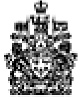

Veterans Review and Appeal Board Canada | Tribunal des anciens combattants (révision et appel) Canada

Canada

2002-268

Representative: Nancy Kao, BPA
Decision No: 100000374268
Decision Type: Entitlement Review
Location of Hearing: Edmonton, Alberta
Date of Decision: 20 August 2002

As a result of the Applicant's Entitlement Review hearing held 20 August 2002, this Board rules as follows:

RULING

SCHIZO-AFFECTIVE DISORDER

THE BOARD VARIES THE MINISTER'S DECISION.

Award of two-fifths for that part of the disability or aggravation thereof that arose out of or was directly connected with service in peace time in the Regular Force.
Subsection 21(2), *Pension Act*

Entitlement effective 18 April 2001 (the day on which application was first made).
Subsection 39(1), *Pension Act*

DEPRESSION
RIGHT PATELLOFEMORAL SYNDROME
MECHANICAL LOW BACK PAIN

THE BOARD AFFIRMS THE MINISTER'S DECISION

Did not arise out of nor were they directly connected with service in peace time in the Regular Force.
Subsection 21(2), *Pension Act*

______________________________Presiding Member
Rachel DeGagné

Original signed by:
____________________________Member
Mae Cabott

ISSUES

The Applicant appeared before an Entitlement Review Board in Edmonton, Alberta on 20 August 2002 as he was dissatisfied with respect to denial of pension entitlement for his claimed conditions following a Minister's Decision of 6 February 2002. The Applicant was represented at the hearing by Ms. Nancy Kao, Bureau of Pensions Advocates.

EVIDENCE

The Advocate submitted the following exhibits and attachments as evidence:

ER-C1:	Report from Dr. David J. McManus, Psychiatrist dated 8 April 2002;
ER-C2:	Report from Dr. David Kenneth Cochrane, Psychiatrist dated 29 March 2001;
ER-C3:	Report from Dr. A. B. Swift, Captain, Detachment Commander dated 30 May 2002;
ER-C4:	X-ray Report regarding the Applicant's right knee and lumbar spine dated 24 May 2002;
ER-C5:	Copy of the job description for the Applicant while employed at Roads and Grounds CFB North Bay dated 24 May 2002;
ER-Attach-C1:	Thirteen pages of service medical record extracts beginning with a report recorded by Dr. David Kenneth Cochrane, Psychiatrist dated 2 December 1996;
ER-Attach-C2:	Report from Dr. David Kenneth Cochrane, Psychiatrist dated 30 March 2000;
ER-Attach-C3:	Four pages of service medical record extracts; and
ER-Attach-C4:	Entitlement Review Decision for the Applicant dated 19 September 2000.

Schizo-Affective Disorder
Depression

FACTS AND ARGUMENT

The Advocate advised the Board that she would be arguing the two claimed conditions of schizo-affective disorder and depression together.

The Advocate submitted a diagnosis for the claimed condition of depression as recorded in ER-C1 in a Psychiatrist's Report by Dr. David J. McManus dated 8 April 2002 which states, in part:

> I am writing this letter as the treating psychiatrist for the Applicant. He has been my patient since May 7, 2001 following referral from his family physician. Following my initial consultation, I felt that the Applicant was fulfilling criteria for two major psychiatric disorders. The first one would be depression based on the criteria of impaired sleep, depressed mood, limited energy level, poor concentration and focus and significantly lowered stress tolerance…

The Advocate further submitted diagnosis for the claimed condition of schizo-affective disorder as recorded in a report by Dr. David K. Cochrane, Psychiatrist dated 20 September 2001 which states, in part:

> In summary, retrospectively, given my four year involvement with this individual from November 1996 through November 2000, this patient's symptoms are most closely allied with a diagnosis of Schizoaffective Disorder… (as transcribed)

The evidence records that the Applicant joined the Regular Force in July 1996 and did his basic training in St. Jean, Quebec. Following completion of his basic training, he was transferred to CFB North Bay for training as an air defence technician.

In his oral testimony, the Applicant stated that he had done well in basic training in Quebec, but he felt wore down from fatigue and stress. He felt he was "on burn out". He was not sleeping well and restated that he "failed a few tests...We all did that…I just felt worn out". He stated he was sent to see the Base Chaplain.

A letter from the Base Chaplain dated 7 April 2000 states, in part:

> Upon interviewing the Applicant, I noted that there seemed to be some difficulty with the Applicant in his perceptions between what we would normally consider 'fantasy' and reality. In short, the

> Applicant's condition concerned me enough that I immediately sent him to see the Base Medical Officer…who referred him for Psychiatric Assessment. (as transcribed)

The Applicant further testified that he was taken off the air defence technician course, transferred to Roads and Grounds crew and was moved to the second floor, out of the environment of the air defence course. He stated his category was changed and he was placed on medication. He was kept on medical category and the uncertainty of his situation caused him depression. He stated that it was suggested that he leave the military. He did not want to, but he stated, "I stayed because it was a pay cheque and I hoped to overcome my difficulties and make the army a career."

He stated he worked on the Roads and Grounds crew for almost two years doing snow removal and cutting grass. For nine months he worked as a plumbing and carpenter helper and then went back to the Roads and Grounds crew. He also did some janitorial work on his own.

The Applicant stated that he was medically released from the Regular Force service in November 2000.

The Board reviewed a report of Dr. David K. Cochrane, Psychiatrist dated 20 September 2001 which states, in part:

> I first assessed the Applicant in psychiatric consultation November 26, 1996. At that time he had been stationed at CFB North Bay for approximately six weeks. He was training to become an Air Defence Technician. He had completed his basic training in St. Jean, Quebec. At that time the Applicant described his move to North Bay as stressful. He had no formal or informal supports, and he described felling alienated from his colleagues who were also in training at that time…For several months prior to my initial consultation he had been experiencing mild depressive features that included periods of sadness, sleep disturbance with some degree of initial insomnia, decreased energy, poor concentration and mild anhedonia…Since his entry into the course at that time he also reported pervasive thoughts of self doubt around his ability to complete the course load…
>
> Prior to my consultation the Applicant had never been seen by a psychiatrist or any mental health professional for that matter. He had never suffered from any major psychiatric condition in the past…There is a family history in a paternal uncle who has been diagnosed with Schizophrenia but otherwise there has been no other family psychiatric history…
>
> Subsequent to my initial assessment and diagnosis I maintained psychiatric follow-up with the Applicant. I saw him again December 9, 1996 and again February 10, 1997. Over that period of time I had prescribed a course of treatment which was aimed at managing his anxiety symptoms with benzodiazepines, and supportive psychotherapeutic interventions around the adjustments that he was having to his living situation at that time and the demands of his training as an Air Defence Technician. He was not permitted to continue in his training course and he was transferred over to the general maintenance crew. With the supportive interventions and the prescription of benzodiazepines his anxiety symptoms settled and in fact his mood improved and he was much less preoccupied with these over-valued ideas…In December of 1998 just before Christmas I received a phone call from the Medical Officer asking that I see him. He was seen in reassessment in Ottawa and the patient stated that he was told that they wanted him out of the service. I met with him on January 25, 1999 and at that time he had been off Perphenazine for a period of three months, and I did not detect any abnormalities of thought form or content or depressive or hypomanic or manic features…He remained on the 4T6 medical category which had been in effect for two and a half years. I saw him again in April of 1999 and he remained off the medication and was continuing to function well…
>
> Just prior to the Christmas of 1999 I was contacted by the Medical Officer again, requesting that I reinitiate follow-up after the patient was admitted to the North Bay Psychiatric Hospital for a 72 hour stay. I met with him on January 17, 2000 and the patient informed me that beginning in the summer of 1999 he began to experience grandiose, over-valued ideas that progressed to delusions of grandeur and referential delusions and persecutory delusions…No definitive treatment was prescribed while he remained an in-patient at the North Bay Psychiatric Hospital for his 72 hour stay, but after his discharge he was commenced on Olanzapine by the Medical Officer at CFB North Bay.

> From January 2000 through my last contact with the Applicant on November 1, 2000, he remained on treatment with Olanzapine in combination with an anti-depressant. He achieved a definite response to this treatment. The anti-depressant was added because of the emergence of significant depressive features secondary to the many psychosocial stressors that he faced as a result of his illness and pending service discharge. He developed very significant weight gain while taking the Olanzapine and the medication was subsequently switched back to Perphenazine given his prior proven treatment response and good tolerability.
>
> ...
>
> In summary, retrospectively, given my four year involvement with this individual from November 1996 through November 2000 this patient's symptoms are most closely allied with a diagnosis of Schizoaffective Disorder. I suspect that if his symptoms were never identified and if he never entered treatment that he would have had a full blown psychotic episode...The diagnosis of Schizoaffective Disorder is not a pure diagnosis and I state this diagnosis on the basis of his recurrent psychotic symptoms and the presence of his depressive episodes. It may be several years before a more definitive diagnosis can be made...We currently conceptualize psychotic disorders in a stress diathesis framework. We presume that there is an underlying vulnerability and the family history of Schizophrenia in this individual supports this idea. It is my opinion that the vulnerability has been activated by the stressors that he encountered during his basic training and subsequently during his training as an Air Defence Technician. The ensuing stressors and losses which included his loss of job, financial changes and loss of future employability have contributed to the perpetuation of his depressive symptoms. (as transcribed)

Dr. David Kenneth Cochrane, in his letter of 30 March 2000 contained in ER-Attach-C2, states, in part:

> In my opinion, there is a definite relationship between the stressors he encountered in adjusting to Military service and the emergence of his symptoms. There is a clear temporal relationship given the absence of any prior symptoms, and there is no evidence to support that these symptoms emerged in the context of a substance abuse disorder...We presume that there was some underlying biological vulnerability that has been activated by the stressors of his Military service...Certainly there are a number of demographic factors that would support this diagnosis - his age and gender at the time of presentation, and I note that there is a known family history of Schizophrenia.

The Board also reviewed the Consultation Report recorded by Dr. J. R. Trudel contained in ER-Attach-C1, which states, in part:

> As for medical restrictions, I think it would be preferable on the one hand, that he not be overstressed while we are lowering the medication. This is particularly true since the onset of his illness was related to stress. Thus, for the next 6 months, he should serve in a geographical area where a GDMO is readily available... (as transcribed)

The Board has also reviewed ER-C1, the report of Dr. David J. McManus, Psychiatrist, dated 8 April 2002, which states in part:

> I am writing this letter as the treating psychiatrist for the Applicant. He has been my patient since May 7, 2001 following referral from his family physician. Following my initial consultation, I felt that the Applicant was fulfilling criteria for two major psychiatric disorders. The first one would be depression based on the criteria of impaired sleep, depressed mood, limited energy level, poor concentration and focus and significantly lowered stress tolerance. He also fulfilled criteria for schizophrenia based on his description of auditory hallucinations, paranoid delusions, social withdrawal, social isolation and affect flattening.
>
> I do feel that the Applicant's placement in the military service was etiologically involved in the development and aggravation of these two conditions. I base this on the understanding that at the time of his diagnosis he was as described by the Applicant on course and was under a great deal of stress and training in the air weapons controller program. He had just recently finished his basic training and was under a great deal of emotional duress based on lack of sleep, a regimented lifestyle and in fact felt quite burned out. At the start of his air weapons program he noticed a significant change in his behaviour and this precipitated his referral to the base psychiatrist.

> ...There are exceptional circumstances within the military such as the need to be placed in a rank and also the code of service discipline that I think were significant stressors regarding the Applicant's expression of his illnesses.
>
> It is true that schizophrenia and major depression have an underlying biological basis. There is a contributing genetic factor that cannot be completely ruled out, however it is my opinion that these particular circumstances of his placement in the military were the exacerbating trigger that caused the expression of his illness. (as transcribed)

The Advocate submitted there are three medical opinions stating that stress of training in the military re-triggers the claimed conditions and she referred to paragraph 21(3)(f) of the *Pension Act*, arguing that the Applicant was on a training course at the time the symptoms appeared and therefore is related to service.

REASONS AND CONCLUSION

In arriving at this decision, this Board has carefully reviewed all the evidence, medical records and the submissions presented by the Representative, and has complied fully with the statutory obligation to resolve any doubt in the weighing of evidence in favour of the Applicant or Appellant as contained in sections 3 and 39 of the *Veterans Review and Appeal Board Act*.

The Board has carefully reviewed all of the evidence relating to the claimed conditions and was particularly thorough in its review of all the exhibits, attachments, the testimony of the Applicant, the submission of the Advocate and the evidence provided in the documentation.

The Advocate argued this Board could use the date of application for another condition to determine the effective date for payment of this award for "schizo-affective disorder". The Board finds that the argument has no valid legal basis. Subsection 39(1) of the *Pension Act* indicates that an award for schizo-affective disorder would be made effective to the date on which the Applicant first made application for that award, rather than the date when he first made application for another condition. However, the Board is of the view that his argument gives rise to issues of jurisdictional and factual nature which should nevertheless be addressed.

It should be noted that the issues raised by the initial application for the condition of schizophreniform disorder were finally determined at the review level in a decision dated 19 September 2000. The argument that this Board can now go back to the date of the application for schizophreniform disorder in establishing the effective date for payment of the award for schizo-affective disorder implies that this Board has jurisdiction to re-adjudicate the previously determined claim for schizophreniform disorder. This is not correct. Under the *Veterans Review and Appeal Board Act*, once the issue of entitlement to a pension award for particular diagnosis has been finally determined by a Review Panel of this Board, any further appeal would have be taken to the next level in the appeal process, which is before an Appeal Board. Another Review Panel would have no jurisdiction to review that issue again.

This Board also notes that the proposition that an application which was made in relation to a particular award which was then adjudicated and denied, could later be resurrected and deemed to be an application for another award, has already been rejected in a recent Federal Court decision. In *Sangster vs the Attorney General of Canada* decision, Mr. Justice Yvon Pinard rejected the argument that an initial application for an award which was made in relation to a particular medical diagnosis, and based upon a particular set of facts and specific medical considerations, could be considered a constructive or implied application for any subsequent awards for other conditions which a pensioner may later wish to pursue. This principle clearly applies to the case at hand, and supports the Board's conclusion that there is no valid legal basis upon which it can be argued that the date of application for the condition of schizophreniform disorder, could now be deemed to constitute the effective date for the schizo-affective disorder award.

The final problem with the Advocate's submissions is that they impliedly presume that the diagnosis of schizophreniform disorder, which was previously adjudicated in 2000, is the same medical condition as schizo-affective disorder. However, the decision of 19 September 2000 in which the Review Panel determined the question of entitlement to the pension application for shizophreniform disorder shows why this proposition is unsupportable. At page 5 of the Review Panel's decision, the Board noted that schizophreniform disorder was a short-term rather than a permanent disability, and the Board's reasons were well supported by reference to diagnostic features of schizophreniform disorder as reported in the *Diagnostic and Statistical Manual of*

Mental Disorders (4th Edition). The previous Review Panel's reasons on schizophreniform disorder highlight very clearly that schizophreniform disorder is a distinct medical diagnosis from that of schizo-affective disorder.

For these reasons, this Board cannot therefore consider the application for schizophreniform disorder to be one and the same as that for schizo-affective disorder. Nor can it legally deem the date of application for these two distinct conditions to be interchangeable. The proper effective date for the two-fifths pension which this Board has awarded in relation to the claimed and diagnosed condition of schizo-affective disorder under subsection 39(1) of the *Pension Act* is the date on which the Applicant first made application for that particular condition. The information on file indicates that the date of application for schizo-affective disorder was 18 April 2001. Thus, 18 April 2001, shall be the effective date for payment of the award of two-fifths for the condition of Schizo-affective disorder. Three-fifths pension entitlement is withheld due to the genetic factor of schizophrenia in the family psychiatric history as documented in the evidence on file.

The next issue concerns the Applicant's claim for the condition of "depression". The Board has carefully reviewed all of the evidence on file and concludes that while the documentation and medical evidence on file supports the inference that the Applicant suffers from symptoms of depression, the totality of the evidence on file leads to the conclusion that depression is part of the overall diagnosis of schizo-affective disorder, rather than as a separate diagnosis which stands on its own, and gives rise to entitlement to a separate pension.

The comprehensive and reasoned formal diagnosis of the Applicant's psychiatric problems provided in the report of Dr. Cochrane dated 20 September 2001 indicates that the Applicant was diagnosed with schizo-affective disorder. There is no mention within Dr. Cochrane's report of the Applicant having been diagnosed separately with "depression"; although, it is clear that Dr. Cochrane has taken the Applicant's depressive episodes into account in the diagnosis of schizo-affective disorder. At page 5 of the opinion Dr. Cochrane notes in the first full sentence at the top of the page:

> The diagnosis of schizo-affective disorder is not a pure diagnosis and I state this diagnosis on the basis of recurrent psychotic symptoms and the presence of his depressive episodes. It may be several years before a more definitive diagnosis can be made. My opinion at present is that he does not meet full diagnostic criteria for schizophrenia....."

As well, the Board notes that on page 4 of Dr. Cochrane's opinion, the only diagnosis offered by Dr. Cochrane under Axis I is that of schizo-affective disorder. There is no evidence before this Board to suggest that the diagnosis of schizo-affective disorder with depressive episodes is akin to a diagnosis of schizo-affective disorder and a diagnosis of depression. To assist in the interpretation of the medical evidence, the Board has referred to the *Diagnostic and Statistical Manual of Mental Disorders (fourth edition)*, ("DSM-IV"), which is used by the psychiatric profession to reach their diagnostic conclusions. The information in the DSM-IVindicates that where depression exists as a separate diagnosis, this would be indicated as such on "Axis I." A review of the DSM-IV sections on schizo-affective disorder indicates that the existence of major depressive episodes are part of that diagnosis. As well, the section within the DSM-IV which deals with the diagnosis of depression as an independent condition - which is known as "Major Depressive Disorder" - indicates where depression (and depressive episodes) can be accounted for by schizo-affective disorder, it would not constitute a separate diagnosis.

While there is no diagnosis mentioned of depression as a separate condition in Dr. Cochrane's report, the medical report of Dr. D. McManus dated 8 April 2002, diagnoses depression as well as schizophrenia. The Board must note that Dr. McManus' opinion is not consistent with the opinion of Dr. Cochrane on the key issue of diagnosis of the claimed condition of schizo-affective disorder. Dr. Cochrane specifically addressed and eliminated the diagnosis of schizophrenia in his report, while indicating that it is not the same condition as schizo-affective disorder. However, Dr. McManus did not address or explain this issue, and his conclusions are not explained or supported in the same way that Dr. Cochrane's are.

Dr. Cochrane's detailed medical-legal opinion is based on a comprehensive historical review of the progression and features of the Applicant's psychiatric complaints and of his various diagnosis and treatment between 1996 and 2001. The opinion is also well supported with reference to the DSM-IV and the facts of the case which suggests a diligent effort to diagnose the Applicant's precise psychiatric condition in light of the criteria contained in the DSM-IV. For these reasons, this Board finds Dr. Cochrane's opinion and the diagnosis presented within it to be the more reliable and persuasive of the two opinions presented to the

Board. **It should also be noted that only Dr. Cochrane's opinion actually support the Applicant's request for an award in relation to the claimed condition of schizo-affective disorder**.

Accordingly, the Board concludes that a review of the facts, circumstances, and medical evidence placed before it, in relation to the claim for depression, could reasonably support the inference that the depressive episodes experienced by the Applicant are part of his primary psychiatric problem of schizo-affective disorder. However, the evidence does not reasonably support the inference that the Applicant is entitled to a separate pension for depression.

Right Patellofemoral Syndrome
Mechanical Low Back Pain

FACTS AND ARGUMENT

The Advocate stated that she would argue the two claimed conditions of right patellofemoral syndrome and mechanical low back pain together. The Advocate stated that the Applicant was required to shovel snow, cut grass, dig dirt and lift heavy objects in the Regular Force.

Diagnosis of "Mechanical low back pain" is recorded in a Physician's Statement dated 24 April 2001 and diagnosis of "mild patello femoral syndrome" is recorded in another Physician's Statement also dated 24 April 2001.

The Advocate drew the Board's attention to a Medical Attendance Record dated 12 November 1997 in ER-C1 which states "c/o sore back started 1 ½ wk ago while doing weight lifting..."

A Medical Examination For Release contained in ER-Attach-C1 dated 13 December 1999 states, in part:

> ...(R) knee pain x several months. (+) up/down stairs. While walking he's noticed painful crepitus. Will send to physio...
>
> ...(R) Knee - pain palpation on lateral collateral ligament. Knee stable otherwise...Ø effusion. No joint line tenderness. (as transcribed)

The Board has reviewed the medical report contained in ER-C3 from Dr. A. Swift, Captain, Detachment Commander, dated 30 May 2002, which states in part:

> The Applicant first presented for medical evaluation for right knee pain on 13 Dec 1999. This is the only time in his service career that he presented with right knee pain. This presentation occurred after he had been working for some time on the roads and grounds crew on the wing doing manual labour apparently. At the time he complained of sharp, intermittent anterior right knee pain, worse going up and down stairs. His clinical examination at that time was largely unremarkable with the only positive finding being some mild pain with palpation of his lateral collateral ligament. He was diagnosed with Patellofemoral Syndrome and prescribed physiotherapy. According to his records he did not return for follow-up for this condition...His knee neither swells nor locks and he doesn't use medication for the pain. Recent clinical examination reveals some crepitus on full flexion, which was not there previously, but otherwise his knee exam reveals no other abnormality or ligamentous instability. Right knee x-rays dated 24 May 02 are reported as normal...
>
> The Applicant presented initially with low back pain on 10 Oct 2000. He was diagnosed with Mechanical Low Back pain at that time and treated with physiotherapy and non-steroidal anti-inflammatory medication...His back pain had been going on for a few weeks at that point but he did not display any neurological signs or symptoms. His clinical examination did not reveal any evidence of sciatica or neurological impairment. His L/S spine x-rays at that time were normal...Recent lumber spine x-rays show degenerative change in the posterior facet joints, especially in the right L5/S1 facet. The disc spaces are well maintained. In summary, the Applicant continues to suffer from some Mechanical Low Back pain which seems to have started after working for some time on the roads and grounds crew at 22 wing...
>
> It is difficult to make the determination whether these two clinical conditions are solely related to the Applicant's military duties at the times of their initial presentation. On the one hand, these are very common medical conditions that occur in many non-military people who do no form of manual

> labour. On the other hand, their presentations do seem to correlate with starting after he assumed new duties on the roads and grounds section of 22 wing... (as transcribed)

The Applicant, in his oral testimony, stated that while in the service he lifted weights to keep fit as he was not required to do a regular PT program. He believed his right knee problem was caused by only having one pair of work boots and he did not get his second pair until he was almost finished his military service because of being on a temporary category. He further stated, "There should be more records regarding my back - they must be lost".

REASONS AND CONCLUSION

In arriving at this decision, this Board has carefully reviewed all the evidence, medical records and the submissions presented by the Representative, and has complied fully with the statutory obligation to resolve any doubt in the weighing of evidence in favour of the Applicant or Appellant as contained in sections 3 and 39 of the *Veterans Review and Appeal Board Act*.

The Board has carefully reviewed all of the evidence relating to the claimed conditions and was particularly thorough in its review of the Applicant's testimony, the Advocate's submission and the evidence contained in ER-C3 to ER-C5.

However, the Board has not been presented with any Report of Injuries or treatment for the claimed conditions notwithstanding the opinion of Dr. A. B. Swift in ER-C3, the Board has not been presented with any medical evidence of injury or treatment to show a relationship between the claimed conditions and the Applicant's Regular Force service. The Board, therefore, affirms the Minister's Decision dated 6 February 2002.

NOTE:

Section 25 of the *Veterans Review and Appeal Board Act* provides that an Applicant who is dissatisfied with the decision of a hearing may, by notice in writing, appeal the decision to the Veterans Review and Appeal Board. Representation is available, free of charge, from the Bureau of Pensions Advocates or from the service bureau of a veterans' organization or from any other representative of the Applicant's choice, at the Applicant's expense.

If the Applicant should require further information in regard to the foregoing, it will be available from the nearest district office of the Department of Veterans Affairs or from the representative who assisted with the present application.

RELEVANT LEGISLATION

Paragraph 21(2)(a) of the *Pension Act* states that in respect of military service rendered in the non-permanent active militia or in the reserve army during World War II and in respect of military service in peace time, where a member of the forces suffers disability resulting from an injury or disease or an aggravation thereof that arose out of or was directly connected with such military service, a pension shall, on application, be awarded to or in respect of the member.

Paragraph 21(3)(f) of the *Pension Act* provides the following:

For the purposes of subsection (2), an injury or disease, or the aggravation of an injury or disease, shall be presumed, in the absence of evidence to the contrary to have arisen out of or to have been directly connected with military service of the kind described in that subsection if the injury or disease or the aggravation thereof was incurred in the course of

> (f) any military operation, training, or administration, either as a result of a specific order or established military custom or practice, whether or not failure to perform the act that resulted in the disease or injury or aggravation thereof would have resulted in disciplinary action against the member.

Subsection 39(1) of the Pension Act states that a pension awarded for disability shall be made payable from the later of

(a) The day on which application therefor was first made, and

(b) a day three years prior to the day on which the pension was awarded to the pensioner.

Section 18 of the *Veterans Review and Appeal Board Act* states that the Board has full and exclusive jurisdiction to hear, determine and deal with all applications for review that may be made to the Board under the *Pension Act*, and all matters related to those applications.

Section 21 of the *Veterans Review and Appeal Board Act* states that a review panel may

(a) affirm, vary or reverse the decision of the Minister being reviewed;

(b) refer any matter back to the Minister for reconsideration; or

(c) refer any matter not dealt with in the decision back to the Minister for a decision.

Section 84 of the *Pension Act* states that where an Applicant who is dissatisfied with a decision made by the Minister under this Act or subsection 34(5) of the *Veterans Review and Appeal Board Act* may apply to the Veterans Review and Appeal Board to review this decision.

Section 3 of the *Veterans Review and Appeal Board Act* states that the provisions of this Act and of any other Act of Parliament or of any regulations made under this or any other Act of Parliament conferring or imposing jurisdiction, powers, duties or functions on the Board shall be liberally construed and interpreted to the end that the recognized obligation of the people and the Government of Canada to those who have served their country so well and to their dependants may be fulfilled.

Section 39 of the *Veterans Review and Appeal Board Act* states that in all proceedings under this act, the Board shall draw from all the circumstances of the case and all the evidence presented to it every reasonable inference in favour of the applicant or appellant; accept any uncontradicted evidence presented to it by the applicant or appellant that it considers to be credible in the circumstances; and resolve in favour of the applicant or appellant any doubt, in the weighing of evidence, as to whether the applicant or appellant has established a case.

DECISION BEING APPEALED

SCHIZO-AFFECTIVE DISORDER
DEPRESSION
RIGHT PATELLOFEMORAL SYNDROME
MECHANICAL LOW BACK PAIN

Not pensionable under subsection 21(2) of the *Pension Act*, Regular Force Service.
Minister's Decision, 6 February 2002

The Applicant first applied for pension entitlement for:

Schizo-Affective Disorder - 18 April 2001;
Depression - 8 August 2000;
Right Patellofemoral Syndrome - 12 April 2001; and
Mechanical Low Back Pain - 29 September 2000.

Date Modified: 2012-01-31