the medical information does not indicate [the Appellant] had a stroke or cerebrovascular condition following the collision. It is noted that the initial differential diagnosis included stroke, but this diagnosis was ultimately ruled out following secondary assessment and investigation.
>
> The medical evidence does not support a collision-related impairment which would limit [the Appellant] from his regular work."

Evidence and Submission for the Appellant:

Evidence of [text deleted]

The Appellant's former common-law spouse was the first witness to testify at the hearing into his appeal. They lived together between 2001 and January 2016. In November 2015, she was

doing a courier job with her grandson and the Appellant, in his truck. She was on the passenger side and recalled hearing a “big bang” just as they were leaving the place, while still in the driveway. On cross-examination, she confirmed that neither she nor her grandson were hurt, but that she saw the Appellant hit his head on the back of the driver side seat, although he did not complain of any injuries at that time. No ambulance, police or paramedics were called. The Appellant exited the vehicle and assessed the damage with the other driver, and then again had to catch up with the other driver to exchange particulars. The damage to the vehicle was not extensive, and the amount of about $1100.

On the way home, she noticed he was going through stop signs. Later that week, they took a trip to [city] and he was doing the same thing-his eyes were blurry and he was going through stop signs. She took him to the hospital in [city] and they kept him there. She did not know what the doctor said as she was not in the room at the time; she stayed in the waiting room.

On cross-examination, she confirmed that the Appellant was a frequent smoker, smoking about two packs a day. He drank, but not every day. She did not agree that he was a binge drinker and said she had no concerns about his drinking. She did not recall telling [medical centre] hospital staff, as noted in the consultation form, that he had a 10-12 drink binge about two weeks prior to the MVA. He had a problem with alcohol several years before, so she had told him that if he drank he should stay somewhere else. Upon further questioning, she did agree that she spoke with an occupational therapist at [medical centre] who had noted her concern with his drinking, and that she was worried about it in November 2015.

She confirmed that she had noticed a change in the Appellant’s behaviour on the day after the MVA. He appeared to be confused and had issues with erratic driving. He had blurry eyes and

bought an eye patch and eye drops. She did not recall the Appellant being verbally abusive towards her.

She agreed that he appeared to be back to baseline when discharged from hospital, but that he was admitted again to [medical centre] as a result of continued confusion. She did not recall some instances from the hospital documentation, such as him taking raw meat into the bathroom, but he was speaking more slowly and she had a hard time making out what he was saying.

Evidence of the Appellant

The Appellant testified at the hearing into his appeal. He explained that on November 23, 2015 he was with his ex-wife, on the job and making a delivery. A truck hit him and he banged the back of his head on the headrest around his neck.

The next day he went to [hospital] because he was acting crazy. They transferred him to [medical centre]. He said the noise was unbearable with people all around him and a lot of noise in the background. He could hardly see and everything was not supposed to be that way. He thinks they just gave up on him and filled out the paperwork so that he finally got out of the hospital on December 6, 2015. He felt back to himself then. He felt really good. He knows that he had the symptoms of a stroke and everything has changed for him since then. He described this as a mini-stroke. He had several small ones in the past, but the one after the MVA was bigger and he was scared. He doesn't understand why the doctor at [medical centre] said that he did not have one.

After he got out of the hospital in 2015 he was feeling better, but every once in a while the symptoms would come back, his face would start twitching and he might have trouble forming words.

The Appellant believed that he should be compensated for the price of his medicine and for not working. He had spent $6000 on medicine and lost $75,000 with missing work and hardship.

On cross-examination, the Appellant indicated that he was [age]. He had lived with [Appellant's former spouse] between 2001 and 2015, moved out on December 31, 2015, and was not currently living with her. He started working as a courier driver for [text deleted] about three months before the MVA. He had not worked there since the MVA.

The Appellant indicated that he had a grade 11 education and was a smoker who smoked one pack a day. He denied having smoked two packs a day but agreed that he had started smoking when he was 15 years old. He admitted that he had been a heavy drinker when he was younger but that he did not drink heavily now. Nor did he drink heavily back in 2015 beyond sometimes having a couple of beers. He indicated that since he had been with [Appellant's former spouse] he had not been binge drinking, although he did admit to one episode of having 10 to 12 drinks at a time.

The Appellant was also asked about references in the file to his use of benzodiazepines. He admitted to having used these, indicating that they helped him with his stroke symptoms. He said that his family doctor gave him benzodiazepine. He could not point to any documentation of a history of strokes, although he indicated that his doctor had told him he had a mini stroke many

years ago from lifting heavy stuff. He also admitted that he was taking benzodiazepines before the MVA, insisting that they had been prescribed to him by a doctor in the [medical centre #2].

The Appellant confirmed that he had hit his headrest right at the neck, during the MVA but that he did not feel injured. He checked with the other occupants of the vehicle and they were okay. He was able to get out of the vehicle and check for damage and speak to the other driver. He thought there was some damage to the bumper. He filed a police report where he indicated he thought the other driver had been speeding. He agreed that the damage to the vehicle was approximately $1200 and that since he was working he had first filed a claim with WCB.

The Appellant admitted that no ambulance had been called and he did not go to the hospital or drive there on the date of the MVA. He did not lose consciousness but he had some blurry vision. He then described going to [hospital] the day after the MVA. When counsel for MPIC suggested that the hospital reports show that he did not attend there until November 27, 2015, four days after the MVA, when taken there by ambulance, the Appellant said that this was wrong and that he went there, by taxi the day after the MVA. Upon further reflection and review of the documents, including his attendance to [family doctor] two days after the MVA, the Appellant agreed that he went to [hospital] on November 27, 2015.

The Appellant was asked on cross-examination about the symptoms he showed which led to him going to the [hospital]. He said he did start to feel cold and was having trouble sleeping. He did not recall being verbally abusive towards his family. He did not recall taking or selling T3 medication at the time and did not know if he had any benzodiazepines in his system, although he did agree that blood tests showed both benzodiazepine and alcohol in his system. He recalled being referred to the stroke clinic and going to [medical centre] on November 30, 2015 to see a

neurologist. He recalled having trouble with driving and going through a stoplight. He received a ticket for that. He recalled having difficulty with his vision and purchasing eye drops. He thought it might help his blurry vision. He also recalled having an MRI test and how uncomfortable he was in the loud machine.

The Appellant admitted to sometimes using alcohol and benzodiazepines at the same time. He also recalled that he felt well when he was discharged from the hospital but that two days later, on December 4, 2015, he was in a restaurant and the machines were so loud he became upset. He did not recall taking raw meat into the washroom, as some notes indicated, but did recall that an ambulance was called and that he was taken to [hospital #2] where he was diagnosed with delirium.

When asked about telling his doctors that he had quit drinking, the Appellant indicated that this meant he only had one or two drinks a day. He didn't recall having discussions with his doctors of the hospital about getting help to quit drinking.

The Appellant admitted that his claim for benefits from WCB was denied and that he came back to MPIC to pursue a claim. He could not recall details of a conversation he had with his case manager on February 22, 2016 indicating that he had been off work as he recently had another stroke.

He indicated that since the MVA he had been doing some work for a friend, raking leaves and doing lawn care. He had not returned to [medical centre] with symptoms of confusion since he left there on December 6, 2015.

Submission for the Appellant

Counsel for the Appellant submitted that after the MVA the Appellant was affected. He was getting dizzy and mumbling and this was from the MVA so he should be getting something. She submitted that he suffered a stroke after the MVA and not before. He was not drinking during the MVA and was working at the time, so he should get some kind of payment.

Submission for MPIC:

In addressing the question of whether the Appellant suffered a concussion as a result of the MVA, counsel for MPIC indicated that the MVA was so mild the Appellant did not initially believe his vehicle had been damaged. Ultimately, the MVA caused less than $1200 in damage and the Appellant did not experience any immediate injuries. He felt fine that day and did not report to a doctor or a hospital.

The next day, [Appellant's former spouse] reported the Appellant was exhibiting bizarre behaviour such as driving erratically and having trouble sleeping. According to the medical reports on intake, he was also verbally abusing members of his family. However, it was important to note that this was possibly around the same time that he was consuming 10-12 alcoholic drinks in a binge fashion.

When the Appellant was examined by his family doctor, two days after the MVA, he opined that it was *possible* that the Appellant has sustained a concussion, but minimized the severity of his injury stating "certainly has not had or got a severe whiplash injury or a severe lumbar injury". The Appellant was sent home and told to stay off strong medication but not told to remain off work or given any other restrictions.

Two days later, on November 27, 2015, the Appellant attended [hospital] with complaints of confusion and coldness. He admitted to consuming beer, and alcohol was noted in his blood along with benzodiazepines. He was initially diagnosed with a possible small cerebrovascular accident (CVA) or TIA, but his condition ultimately resolved while he was in hospital and so the Appellant was referred to [medical centre] for further investigation.

In reviewing information from these hospital visits, MPIC's Health Care Services consultant prepared a report which noted a possible diagnosis of whiplash. But the medical information did not support the presence of acute features traditionally associated with concussion or traumatic brain injury. The suspicion of a stroke was ultimately ruled out.

When the Appellant attended [medical centre] on November 30, 2015, he was examined by the Neurology Department and discharged a few days later with a diagnosis of acute confusional state, likely secondary to alcohol and/or benzodiazepine use/abuse. He was not diagnosed with a stroke or concussion. [neurologist] identified a long history of alcohol abuse and noted that he was a well known abuser of benzodiazepines. The Appellant tested positive for benzodiazepines which had not been prescribed or given to him while in hospital. An MRI did not identify acute intracranial abnormality or restriction to suggest an acute infarct. The Appellant's condition greatly improved and his cognitive status returned to baseline. The occupational therapist noted concerns about the Appellant's drinking.

Two days later the Appellant returned to [medical centre] exhibiting bizarre behaviours. On admission, he admitted to recent alcohol consumption and a 10-12 drink binge two weeks prior but a CT scan of his brain showed nothing acute and his condition again improved with time in hospital.

In later reports, his family doctor again noted the risks of combining alcohol and benzodiazepines and warned the Appellant against this.

In reviewing all of the above medical history, counsel for MPIC submitted that the available evidence did not support the claims of the Appellant that he suffered a concussion and stroke as a result of the MVA. At most, the Appellant suffered whiplash which was not described as severe and which appeared to have quickly resolved itself without treatment. There is no medical evidence connecting any whiplash injury to any cognitive deficits.

The Appellant did receive a sick note when discharged from the [hospital], but the reason for the note was the concern that he may have had a stroke. His confusion was later diagnosed by [medical centre] as primarily caused by alcohol/drug abuse. This situation resolved by the time of his discharge on December 2, 2015 and [medical centre] did not provide him with a sick note. He returned to the hospital on December 4, 2015, but no connection was drawn at that time between his presenting confusion and any whiplash injury or MVA. His condition simply improved with time and when he was discharged on December 6, 2015, there was no indication of a requirement to be off work.

Counsel also noted that although the Commission was not bound by the decision of the WCB in the Appellant's case, their finding regarding a lack of a causal relationship between his reported symptoms and the MVA should be influential.

It should also be noted, it was submitted, that when the Appellant spoke to his case manager by telephone the reason he gave for not working was not his injury, but rather that his wife had "sold his truck".

Finally, counsel for MPIC referred to the Health Care Services report which opined that medical evidence does not support a collision related impairment which would limit the Appellant from his regular work. The Appellant produced no medical evidence to substantiate his claim that he was unable to work as a result of cognitive deficits caused by an injury sustained in the MVA. The Appellant was never actually diagnosed with a concussion or stroke following the MVA. Therefore, it was submitted, that the Commission cannot accept, on a balance of probabilities, that the Appellant's stays in hospital were caused by a concussion or stroke resulting from the MVA, based on the available evidence.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities, that he suffered cognitive defects as a result of the MVA which would entitle him to PIPP benefits. The MPIC Act provides:

> **Definitions**
> 70(1) In this Part,
>
> **"accident"** means any event in which bodily injury is caused by an automobile; (« accident »)
>
> **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile, but not including bodily injury caused…

The panel has reviewed the documentary evidence on file along with the testimony of the witnesses and submissions of [Appellant's former spouse] and counsel for MPIC. We found the witnesses to be credible in trying to tell us what they believed, to the best of their ability to recall. the Appellant's doctor. Although these documents noted reports of the Appellant's

fragmented memory, with impacted speech, and unusual behaviour, no diagnosis of concussion or stroke was arrived at.

While we accept that the Appellant experienced a variety of concerning symptoms which he attributed to a stroke caused by the MVA, there is no evidence to connect these symptoms to the MVA in any way. In addition, the documentary evidence shows that stroke was just a possibility being explored, but not the final diagnosis. Rather, the final reports arrived at a diagnosis of the effects of combined alcohol and benzodiazepine abuse.

The panel has therefore given more weight to the documentary evidence prepared by professional experts than we have to the weaker, albeit well-intentioned, testimony of the two witnesses. The documentary evidence was prepared by professional experts, contemporaneously to the hospital admissions and was consistent throughout in basing opinions on the evidence presented. This included the Appellant's history, chart notes, DPIN record, tests and bloodwork.

Nor has the Appellant met the onus upon him of showing that he had restrictions or was unable to continue working as a result of MVA related injuries.

We find the evidence of the health care professionals noted at the time to be more reliable and therefore to have more weight than the testimony of the two witnesses. The evidence does not establish that the Appellant suffered a concussion or stroke as a result of the MVA.

Accordingly, the Commission finds that the Appellant has not met the onus upon him of showing that the Internal Review Decision was in error in concluding that the Appellant had injuries caused by the MVA which would entitle him to PIPP benefits.

The Internal Review Decision of March 17, 2017 is therefore upheld and the Appellant's appeal dismissed.

Dated at Winnipeg this 30th day of December, 2019.

LAURA DIAMOND

GUY JOUBERT

SANDRA OAKLEY