Federal Court  Cour fédérale

Date: 20110519

Docket: T-1565-07

Citation: 2011 FC 591

Ottawa, Ontario, May 19, 2011

PRESENT: The Honourable Mr. Justice Rennie

BETWEEN:

MILENKO PANTIC

Applicant

and

ATTORNEY GENERAL OF CANADA

Respondent

REASONS FOR JUDGMENT AND JUDGMENT

[1] The applicant seeks judicial review pursuant to section 18(1) of the *Federal Courts Act* (R.S., 1985, c. F-7) of a decision of the Canada Pension Appeals Board (PAB) denying him leave to appeal an adverse decision of the Review Tribunal.

[2] The PAB denied leave to appeal the decision made by the Review Tribunal, which dismissed the applicant's claim for disability benefits under the *Canada Pension Plan* (R.S., 1985, c. C-8) (CPP). The applicant's application for leave was denied by the PAB because he did not

demonstrate, in the opinion of the PAB member, that he had an arguable case upon which the appeal might succeed. The Federal Court of Appeal has held that an arguable case in the context of an application for leave to appeal requires that some reasonable chance of success, at law, be established: *Fancy v Canada (Minister of Social Development)* 2010 FCA 63.

[3] It is the leave to appeal decision which is under review here, not the Review Tribunal's decision. However, only by considering the latter can the reasonableness of the former be ascertained. This necessitates a closer review of the record before the Review Tribunal. However, the entire matter turned on the determination by the Review Tribunal that the applicant did not and does not suffer injuries which are severe and prolonged, a necessary showing under subsection 42(2) of the CPP in order for a disability pension claimant's claim to be approved.

[4] The applicant originates from Bosnia-Herzegovina. He came to Canada in 1996. He had a college education upon his arrival in Canada. He studied and learned English for a year, and then went to work for Canada Post doing quality control work and was later employed there as print room operator. The applicant was working full-time in this capacity when he apparently suffered a back injury in October 2002 at the age of 46.

[5] On February 24, 2005 the applicant applied to Human Resources and Skills Development Canada (HRSDC) for disability benefits under the CPP. That application was denied for failing to meet the criteria set out in subsection 42(2) of the CPP. The CPP sets out the following in subsection 42(2):

When person deemed disabled Personne déclarée invalide

(2) For the purposes of this Act,

(a) a person shall be considered to be disabled only if he is determined in prescribed manner to have a severe and prolonged mental or physical disability, and for the purposes of this paragraph,

(i) a disability is severe **only if** by reason thereof the person in respect of whom the determination is made is incapable regularly of pursuing any substantially gainful occupation, and

(ii) a disability is prolonged **only if** it is determined in prescribed manner that the disability is likely to be long continued and of indefinite duration or is likely to result in death; …

[Emphasis added]

(2) Pour l'application de la présente loi:

a) une personne n'est considérée comme invalide que si elle est déclarée, de la manière prescrite, atteinte d'une invalidité physique ou mentale grave et prolongée, et pour l'application du présent alinéa:

(i) une invalidité n'est grave **que si** elle rend la personne à laquelle se rapporte la déclaration régulièrement incapable de détenir une occupation véritablement rémunératrice,

(ii) une invalidité n'est prolongée **que si** elle est déclarée, de la manière prescrite, devoir vraisemblablement durer pendant une période longue, continue et indéfinie ou devoir entraîner vraisemblablement le décès;…

[Notre soulignement]

[6] While HRSDC determined that the applicant had met the contributory requirements of the CPP, it determined that he had not met the criteria in subsection 42(2)(a)(i) and (ii), namely, that his claimed disability was not severe and prolonged.

[7] The applicant requested a reconsideration of this initial decision denying him benefits. On January 23, 2006, that request for reconsideration also resulted in a denial of disability benefits by another adjudicator:

> The information on file shows that the specialists can not find the reason for your pain. As such, there is no objective medical reason to support your incapacity for work. There is also no evidence of your attending a pain management program which may assist in your pain control.

> The information in your file indicates that when you applied for the disability benefit, you were able to do some type of work on a regular basis suitable to your condition and limitations. Therefore your medical condition cannot be considered 'severe' according to the Canada Pension Plan legislation and you are not eligible for disability benefits.
>
> You can appeal this decision to a Review Tribunal.

[8] The applicant did indeed appeal this second decision to a Review Tribunal. On March 7, 2007 the Review Tribunal dismissed this appeal, finding, among other things, that:

> The Tribunal has reviewed the documentary evidence submitted and notes that it fails to reveal objective findings that would support the Appellant's claim of a severe and prolonged disability in or before December, 2004. For example, in the report of Dr. MacGregor (page 33, HCF) dated April 2003 she noted that the Appellant was working for four hours a day and doing physio for four hours a day which clearly indicates he is not disabled. Dr. MacGregor also notes that despite the Appellant's self-limiting behaviour, he should be able to continue to work at a light level. Also, in a report of Dr. Day dated May 2003 (page 35, HCF) he notes that the Appellant's concerns appear to be from fear rather than a mechanical injury. In the CT Scan dated October 2003 (page 47, HCF) a slight impingement of the L4 nerve root was noted on the left side, however, no surgery was recommended at that time (page 52, HCF). In the report of Dr. Rhodes dated October 2004, some two months prior to the date of the MQP, he notes "Very mild degenerative change in the mid and lower thoracic spine". And in the EMG report of Dr. Pringle dated December 2004 he notes there is evidence of left-sided LA radiculopathy with some degree of denervation.
>
> The Tribunal notes that many of the foregoing medical reports which are dated prior to December 2004 do not indicate the Appellant has a severe back problem that would preclude a return to work. Rather, the reports cited indicate that the Appellant's objective findings do not correlate with his subjective complaints nor do these reports describe functional limitations which would preclude the Appellant from working prior to December 2004. While there is evidence of radiculopathy, there is no other evidence that this condition was so severe to have prevented the pursuit of employment.

> Further, with respect to the Appellant's testimony at the hearing, it was clear to the Tribunal that the Appellant was a relatively young man with a high level of education, skill, and intelligence. The Appellant's testimony, despite having a translator at the Hearing, also indicated, that he had a good grasp of English. For examples of the foregoing, the Appellant was able to find work that required a strong degree of English competency a mere year after to moving to Canada. Also, the Appellant was trained for his last job, a somewhat skilled position, in English. The Appellant's skills, education and training would suggest these were and are not now barriers to his finding work in the real world. Yet despite the Appellant's obvious talents, he does not appear to have made serious attempts to retrain or re-enter the workforce in any capacity. The Tribunal can sympathize with the Appellant when he states he is unable to work today; nevertheless, the Tribunal cannot rule on compassionate grounds and the appeal is therefore dismissed. [Emphasis added]

[9] The applicant then sought leave to appeal the decision of the Review Tribunal to the PAB. He offered four supporting grounds of appeal. No new medical evidence was provided in support of the four proposed grounds of appeal.

[10] On July 24, 2007 the Honourable K.C. Binks, Chair of the PAB dismissed the leave to appeal application:

> The Appellant seeks leave to appeal the Tribunal's decision dated April 17, 2007.
>
> The evidence before the Tribunal clearly showed that the applicant did not have an arguable case which is necessary to obtain leave.
>
> Accordingly, the application is dismissed.

[11] The review by this Court of the PAB decision refusing the applicant's application for leave to appeal involves two issues:

> i. whether the PAB has applied the right test—that is, whether the application raises an arguable case without otherwise assessing the merits of the application, and

> ii. whether the PAB has erred in law or in appreciation of the facts in determining whether an arguable case is raised. If new evidence is adduced with the application or if the application raises an issue of law or of relevant significant facts not appropriately considered by the Review Tribunal in its decision, an arguable issue is raised for consideration and it warrants the grant of leave.
>
> *Callihoo v Canada (Attorney General)* 2000 FCJ No 612 at para 15.

Whether the PAB Applied the Right Test

[12] The first question is subject to a correctness standard of review; the second to a reasonableness standard of review: *Mebrahtu v Canada (Attorney General)* 2010 FC 920. The Court of Appeal has added precision to this test, holding that an arguable case in the context of leave to appeal requires that the identification of a ground of appeal with some reasonable chance of success be established: *Fancy*, above.

[13] No issue is taken with respect to whether the PAB member applied the right test. While the PAB decision is brief, the PAB member adopted the correct test. I note that the adequacy of the reasons was not raised as a ground by the applicant.

Whether an Arguable Case was Disclosed

[14] I now turn to the question of whether the decision that no arguable ground of appeal with some reasonable chance of success had been established was reasonable. In *Williams v Canada (Attorney General*), 2010 FC 701 at paras 13-15 Justice Blanchard outlined the correct approach:

> The issue is whether the conclusion of the designated member of the Board that the applicant did not raise an arguable case, is reasonable. According to *Callihoo*, at paragraph 22:

> In the absence of significant new or additional evidence not considered by the Review Tribunal, an application for leave may raise an arguable case where the leave decision maker finds the application raises a question of an error of law, measured by a standard of correctness, or an error of significant fact that is unreasonable or perverse in light of the evidence...
>
> The Review Tribunal found that the applicant was not disabled within the meaning of subsection 42(2) of the CPP as his disability was neither severe nor prolonged. The Review Tribunal correctly stated the law. It explained the concept of disability under the CPP, and properly defined "severe" and "prolonged".

[15] As I have already stated, the Federal Court of Appeal has held that an arguable case in the context of an application for leave to appeal requires that some reasonable chance of success, at law, be established. The applicant did not demonstrate to the PAB that his application for leave had a reasonable chance of success. In turn, the applicant has not, now before this Court, established that the decision by the PAB denying him leave to appeal was unreasonable. Furthermore, the applicant has not demonstrated any errors of fact or law in the Review Tribunal's decision that are unreasonable or perverse in light of the evidence or which might give rise to an arguable case with some reasonable chance of success.

[16] The statutory and jurisprudential framework having been set, the applicant's proposed grounds of appeal and an assessment as to whether the PAB's finding that they do not disclose an arguable case is reasonable:

i. The Tribunal erred in stating there was lack of medical evidence on file to support a disability as of December 2004, when there were medical opinions expressed that the appellant was disabled from employment including those of Dr. Lee, Dr. Chan, Dr. Halle and Dr. Forget.

ii. The Tribunal erred in requiring objective findings to support a claim of disability.

iii. The Tribunal erred in failing to consider objective evidence of pathology related to the appellants [sic] symptomology and associated disability.

iv. The Tribunal erred in relying upon the opinion of Dr. MacGregor, which was provided on the basis that the appellant's condition was a muscular injury without neurological involvement or spinal condition and was thus given on the basis of a misdiagnosis.

[17] I do not, for the purposes of this judgment, intend to review all of the medical evidence, save to say that the applicant could not point to any significant factual error that was unreasonable or perverse in light of the evidence. Additionally, the record does not support the assertion that the weight of the evidence pointed in favour of finding that the applicant suffered from a severe and prolonged disability. Indeed, the preponderance of relevant evidence was to the contrary:

a. Dr. Lynne MacGregor, M.D., F.R.C.P.C., Physical Medicine & Rehabilitation, wrote to the Workplace Safety and Insurance Board (WSIB) on March 11, 2003 explaining that:

> Mr. Pantic was seen today for follow up of his low back pain relating to a work injury from October 2002…It was my impression he had mechanical low back pain of soft tissue and ligamentous etiology with no neurological or articular findings specifically other than reduced spine range with self limiting behaviours and he was quite pain focused and deconditioned. I referred him to the Back Institute in Gatineau for pain management and exercise. He did call in his medications after his last visit and was Oxy Contin and Flexeril.
>
> He has been in Gatineau CRD for three weeks now and has continued to do a work program at the same time with his employer on modified hours and duties. He is working four hours per day while he is going to physiotherapy. His daughter stated that he is on modified duties but was not certain what the functional abilities were at this point in time and I did not receive a copy of his current functional abilities. I did receive the original report, or assessment, from CRD but no updated forms were brought in today. His daughter reports he is getting a little better. He is doing his exercises but is still quite focused on his pain.
>
> I would like to see him in about three to four weeks with a progress note and have asked him to have one faxed to me about his current functional abilities. I stated to both of them that it is usual that the physical demands of his work are known to the physiotherapist or

> can be obtained from the employer and that is usually taken into consideration when looking at light or modified duties. I will see him for follow up but I do agree with the current plan. [Emphasis added]

b. In another letter to the WSIB, dated April 10, 2003, Dr. MacGregor further wrote:

> The purpose of the evaluation today was to see how she [sic] was doing with his physiotherapy program at the Canadian Back Institute where he had been going in Hull from February through until April 2001. He reports he has been discharged and, overall, the CRD discharge report indicates he was functioning within the light level and that, from an objective point of view, he had improved. From a subjective point of view, Mr Pantic reported a slight decrease in the pain but was having difficulty with tasks at work. His functional abilities were summarized and he was able to carry 20 pounds a distance of 30 feet and lift up to 20 pounds repetitively from waist to shoulders and from floor to waist 5 pounds repetitively. Overall, they stated he demonstrated the ability to work at a light level as defined by the physical demands and characteristics of work found in the Dictionary of Occupation Titles. It was noted he was able to lift 20 pounds occasionally, 10 pounds frequently. During the functional evaluations he did not demonstrate the signs of maximal effort normally observed on exertion. He demonstrated self limiting behaviour due to an exacerbation of his symptoms when accomplishing tasks. Therefore they stated he might be able to lift heavier loads than demonstrated. The work hardening was terminated April 2 as discussed with WSIB.
>
> There was a brief summary noted of job descriptions, regular duties, which outlined his job as a printer/operator. They noted the average weight carrying before was between 100gm to 14K but it was noted that he could use a dolly depending on the quantity of the files he had to carry and there was assistance with everyone's help to put away stock orders. This report, which is just a page without any other comments on it, states his modified duties are sitting alternating with walking whenever he felt like it, watching printers, replacing ribbons, carrying small packages to the dolly and setting up printers with the average weight being between 100 and 400 gm. It was noted he does not do any of the heavier box lifting. I reviewed this in front of Mr Pantic who did not seem to concur with the job description. I explained that, if he disputed the physical demands of the job that he would need to get a proper signed physical demands [sic] from his employer and that he would have to look at the specific details. However, from the Dictionary of Occupations and the form that was

> presented and presented to the physiotherapist, it seems they felt he was able to meet light level work. He is currently working four hours and is going to physiotherapy four hours per day for an effectively full work day. He was working harder in physiotherapy, according to the physiotherapy report, than at work. I explained to Mr. Pantic and his wife today that it would be reasonable for him to increase his hours to full time duties and that it is felt he is able to work within the light level. I explained to him again the concept of hurt versus harm and that he has a musculoligamentous low back problem that might not completely resolve. He and his wife had difficulty with this concept it seemed. I redirected them to you to review the dispute about the physical demands of his work. However, I think that if it is anywhere near the light level with alternating changes of position, he should be able to manage that. I explained to him that I did not need to see him for follow up as I did not really feel I had any further role at this point and re-referred him back to his family physician and yourself. [Emphasis added]

c. On May 22, 2003, another physical and rehabilitation specialist, Dr. Edward Day, provided a letter to one Dr. Vincent Chan, Mr. Pantic's Ottawa family physician, in which Dr. Day stated:

> It would appear to me that this man's problem is mechanical. It would seem to be that from the history and from the findings. He had facet blockage at C7 and Ti, bilaterally, L5 bilaterally, and the left sacroiliac joint was blocked.
>
> He seemed to be suffering from so much pain, that I had doubts that I could release the joints. In fact, it was easy. I had no difficulty whatever, to the point where I questioned the correlation between the amount of pain and the ease with which the joints were released. He claimed no benefit from releasing the joints.
>
> I will see him again, but I hesitate to think I can help your patient. It seems to me that his concerns are more from fear or some other problem rather than a simple mechanical injury. [Emphasis added]

d. Then on June 12, 2003, Dr. R.J. McKendry, M.D. F.R.C.P.C, Rheumatic Disease Unit at the Ottawa Hospital also wrote to Dr. Chan, explaining that:

> Physical examination revealed a pleasant, apprehensive looking man who moved slowly in the exam room. His daughter was there for support and to act as an interpreter. On MSK exam there was some restricted movement of his cervical spine in all planes with

> discomfort in each direction. It was difficult to examine him thoroughly because movement of any kind seemed to make him uncomfortable. As far as I could ascertain straight leg raising was normal and his reflexes were equal all be it somewhat hypoactive. He did not have many of the usual fibromyalgia tender points.
>
> The diagnosis of posttraumatic musculoskeletal pain syndrome best fits the clinical features. As is typical of this condition a relatively minor injury is followed by much more widespread and increasing persistent pain. These patients often end up on narcotic medications and Mr. Pantic is now on a Duragesic patch of 30 mg every two or three days. He tells, me that this does not produce any relief. I gather he has been extensively investigated by others although I do not have the details. If he has not yet had a technetium bone and joint scan this might be worthwhile partly to demonstrate that he does not have a widespread inflammatory process. His laboratory tests, which you sent, done in March of this year are all quite normal or negative including sedimentation of 5 and a negative ANA and a negative rheumatoid factor. Mr. Pantic's pain is becoming more pervasive and is now a defining characteristic of his life. Unfortunately, I don't know of any way to affectively improve the situation. I wonder if using antidepressants would be helpful or even an evaluation by a psychiatrist perhaps with involvement of the family to see if there are stresses or other circumstances, which might have a bearing on his condition. [Emphasis added]

e. On July 8, 2003 Dr. Robert Forget, M.D., B.A., C.S. (PQ), F.R.C.S.(C), also wrote to Dr. Chan, and explained that:

> On examination, we can see a gentleman in obvious distress who has difficulty walking, sitting righting himself. He keeps his neck flexed anteriorly. He has quite a resistance to passive manipulation of his neck in hyperextension, flexion, right and left external rotation. Regarding his low back, he has pain at the L5-S1 infraspinous area. He has no neurological or vascular deficits of his lower extremities. He has no positive straight leg-raising.
>
> X-rays of his lumbar spine were within normal limits. X-rays of his **neck** show severe degenerative disc disease at C5-C6.
>
> Would you please refer this patient for a neurosurgical assessment of his cervical spine. [Emphasis added]

f. Then on July 11, 2003 Dr. Reda El-Sawy, M.B., B.Ch., F.R.C.P.(C), another physician, a physiatrist, who saw the applicant, wrote to Dr. Chan:

> All symptoms [of his back pain described to me] were non-specific, there was no particular distribution and he was unaware of any aggravating or ameliorating factors.
>
> …
>
> Examination revealed a physically healthy looking muscular man who was in no acute distress. He sat down during the whole period of history taking. As soon as the "examination started" he presented with extremely dramatic functional problems. He was unable to walk. Actually he walked as though he was walking on a rope and he may fall down any time but he never did. When asked to walk on his tip toes or heels or squat, he would not do any of the above but would try "very hard" for a long period of time during which time he would be trembling and shaking all over but again never fell down.
>
> Examination of the spine revealed no guarding spasm or tenderness. He would not move any part of the spine in any direction to any degree. However, during examining other areas and obviously when he was sitting down in the interview, he had normal associated movements of the cervical spine. Even the upper limb joints, he would not move any of them.
>
> Neurological examination revealed no wasting or fasciculation. There was no change in the deep tendon reflexes and both plantar reflexes were down going. I was unable to assess the strength properly. There was no sensory deficit. Abdominal auscultation, peripheral pulses were normal.
>
> Examination of the peripheral joints was very difficult but I could not detect any synovial swelling, bony hypertrophy, or any evidence of acute inflammation. The upper limb joints were normal.
>
> The history and physical examination do not suggest any organic problem. One is reassured by the negative x-rays and CT scans as you mentioned in your letter. The signs however, are not typically that of conversion neurosis as it is even worse. Therefore the origin of these signs, cannot be determined in today's examination. I suppose that these will need an extensive specialized psychological testing and interviewing. I spoke with Mr. Pantic at length. I told him that he should see a psychiatrist. As you know, he already feels depressed and has significant sleep disturbance and energy loss, consistent with anxiety/depression.

> I have no further recommendation. I would only suggest that the longer he stays off work, the more difficult it will be to return him back to any kind of gainful employment and this is of course terrible because of his very young age. [Emphasis added]

g. A July 30, 2003, Neurophysiology Electromyogram exam conducted at the Ottawa Hospital concluded:

> These electrophysiologic tests are normal apart from the absent H-reflex in the right soleus muscle which is simply the electrophysiologic correlate of an absent snide jerk on the right. There is no active denervation seen in the right S1 myotome however. [Emphasis added]

h. In an October 20, 2003 letter, Dr. Forget wrote once again to Dr. Chan, and suggested that a "CAT scan of his lumbar spine has shown a slight impingement of the L4 nerve root on the left side." [Emphasis added]

i. Dr. Peter Jarzem, B.Sc., M.D. F.R.C.S, an Orthopaedist determined that the applicant was "not a surgical candidate."

j. Dr. I. N. Rhodes, provided, in a letter to Dr. Chan, the following diagnosis in respect of Diagnostic imaging conducted at CML Health Care on the applicant:

> There is no fracture demonstrated. There are some slight lateral ozteophytes involving the lower thoracic spine. The intervertebral disc space heights are normal. The posterior elements and para-vertebral soft tissues are normal. Very mild degenerative changes in the mid and lower thoracic spine. [Emphasis added]

[18] In a May 2005 letter from Dr. Ian J. Harrington, M.D., F.R.C.S.(C), M.S., M.Sc., Associate Professor, University of Toronto to Dr. Weatherhead, the applicant's new family physician in Toronto, Dr. Harrington summarized much of the above history but wrote in reference to his own examination of the applicant:

> On clinical examination, Mr Pantic is noted to be a tall, fit looking gentleman. He walked with a cane in his left hand, complaining bitterly of low back and left buttock discomfort. He complained also

> of neck and upper back pain. With encouragement, it was possible to demonstrate that he was able to walk on his tip toes and heels. He showed a fairly good range of movement of his cervical spine but complained of pain in all planes of motion. There was an exaggerated pain response to palpation of his cervical spine, posteriorly. There was no evidence of paracervical muscle spasm. Movement of Mr. Pantic's lumbo-sacral spine was restricted. He flexed so that his finger tips came to 3 or 4 inches above kneecap level. Further attempts at flexion caused increasing back pain. Lateral bending, rotation and extension movements were restricted as well causing pain referred to the lumbosacral area. Rotating his pelvis from side to side without moving his back also caused lumbar pain. Neurological examination revealed that reflexes in Mr. Pantic's upper and lower extremities tended to be hyporeflexic but equal bilaterally. He showed an unusual pattern of hypoaesthesia affecting his right leg, right arm and parts of the right side of his trunk and thorax, not distributed in derrnatomal fashion - basically glove and stocking. Any attempt at straight leg raising on either side when examined supine was resisted vigorously, in the sitting position, however, it was possible to carry out straight leg raising to 90 degrees bilaterally without any complaints of back or leg pain. Plantar responses were down going. There was no ankle clonus - no evidence of an upper motor neuron lesion. Examination of both shoulders, elbows, hands, wrists, hips, knees, feet and ankles was considered normal although Mr. Pantic complained of discomfort in both shoulders with full abduction/external rotation. Axial compression of Mr. Pantic's head caused upper thoracic and lower back discomfort. [Emphasis added]

[19] Finally, in a December 12, 2005 letter sent to Mr. D. Rideout, the Medical Adjudicator who denied the applicant's request for reconsideration regarding disability benefits (i.e. the second decision), Dr. William J. Kraemer, M.D. F.R.C., of the Toronto East General and Orthopaedic Hospital and lecturer at the University of Toronto, wrote:

> The information in this report is based on one office visit on October 25th, 2005, referred by Dr. Harrington.
>
> …
>
> On physical examination, he [Mr. Pantic] had a somewhat unusual demeanor in reaction to examination, with flailing of his arms and

> unsteadiness when he was standing. Inspection of his lumbar spine was normal. On palpation, he indicated pain in the middle of the lower lumbar spine, as well as in the paraspinal muscles, and pain in the upper thoracic spine, as well as the mid-thoracic spine. He could only flex a few degrees and he flailed his arms when he did this and indicated severe pain. Extension was just past neutral and lateral bending was similarly limited. He had difficulty walking on his heels and on his toes because of pain. Manual motor testing revealed painful giving way but I did not detect any motor weakness. Sensory testing was normal. His reflexes were intact and symmetric. Straight-leg- raising test reproduced back pain severely but did not reproduce radicular pain. He had normal pulses in his feet. Rotation of his hips revealed full range of motion; however he complained of severe pain in his back during rotation of the hips.
>
> The MRI scan did not reveal any evidence of nerve root compression or thecal sac compression at any level. There was an incidental finding of a benign hemangioma (benign vascular tumor) in the L1 vertebral body, which extended into the left-sided pedicle. There was no bony expansion or soft tissue extension into the spinal canal, and again no evidence of any nerve root impingement at this level.
>
> In summary, this patient complains of very high pain levels in multiple areas of his spine; however the MRI scan did not reveal any explanation for this pain. The prognosis for improvement is poor, given the chronicity of the symptoms, the unusual pain behavior and the essentially normal MRI scan.
>
> This patient would not benefit from surgical intervention. With regard to his capacity to work, I did not find any significant spinal condition on the MRI films. Therefore I do not know the source of his pain. Essentially, any incapacity for work would be based on his own pain limitations, rather than on restrictions imposed by a physician. [Emphasis added]

[20] Such was the evidence before the Review Tribunal and the PAB when they made their respective decisions. As the medical history indicates, none of the evidence before the Review Tribunal approaches the threshold constituting an arguable case. While there are some references to limitations on the applicant's ability to work, to nerve impingement in his spine and of pain arising from certain tests, the findings of the PAB that the proposed appeal had no reasonable chance of

success is reasonable. The applicant cannot point to evidence which supports the argument that his injury is severe and prolonged, as it must be under 42(2) of the CPP. Absent the requisite evidentiary foundation, the presentation of new evidence adduced with the application, or the application raising an issue of law or of relevant significant fact not appropriately considered by the Review Tribunal in its decision, this ground of appeal had no reasonable prospect of success.

[21] The second ground of the proposed appeal can be dealt with quickly. It is not an error of law to require objective evidence of the disability. As the Court of Appeal noted in *Warren v Canada (Attorney General)* 2008 FCA 377 at para 4:

> In the case at bar, the Board made no error in law in requiring objective medical evidence of the applicant's disability. It is well established that an applicant must provide some objective medical evidence (see section 68 of the *Canada Pension Plan Regulations*, C.R.C., c. 385, and *Inclima v. Canada (Attorney General)*, [2003] F.C.J. No. 378, 2003 FCA 117; *Klabouch v. Minister of Social Development*, [2008] F.C.J. No. 106, 2008 FCA 33 …

[22] The third ground of appeal could not be assessed by the Court as it could not be explained or elucidated with sufficient clarity as to be considered, nor was it advanced in argument before the Court. As such, it cannot be said to have any reasonable chance of success.

[23] The final ground of appeal arises from reliance by the Review Tribunal on the report of Dr. MacGregor, noted above. It was contended that the Review Tribunal erred in relying on Dr. MacGregor's reports because Dr. MacGregor's opinion was a misdiagnosis. The applicant framed the argument as follows:

> …the argument presented by the Ministry (formally [sic] the HRSD) relies on the opinion of by [sic] Dr. Lynne McGregor [sic], Physiatrist. Dr. McGregror [sic] determined that my condition was a

> muscular injury without neurological involvement or spinal condition. Her opinion was thus given on the basis of a misdiagnosis (the CT scan and nerve test are proof of this). She sent me to a pain management clinic (CRD) where they explained to me that my nerve was stuck in between vertebrae. They told me to do exercises which they said would free the nerve. This doesn't make sense. It's very unclear why she persistently stated that the injury was purely muscular but she sent me to get nerve treatment. [Emphasis added]

[24] It is not the role of this Court on judicial review of a PAB decision refusing leave to appeal the Review Tribunal's decision to accept as a premise for the proposed appeal that a medical opinion was in error. While it is true that the CT scan did indicate "very mild degenerative changes in the mid and lower thoracic spine" there is no evidence on the record supporting the argument of a prolonged and severe disability on the part of the applicant. Indeed, the evidence was to the effect that the applicant could undertake light work.

Conclusion

[25] This court's function is to adjudicate on the reasonableness of the PAB's decision to deny the applicant's leave to appeal application. The applicant failed to establish in his application for leave, grounds for appeal with some reasonable chance of success at law. For that reason, I find that the decision of the PAB is within the range of possible, acceptable outcomes defensible in light of the facts and law and therefore is reasonable: *Dunsmuir v New Brunswick*, 2008 SCC 9 para 47.

JUDGMENT

THIS COURT'S JUDGMENT is that:

1. The application for judicial review be and is hereby dismissed.

2. There is no order as to costs.

3. The style of cause herein is amended to correctly name as respondent the Attorney General of Canada.

"Donald J. Rennie"
Judge

FEDERAL COURT

SOLICITORS OF RECORD

DOCKET:	T-1565-07
STYLE OF CAUSE:	MILENKO PANTIC v. ATTORNEY GENERAL OF CANADA
PLACE OF HEARING:	Toronto
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REASONS FOR JUDGMENT AND JUDGMENT:	RENNIE J.
DATED:	May 19, 2011

APPEARANCES:

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