Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant] (Estate of [text deleted])
AICAC File No.: AC-15-012

PANEL:	**Laura Diamond, Chairperson** **Leona Barrett** **Linda Newton**
APPEARANCES:	**The Appellant, [text deleted], appeared on her own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Anthony Lafontaine Guerra.**
HEARING DATE:	**January 19, 2021; January 20, 2021; February 19. 2021**
ISSUE(S):	**Whether the Appellant is entitled to PIPP benefits in relation to the motor vehicle accident (MVA) of April 30, 2013.**
RELEVANT SECTIONS:	**Sections 70(1) and 119(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

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

Reasons For Decision

Background:

The Appellant is the widow of [text deleted], who was injured in a motor vehicle accident (MVA) on April 30, 2013. She represents his estate in a claim for Personal Injury Protection Plan (PIPP) benefits under the MPIC Act. [Appellant's husband] died on May 7, 2013. The Appellant takes the position that his death was caused by injuries sustained in the MVA.

On April 30, 2013, the Appellant and her husband were driving on the highway during a snowstorm. The MVA occurred when the vehicle slid off the roadway and became stuck in a snow bank. The Appellant and her husband were unable to exit the vehicle and remained there for some hours, until a passerby provided assistance. After they returned home, the Appellant's husband began to feel unwell, complaining of low back pain which was worse when taking a deep breath. He attended the hospital twice, and was admitted with a diagnosis of right lung pneumonia. He passed away on May 7, 2013. A discharge summary indicated a diagnosis of death due to pneumonia, end-stage renal failure and type II diabetes.

When the Appellant sought PIPP benefits from MPIC, the case manager provided a decision dated January 27, 2014 which indicated that, on the balance of all medical probabilities, [Appellant's husband]'s pneumonia was not related to the MVA and MPIC was unable to offer coverage.

The Appellant sought an internal review of this decision and on October 28, 2014, an Internal Review Officer (IRO) upheld the case manager's decision, finding that the passing was not causally related to the MVA.

It is from this Internal Review Decision (IRD) that the Appellant has now appealed.

Procedural Matters:

Due to pandemic procedures, the hearing of the appeal was scheduled to take place by videoconference on January 19 and January 20, 2021, at 9:30 a.m.

At approximately 9 a.m. on January 19, 2021, the Appellant advised Commission staff that she was having some difficulty trying to get online and that she was waiting for her son (who had planned to testify at the hearing) to assist her with his computer. However, at 9:30 a.m., the Appellant advised that her mother had been taken to hospital after a fall. Her son was attending to her mother and could not assist her. Further, the Appellant asked to adjourn the hearing so that she could go to the hospital to help her mother.

The hearing was adjourned for the morning session and scheduled to reconvene at 1 p.m. At that time, the Appellant advised that she was prepared to proceed by teleconference (as she no longer had access to her son's computer), and that she would be the only witness for the Appellant. Counsel for MPIC agreed and the hearing proceeded with both parties participating by telephone.

The hearing reconvened at 9:30 a.m. on January 20, 2021, to hear evidence from [MPIC's HCS medical consultant] of MPIC's Health Care Services team. Counsel for MPIC and [MPIC's HCS medical consultant] participated by videoconference and the Appellant by teleconference. The evidence was followed by the Appellant's closing submission. She was then advised that counsel for MPIC would make his closing submission, and that after that she would have an opportunity to reply.

However, during MPIC counsel's presentation of his submission, at approximately 2:30 p.m., the telephone connection with the Appellant was lost. Although the Commission tried many times to contact her, these efforts went straight to voicemail. As counsel for MPIC had already prepared and provided a written copy of his submission, it was agreed that the Commission would send a written copy of the submission to the Appellant and that she would be given an opportunity to provide a reply.

After the hearing on January 20, 2021, Commission staff left another voicemail message for the Appellant, but no reply was received.

The Commission wrote to the parties on January 22, 2021, providing the Appellant with a written copy of MPIC's submission and advising that any reply from the Appellant should be received by the Commission by February 19, 2021:

> ...
>
> Therefore, enclosed [the Appellant] will find a copy of the **written Submission of MPIC**.
>
> Please note that this is **NOT** a copy of the Commission's Decision or Reasons for Decision in this matter.
>
> We are providing this written Submission to [the Appellant] so that she can review the arguments made by MPIC and have an opportunity to respond or reply.
>
> Please provide any Reply Submission in writing to the Commission by **Friday, February 19, 2021.**
>
> The Reply Submission can be returned by mail or via email to… <u>or by mail in the enclosed self-addressed envelope.</u>
>
> If you have questions, or require assistance, please contact the Appeals Officer… who can assist you.
>
> If [the Appellant] chooses not to submit a Reply Submission, the panel will then proceed in due course to make its Decision and provide it to the parties along with Reasons for Decision.
> …

After February 19, 2021, the Appeals Officer advised the panel that no further submission or communications had been received from the Appellant and the panel proceeded to make its decision regarding the appeal.

<u>Issue:</u>

The issue before the panel was whether the Appellant is entitled to PIPP benefits in relation to the MVA of April 30, 2013. The parties agreed that this was an issue of causation, as the IRD of October 28, 2014 upheld the case manager's decision that [Appellant's husband]'s death was not causally related to the MVA.

Following a review of the documentary evidence, witness testimony and the submissions of the parties, the Commission finds that the Appellant has failed to show, on a balance of probabilities, that her husband's death was causally related to the MVA of April 30, 2013.

Evidence for the Appellant:

Documentary Evidence

The Commission was provided with an ambulance report dated May 3, 2013. It noted that the Appellant's husband had been feeling unwell, suffering from back pain and that it hurt him to breathe. Outpatient and admission records from [hospital] dated May 4, 2013 noted that he had been feeling unwell following a MVA in a ditch, and was suffering from mechanical lower back pain, difficulties with breathing and reflux. The hospital admission assessment of that date indicated lower back pain following an MVA with increased pain.

An x-ray report dated May 4, 2013 was unremarkable.

A hospital summary dated May 4, 2013, noted that he had presented to hospital on May 4 feeling unwell following the MVA in the ditch. His lower back pain was worse with taking deep breaths and with movement. The report noted that an examination showed him to be in no acute distress, that he improved with medication overnight and wanted to go home. He was discharged home the next day, following a diagnosis of mechanical low back pain and reflux symptoms.

The Appellant was taken back to hospital by ambulance on May 6, 2013. A report from a chest x-ray taken May 6, 2013 noted a suspected right lower lobe pneumonia. A history and physical examination report diagnosed right lung pneumonia, chronic disease, hypertension, type II diabetes and neuropathy.

On May 7, 2013 [Appellant's husband] died.

The hospital discharge summary following his death described a significant rise in creatinine. Medications were prescribed to address this.

> …Early in the evening, he deteriorated fairly quickly. He showed signs that he probably had acute on chronic renal failure and passed away with his family present.
>
> **DIAGNOSIS OF DEATH:** **PNEUMONIA**
> **END STAGE RENAL FAILURE**
> **TYPE 2 DIABETES**

The Appellant also provided a report dated July 3, 2014, from [text deleted], a physician with expertise in respiratory medicine. This report described some of the circumstances which followed the MVA and [Appellant's husband]'s experiences in accessing treatment, which was hampered by weather conditions. He described the vehicle being stuck in the snow in the ditch and the victim being confined to the car for approximately 4 hours until a passerby assisted them in returning to their home. A few hours after he returned home he complained of being cold and chilly with some shivering. The ambulance that was called could not come to the home for 3 days, because of the weather conditions. During that time he complained of back pain, with shivering. When he did arrive at the emergency room he complained of pain in his back with deep breathing and movement. He was examined, but a chest x-ray was not obtained. He was discharged home with a diagnosis of mechanical low back pain and reflux symptoms.

[Respiratory physician] noted that on the evening of May 4, 2013 the deceased again complained of not being well. He was picked up by an ambulance late that evening and taken back to hospital where, on examination, he was found to have rapid shallow respirations at a rate of 24 per minute with poor air entry in the right lung. A chest x-ray showed a right-sided pneumonia. He was started on antibiotics but continued to deteriorate and died May 7, 2013.

[Respiratory physician] noted that the patient was suffering from right-sided pneumonia and possible right pleural effusion. In addition, his diabetes was poorly controlled as was his chronic renal failure. He was noted to be non-compliant with his medication and his diabetes was uncontrolled.

[Respiratory physician] concluded:

> In my considered medical opinion, his pneumonia developed on the basis of his confinement in his motor vehicle accident for 4 hours at the time of his accident. His lung infection was intensified by his uncontrolled diabetes and chronic renal disease. The chest pain was certainly related to pleuripis of the right pleural. I believe that the development of pneumonia was a result of being confined in a closed space and being unable to move around. Because of his chest pain, deep breathing and coughing were compromised. Both diabetes and chronic renal diseases reduce the effectiveness of an individual's immune system leading to pneumonia which caused his death.

Evidence of the Appellant

The Appellant testified about the weather on the day of the MVA. The day started out mild and warm and she and her husband were dressed for spring/summer weather. The snow began on their way home and it was snowing hard. Their car spun out into a drainage ditch and almost rolled. Water came in to the driver side of the car and her husband got wet, so she put him on her side of the car and moved to sit in the back. The Appellant testified that they stayed in the car

until they were picked up because they couldn't get out. They ran the motor for a while but then, after awhile, it stopped working.

They sat there for about 4 hours before another vehicle stopped to help them and they were able to get a ride home. That was when they saw that there were about 30 cars in the ditch and men using snow mobiles to rescue people.

When they arrived home, their children helped to clear a path for their father to reach the house. He leaned on her back and she held his arms and walked him into the house. She helped change him into warm clothes and he lay on the bed. He was shivering so much he was bouncing off the bed so she turned the oven to broil to warm up the house and turned up the heat. She called 911 but they said the roads were closed and no ambulances were attempting any transport. So she did her best to try and keep him warm and when he got up the next morning he seemed fine.

The Appellant described her husband's medical history. She said that she knows he was a sickly man but that he had seen a doctor who told him to keep doing what he was doing, although he might need dialysis in the future. The Appellant and the kids loved him and made sure that he checked his sugars, ate properly and felt okay. Sometimes he missed medical appointments because there were problems with the medical van and transport. She described how it was common for the reserve transport to forget or fail to pick him up for an appointment. Since their truck was old, they relied on medical transport or had to borrow her mother's car.

Days after the MVA, when the roads were finally cleared, the Appellant called the ambulance again and he was taken to hospital. This was a couple of days later, but she could not remember exactly when. The doctor checked him out and he stayed overnight. On the way home, he told

her that he could not stop feeling cold and he did not improve once they got home. The Appellant, feeling scared, called the ambulance again. He stayed overnight and in the morning she called the hospital and was told that he was being released and could come home. She went to the hospital but could not find him. He was not in the waiting room. Finally she found him lying on a bed in the birthing room. She called the doctor to come back and help him, but he was not the same. She knew he was weak as he was gasping for air, and not talking much. The doctor came and poked the bottom of his feet but there was no reaction. He said it was pneumonia.

On cross-examination, the Appellant confirmed that her husband was [age] at the time of his death but had not been a healthy man. Although she confirmed that he was diabetic, she stated that she didn't think that was ever going to take his life or that pneumonia would hit him so hard. She confirmed that even prior to the MVA, in 2013, her husband had a history of difficulties lying flat and difficulty breathing, but she attributed this to a broken rib he had. She described an injury when he had slipped on the stairs carrying groceries. After this injury, he was sore for about 10 days and had to take small breaths.

She confirmed that although he had type II diabetes, he did not take insulin. She did not remember him using an inhaler. When counsel asked about his prescription history for gabapentin and an inhaler, the Appellant indicated that he would only take the inhaler on occasion and probably not much. He smoked about 10 cigarettes a day, used weed a couple of times a week to improve appetite, but did not use alcohol. Although she was asked whether her husband had any history of muscle weakness, feet swelling, shortness of breath, chronic pain, indigestion or heartburn, or issues with his kidneys, the Appellant only remembered that he had bunions, had suffered a pinched nerve and pain in his back due a congenital tailbone condition. He was a big guy, kind of chubby, so found it a bit harder to move around. He had heartburn

when he ate spicy foods. She agreed that he had diabetes and took some pills for it, but that she did not recall him taking insulin. She admitted that due to some of these problems, he often slept sitting up.

The Appellant was asked about a February 28, 2013 appointment her husband had with the [hospital #2] nephrology clinic who were following him for presumed diabetic kidney disease which was progressing. She was asked about reports that he had missed medical appointments and was noncompliant with his medication. The Appellant indicated that the family would try to help him with his pills and water intake but that transportation to appointments was difficult on the reserve. Although she acknowledged that the doctors had found a progression of his kidney disease in the past year before his death, and had talked to him about the likelihood of him developing end-stage renal disease, she indicated that this was not described as being within the next 2 to 3 years, but rather within 10 to 15 years. He hadn't even started dialysis.

She acknowledged that in June 2012 her husband had spent some time in [hospital] for an edema condition, but says that when he was released the family tried to help him restrict his water intake. The Appellant indicated that he was on disability benefits at the time of the MVA because of problems with his vision and eye surgery he needed.

On cross-examination, the Appellant was also asked several questions about the circumstances surrounding the MVA. She indicated that the MVA occurred at a slow speed because they were driving slowly, due to the white-out conditions. But she maintained that because it was springtime, there was water under the snow in the ditch and the water came into the vehicle. It was about 2 feet of water, which got her husband wet, so he had to jump over to sit in the passenger side while she jumped into the back seat. Then, they were not able to keep turning the car on to keep it warm, because the vehicle stopped running.

When asked why, in earlier statements, she had never mentioned there being water in the vehicle or an inability to turn the car on to run at any time, the Appellant blamed her previous lawyer, who she said never really sat down to talk with her about anything and take down information from her.

She was also asked why her counsel had provided a statement dated September 12, 2014 which confirmed that "The car was running for portions of the time, as they were turning it on and off to conserve fuel and prevent the accumulation of any fumes…". She said that it ran for about 45 minutes but they were no longer able to start the engine for the last 3 hours. She maintained that they were partially submerged in water which affected their ability to run the car for warmth and made it necessary for her husband to move away from the driver's side of the car.

The Appellant was asked why they didn't ask the passersby to drive them to the hospital instead of home if her husband was injured. She indicated that she didn't think of this because they had no money to offer them for this and they didn't even know how far any of them would make it, due to the snow and blizzard conditions.

The Appellant confirmed that [respiratory physician] had never treated her husband and was not his doctor, although he had provided a report. She had met with [respiratory physician] in her lawyer's office, but could not recall whether she told him that her husband got wet in the MVA. She said that was the most likely because he got pneumonia and there had to be a link somewhere. Or maybe the lawyer had told him. When asked why there was no reference to this factor in [respiratory physician]'s report, the Appellant indicated that this was again the problem with her lawyer not listening to her, and nobody listening to her.

Evidence for MPIC:

Documentary Evidence

In addition to referring to the deceased's past medical and prescription records, and the ambulance, hospital and caregiver reports surrounding the MVA and his death, counsel for MPIC relied on a report dated March 2, 2013, from [text deleted], a nephrologist who assessed and treated the deceased.

[Nephrologist] was following the deceased for presumed diabetic kidney disease, which was progressing. He recounted several admissions to hospital over the last year, usually due to non-compliance with medications and sodium restrictions with subsequent fluid overload.

> …We have seen some progression in his kidney disease over the last year. His creatinine values now are approaching 200 umol/L, whereas they were 120 umol/L a year ago. I reviewed once again with him the progressive nature of his disease and that he is destined to develop end-stage renal disease likely in the next 2-3 years.

MPIC also provided several reports from its Health Care Services Team, who reviewed the Appellant's medical file.

The first report was dated January 27, 2014, from [MPIC's HCS medical consultant]. He indicated that after reviewing the documents in the deceased's file, it was his opinion that he was involved in a minor MVA which did not result in a significant musculoskeletal injury or adversely affect a pre-existing condition. After the MVA, the Appellant attended for a short period at the hospital and was treated for mechanical low back pain and reflux. His condition was monitored and he was noted to have improved and been discharged home.

[MPIC's HCS medical consultant] noted that the cause of death was right upper lobe pneumonia in the presence of chronic diseases of end stage renal failure, type 2 diabetes, hypertension, congestive heart failure, diabetic neuropathy and diabetic retinopathy. The MVA did not play a medically probable role in the development of the diagnosed pneumonia or death.

Following a review of [respiratory physician]'s July 3, 2014 report, [MPIC's HCS medical consultant] provided another Health Care Services review. In this review he noted the likelihood that on the date of the MVA of April 30, 2013 there would not be snow banks, a blizzard or significant cold temperatures that could probably expose the deceased to extreme temperatures that might affect his health. (These comments were later corrected in a further review by [MPIC's HCS medical consultant] dated October 10, 2018.) He also noted that the hospital reports of May 4, 2013 did not identify findings suggestive of a developing pneumonia, with normal temperature, oxygen saturation and pulse recorded at that time. Based on the totality of the medical evidence, the scenario provided by [respiratory physician] sounded possible but not medically probable. Given the deceased's pre-existing medical conditions, his non-compliance with recommended treatment and his decision to continue smoking, [MPIC's HCS medical consultant] was of the opinion that these had a greater, more probable impact on the final cause of death.

[MPIC's HCS medical consultant] was then asked to provide an opinion if there was a possible cause and effect relationship between the development of the pneumonia and the way the deceased was restricted in the vehicle for 4 hours until help arrived, while occasionally running the vehicle to maintain heat. On October 22, 2014, [MPIC's HCS medical consultant] advised that once again it was his opinion that a medically probable cause and effect relationship did not exist between the MVA and the documented pneumonia or cause of death.

Finally, on October 10, 2018, [MPIC's HCS medical consultant] once again reviewed the file, this time with information about the weather conditions at the time of, and the days following, the MVA. He indicated that a medically probable cause and effect relationship cannot be established between the weather, in general, and the development of pneumonia. Pneumonia can develop in the absence of an individual being exposed to a specific type of weather and even in the summer months. Nor was there a relationship between confinement to tight spaces for long periods and pneumonia, without evidence of respiratory compromise. The hospital reports from May 4, 2013 showed that the deceased did not appear to be in acute distress. His vital signs were quite normal with symmetrical breath sounds and good air entry bilaterally. This was not the clinical picture of an individual experiencing respiratory compromise secondary to a confinement or the clinical picture of an individual in the early stages of developing pneumonia.

[MPIC's HCS medical consultant] went on to opine that the actual impact of the pneumonia had on the deceased's health could not be determined., and that the reference to the *persistence* of patchy opacities within the right lower lobe led him to conclude that the pneumonia was not connected to the MVA and was only suspected but not confirmed:

> …The evidence does not indicate the pneumonia was the primary cause of his death. [Appellant's husband] had significant comorbidities that had a more significant contribution to [Appellant's husband]'s death, in all probability. It is medically probable the significant rise in creatinine (suggesting further compromise of renal function) was the cause of [Appellant's husband]'s demise on May 7, 2013.

Evidence of [MPIC's HCS medical consultant]

[MPIC's HCS medical consultant] testified at the appeal hearing and was qualified as an expert in sports medicine and forensic document review. He advised that although he had not met with the deceased or the Appellant, he had reviewed the documents in the file.

In his opinion, it had not been confirmed that the cause of death was pneumonia, although there was definitely a suspicion of pneumonia as a working diagnosis. There was no evidence that the pneumonia progressively worsened to the point where the patient died. Rather, he pointed to the severe worsening of the deceased's renal function, as well as his other significant co-morbidities, as the likely cause of death.

[MPIC's HCS medical consultant] did not believe that the MVA caused or contributed to the death. There was no indication of trauma or an injury, beyond perhaps a not significant soft tissue injury leading to non-specific back pain.

[MPIC's HCS medical consultant] reviewed some of the pre-existing medical conditions found in the deceased's medical records. He reviewed edema, possible heart, liver and kidney issues, varicose veins, diabetes which was not under good control, a history of smoking, chronic heartburn or indigestion, and possible diabetic neuropathy. Previous consultations with nephrologists were noted.

He reviewed the medical history, physical examination and tests done in the hospital upon admission, such as temperature, bloodwork and x-rays. He found no evidence to support a conclusion that the deceased's pre-existing renal decline was worsened as a result of exposure to bad weather or any immobility in the vehicle during the MVA. Exposure to cold was not described and is not a risk factor for pneumonia or renal disease. He may have been unable to leave the vehicle for a few hours, but he was not confined such that he was prevented from moving about and doing things inside the vehicle.

In [MPIC's HCS medical consultant]'s opinion, the deceased's health was deteriorating well before the MVA. There was no indication that his respiratory function declined further once the diagnosis of suspicion of pneumonia was made or that he became more septic because of it in a way that would affect his renal function. In his view, the cause of death was the worsening of the deceased's pre-existing poor renal function and was not in any way connected to the MVA.

Submission for the Appellant:

The Appellant explained that she learned to take care of other people from her grandmother, mother, teachers and older siblings. She has spent a lot of time with elders and all of her life taking care of people. After she graduated, she wanted to become a home health care worker, but instead became a mother to her 4 children. She took good care of them and her husband, even in the face of some of their medical challenges.

The Appellant went on to describe the hurt, frustration, shock and anger she felt at the hospital with her husband. She did not believe that they were taking good care of him. She felt they were not communicating with her, and that some staff was even mocking her.

But from her experience in raising children and caring for her husband, she knows when someone has pneumonia, and when they have a fever or are so uncomfortable that they need to rest. In the hospital, she tried to comfort her husband before he died, but his death left her and her children traumatized.

The Appellant remains convinced that her husband got sick because his clothes got wet in the vehicle, and he was not well after that. She believes that the lack of communication and politics in her community played a part in impeding his access to medical care, both for his regular

appointments and in emergencies. Her husband, who had been an experienced bus driver, suffered as a result of the MVA. This, she submitted, was the cause of the illness which took him to the hospital and led to his death.

Submission for MPIC:

Counsel for MPIC indicated that this was a difficult appeal from an emotional perspective, acknowledging the Appellant's difficult loss and painful memories. However, this appeal concerns a question of causation, and whether the MVA caused or materially contributed to her husband's death such that certain benefits should flow. He submitted that the deceased was already a very sick man before the MVA, with a shortened life expectancy. He was a smoker who suffered from uncontrolled diabetes, obesity, hypertension, a prior pleural effusion and kidney disease.

Counsel relied upon s. 119(1) of the MPIC Act, which defines the term "deceased victim" to mean a victim who died as a result of the accident. The terms "victim" and "accident" are defined in s. 70 (1) of the Act as a person who suffers bodily injury in an accident and an event in which bodily injury is caused by an automobile.

In order to establish that a death benefit is payable to anyone, the Appellant must first show that the deceased was involved in an event in which he suffered physical or mental injury caused by an automobile and that, as a result of that injury, he ultimately died.

Counsel pointed out that the evidence established that the MVA was relatively minor in nature. Although the Appellant testified that the vehicle became partially submerged in water, that the engine stopped working and there had been vehicle damage, there was no evidence to

corroborate any of this testimony. In fact, the MVA details had been recounted to MPIC by the Appellant and her legal representation in a different manner, which made no reference to the vehicle being submerged in water, not operational or damaged.

The Appellant and her husband did remain in the vehicle for approximately 4 hours. Although the Appellant indicated that her husband was then in some distress, she did not ask for a ride to the hospital. Although she testified that she called for an ambulance upon their return home and was refused, no phone records or other EMS records were produced to support this.

[Respiratory physician]'s report only made reference to some of these facts, noting that the deceased shivered and complained of being cold a few hours after he returned home, and that an ambulance was requested several times but did not respond. He did not mention the deceased getting wet, whether the vehicle remained operational or where he was seated. Based upon the Appellant's frustration with her lawyer, [respiratory physician] may have based his report on erroneous facts, but it is not possible to confirm this. While MPIC did not dispute the expertise of [respiratory physician], counsel respectfully submitted that the Commission ought to give little weight to his findings. His report did not cite sources and a number of material facts alleged were not supported by the available medical records. He accepted the May 6, 2013 diagnosis of pneumonia but failed to reconcile his belief that the deceased developed pneumonia as a result of his confinement on April 30, 2013 with the absence of symptoms necessary to support any such diagnosis when the deceased was first examined on May 4, 2013. Finally, unfortunately and through no fault of the Appellant, [respiratory physician] was not able to be present to explain his evidence and be subject to cross-examination.

When the deceased was transferred to hospital by ambulance, the ambulance report indicates that he reported feeling ill and complained of back pain that translated into pain on breathing. The hospital outpatient record reported a 2-3 day history of feeling generally unwell with no reference to chills, shivering or having been involved in an MVA. There were no notes of any exposure to cold temperatures, and pneumonia or even suspected pneumonia were not diagnosed at that time. Low back pain was present even before the MVA and the evidence established that he did not always seek out medical attention for his injuries. Further, an x-ray taken of the deceased's lumbar spine on May 4, 2013 did not suggest any pathology and there was no medical evidence linking any complaints of back pain to the MVA.

[MPIC's HCS medical consultant]'s review of the evidence, including [doctor]'s reports of May 4, 2013 of normal vital signs and symmetrical breath sounds with good air entry bilaterally, with improvement prior to discharge, did not present a clinical picture of an individual experiencing respiratory compromise secondary to confinement or the clinical picture of an individual in the early stages of developing pneumonia.

Counsel also argued that while [MPIC's HCS medical consultant] did not support the theory that confinement made it more difficult for the deceased to breathe and clear his lungs to prevent infection, counsel also maintained that confinement is not a bodily injury and that s. 119 of the Act requires an injury.

[MPIC's HCS medical consultant] was also of the view that it was at least equally likely that the deceased developed pneumonia from an exposure many days after the MVA.

Counsel pointed out that according to the evidence a second ambulance was not dispatched to the deceased's home until May 6, 2013. The evidence indicated that this time the deceased presented at the hospital differently than he had 2 days earlier. He now had a productive cough and was complaining of right sided chest discomfort and numbness in his right arm. His white cell blood count, urea and creatinine levels were each raised. He had anemia and abnormal liver function test results. These findings, along with his reported shortness of breath, support [MPIC's HCS medical consultant]'s conclusion that the deceased's kidneys were failing.

However, in addition to kidney failure, [doctor] also diagnosed the deceased with the right lung pneumonia, a diagnosis which [respiratory physician] accepted. [MPIC's HCS medical consultant] was skeptical of that diagnosis because the x-ray report indicated the *persistence* of patchy opacity's, suggesting that the condition predated the MVA by a number of months and because the evidence did not confirm the development of pneumonia. Testing was limited and no sputum samples were sent to the lab for testing. Further, many of the symptoms exhibited by the deceased were consistent with end stage renal failure.

Even if one accepted that the deceased had pneumonia when he presented to hospital on May 6, 2013, that fact alone does not establish that he contracted pneumonia as a result of the MVA. It is impossible to establish where the deceased was exposed to an agent that would ultimately develop into infection. This could have happened in the vehicle he was driving, in the vehicle which picked him up, or in the hospital. Exposure is not a bodily injury and the fact that the deceased may have been exposed to whatever developed into a pneumatic infection is not enough to establish entitlement to death benefits.

Nor did the MVA make him more vulnerable to developing pneumonia or hamper his ability to fight any infection. The deceased already had a history of orthopnea prior to the MVA and reportedly slept an entire week in February 2013 sitting up. There is no evidence to support the idea that the deceased was prevented from proper breathing or coughing when he was in the vehicle and there was no evidence of respiratory compromise when he first reported to hospital 4 days after the MVA.

Without evidence of respiratory compromise, there is no evidence that the MVA made the deceased any less able to fight off infection. He was, from a medical standpoint, the equivalent of a ticking time bomb and from a legal standpoint he was what is commonly referred to as a "crumbling skull victim". Doctors had already warned him that he had chronic kidney disease that would worsen to kidney failure in the coming years, significantly shortening his life expectancy. One cannot look at the deceased's life immediately before and after the MVA and conclude that the MVA probably altered his lifespan in any material way.

Counsel submitted that the Appellant bears the onus of establishing, on a balance of probabilities, that the deceased died as a result of injuries he suffered in the MVA. He submitted that the weight of evidence supported [MPIC's HCS medical consultant]'s opinion and testimony that the deceased died as a result, not of the MVA, but rather of the unfortunate culmination of pre-existing medical conditions and end stage renal failure.

Appellant's Reply:

The Appellant was provided with a copy of counsel for MPIC's written submission by letter dated January 22, 2021 and invited to submit any reply by February 19, 2021. No reply submission was received by the Commission.

Discussion:

The MPIC Act provides as follows:

> **Definitions**
>
> 119(1) In this Division,
>
> > **"deceased victim"** means a victim who died as a result of the accident; (« victime décédée »)
>
> **Definitions**
>
> 70(1) In this Part,
>
> > **"accident"** means any event in which bodily injury is caused by an automobile; (« accident »)
> >
> > **"bodily injury"** means any physical or mental injury, including permanent physical or mental impairment and death; (« dommage corporel »)

The onus is on the Appellant to show, on a balance of probabilities, that the estate is entitled to benefits under the MPIC Act because her husband's death was causally related to the MVA. The panel has reviewed the documentary evidence on file, the testimony of the Appellant and [MPIC's HCS medical consultant], and the submissions of the parties. We have concluded that the Appellant has failed to meet the onus upon her of showing that, on a balance of probabilities, her husband's death was causally related to the MVA.

Counsel for MPIC took the position that the deceased did not have pneumonia when he died, but rather that the references in his medical file at that time were only to "presumed pneumonia". Although listed as one of the causes of death in his records, counsel submitted that it is not possible to know with scientific certainty that the Appellant had pneumonia.

The Commission does not require a standard of scientific certainty. When the deceased presented to hospital on May 6, 2013, he was in acute distress, with lower oxygen levels, edema and decreased air entry of right versus left. This presentation, combined with x-ray results from that day, led the hospital staff to suspect and treat him for pneumonia. The panel finds overall, on a balance of probabilities, that the deceased suffered from and was diagnosed with pneumonia on May 6, 2013.

The Appellant submitted that the pneumonia and death were caused by exposure to cold temperatures. The evidence established that cold is not a necessary factor in the development of pneumonia. The Appellant testified at the hearing that the deceased got wet in the vehicle. But this factor was not corroborated and did not appear anywhere in various reports in the file, until she testified at the appeal hearing. It was not identified in any of the hospital reports, the Appellant's previous reports to MPIC or by [respiratory physician].

The Appellant relied upon the report of [respiratory physician] to establish that the pneumonia developed as a result of his confinement in the vehicle in the hours following the MVA. He attributed the cause of the illness to confinement and inability to move around in the vehicle.

The evidence showed that although he was seated in the vehicle, the deceased was able to move around and change positions to different seats, turning the motor on and off. The evidence did not show that he was confined to a specific seat or position or forced to lay flat. The evidence reviewed did not lead us to conclude that the deceased was confined and immobilized in the vehicle in a manner that compromised respiratory function.

[Respiratory physician] accepted [doctor]'s diagnosis of right lung pneumonia based upon the deceased's chest x-ray. However, the x-ray report also noted the persistence of patchy opacities, suggesting that the condition may have pre-dated the MVA and there was a lack of further testing (such as lab testing of sputum).

[Respiratory physician]'s report did not account for the days of delay in the diagnosis of pneumonia following the MVA. The panel noted that when the Appellant first presented to hospital on May 4, 2013, a few days after the MVA, he did not have a fever and his vital signs and air entry were noted to be good. He was discharged showing improvement and feeling well. It was not until he returned a couple of days later that he presented with symptoms of pneumonia, along with back and chest pain. An x-ray taken on that date showed signs of suspected pneumonia. Tests also found elevated creatinine levels, and abnormal liver function.

The panel agrees with [MPIC's HCS medical consultant] and MPIC that his death was not caused by the MVA. Rather, along with pneumonia, the deceased suffered from pre- existing uncontrolled diabetes and renal failure. Diagnoses of pneumonia, end stage renal failure and type 2 diabetes were all noted by the attending physician upon his death. The panel agrees that the evidence established that all of these diagnosed conditions led to his demise. On a balance of probabilities, there were too many variables and pre- existing conditions presented in this evidence for the panel to find that the MVA caused confinement and respiratory compromise that led to pneumonia and caused the death of the deceased.

Therefore, the panel finds that his death was not casually connected to the MVA. The evidence established that the deceased suffered from uncontrolled diabetes and renal failure prior to the MVA, and we have concluded that his pneumonia was not caused by the MVA. We do not find

that the MVA materially contributed to or caused these conditions or the death of the Appellant's husband.

Accordingly the Commission hereby upholds the Internal Review Decision of October 28, 2014. The Appellant's appeal is dismissed.

Dated at Winnipeg this 15th day of April, 2021.

LAURA DIAMOND

LEONA BARRETT

LINDA NEWTON