Federal Court Cour fédérale

Date: 20120510

Docket: T-1737-11

Citation: 2012 FC 567

Ottawa, Ontario, May 10, 2012

PRESENT: The Honourable Madam Justice Gleason

BETWEEN:

JULIA SLOANE

Applicant

and

THE ATTORNEY GENERAL OF CANADA

Respondent

REASONS FOR JUDGMENT AND JUDGMENT

[1] In this application for judicial review, Julia Sloane seeks to have the Court set aside the decision of the Veterans Review and Appeal Board [VRAB or the Board], issued on October 3, 2011, in which the VRAB denied Ms. Sloan entitlement to a disability pension under subsection 21(2) of the *Pension Act*, RSC, 1985, c P-6.

[2] Ms. Sloan spent her career serving in the Canadian Armed Forces [CF]. She enlisted in 1970 and has recently retired. The Department of National Defence assumed responsibility for her

medical care when she was in the CF, as it does for all servicemen and women (Pension Review Board, Interpretation Decision I-25 at p 2 [Decision I-25]; *Gannon v Canada (Attorney General)*, 2006 FC 600 at para 20, 292 FTR 280).

[3] Early in her career, Ms. Sloan developed a non-malignant tumour in her ear. As is more specifically detailed below, there was considerable delay in diagnosing the tumour, despite Ms. Sloan's repeated visits to the base physician and frequent complaints of ongoing symptoms of escalating severity. The tumour grew rapidly, and, once discovered, necessitated surgical intervention. Due to the tumour's size, complications from the surgery resulted, which left Ms. Sloan with permanent hearing loss, permanent partial facial paralysis, impaired speech and a corneal abrasion. Ms. Sloan asserts that the severity of the tumour and the complications she experienced were a result of the inadequate medical treatment she received from the base doctor, who failed to conduct the required tests or to refer her to a specialist in a timely fashion.

[4] Ms. Sloan did not apply for pension entitlement until 1990, when her condition worsened. Her application was denied by the Canada Pension Commission (the predecessor to the VRAB). She did not appeal that decision until 2004; however, the *Veterans Review and Appeal Board Act*, SC 1995, c 18 [VRAB Act] does not place time limits on appeals and, accordingly, the appeal was heard on the merits. In 2006, the VRAB denied Ms. Sloan's appeal. Ms. Sloan sought review of that decision to an Entitlement Appeal Panel of the VRAB in 2009, which denied her further appeal. She then sought reconsideration of the Entitlement Appeal Panel's decision, and on April 22, 2010, the VRAB dismissed her reconsideration application. Ms. Sloan brought a judicial review application to this Court in respect of the April 22, 2010 decision, and, on consent, that decision was set aside by

Order of Mr. Justice Zinn, dated January 18, 2011, in which he held that the VRAB had "erred in law by failing to draw the proper inferences from the evidence in light of the facts and record and s.39 of the [VRAB Act]". Pursuant to the terms of Justice Zinn's Order, Ms. Sloan's reconsideration application was remitted back to a different panel of the VRAB, which issued the decision that is the subject of the present application for judicial review.

[5] Ms. Sloan argues that the VRAB's decision of October 3, 2011 should be set aside because the VRAB:

1. failed to properly consider sections 3 and 39 of the VRAB Act in establishing the standard and burden of proof for medical mismanagement claims;
2. erred in law by fettering its discretion in considering Decision I-25 of the Pension Review Board to be a binding precedent setting out the interpretation of when a pension may be awarded for disabilities associate with inadequate medical treatment;
3. erred in law by failing to draw favourable inferences from the medical and affidavit evidence in the record, contrary to section 39 of the VRAB Act; and
4. issued inadequate reasons, thereby violating the requirements of natural justice.

[6] The respondent, on the other hand, argues that the decision was reasonable and should be maintained. More specifically, the respondent asserts that the VRAB's consideration and treatment of sections 3 and 39 of the VRAB Act were reasonable, that the VRAB correctly followed and applied Decision I-25 as it was required to do, that its conclusions and inferences are reasonable and comply with requirements of section 39 of the VRAB Act and that, in light of the recent decision of

the Supreme Court of Canada in *Newfoundland and Labrador Nurses' Union v Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62, [2011] 3 SCR 708 [*Newfoundland Nurses*] inadequacy of reasons cannot constitute a stand-alone basis for judicial review.

[7] For the reasons set out below, it is my view that the VRAB did not inappropriately fetter its discretion and that the alleged inadequacy of its reasons does not provide any basis for intervention. That said, I have determined that the VRAB's decision must be set aside because the Board's findings contradict critical evidence and, in light of the requirements of section 39 of the VRAB Act, the conclusion the VRAB reached in its October 3, 2011 decision was not reasonably open to it.

[8] Counsel for the parties asserted the VRAB's October 3, 2011 decision must be read in conjunction with the earlier VRAB Entitlement Appeal Panel's decision of April 22, 2010 (that was quashed by Justice Zinn's Order) and the October 29, 2009 decision of the VRAB (that was the subject of review in the reconsideration applications). I concur that this context is important for a proper understanding of the Board's October 3, 2011 decision as each of the previous decisions provides a backdrop to it.

[9] Prior to reviewing the three decisions, though, it is necessary to summarize the medical evidence before the VRAB because this judicial review application very much turns on the nature of the factual record before the Board.

I. THE FACTUAL BACKGROUND

[10] In addition to affidavits from Ms. Sloan and her husband, as well as the various medical records relevant to Ms. Sloan's condition and treatment, the Board had before it four medical reports: a report dated March 14, 1974 from Dr. Hill Britton, one of the surgeons who removed Ms. Sloan's tumour; a report dated March 23, 1994 from Dr. Hitselberger, the other surgeon who removed Ms. Sloan's tumor; a third-party expert report dated April 8, 2009 from Dr. Sévigny, an ENT ("Ear, Nose, and Throat" or otolaryngology) specialist; and a report dated February 6, 2006 from Dr. Slaunwhite, the SSO Surgeon General employed by the Canadian Forces, whose report was also a third-party expert report. As is typically the case, the third-party experts based their reports on a review of the medical documentation contained in the file.

[11] Ms. Sloan first consulted the base doctor in 1971, complaining of a sore throat and ear pain. She saw the doctor seven times during the course of the year to complain of the same symptoms, and the treatment prescribed was antihistamines and decongestants. In 1972, Ms. Sloan saw the base doctor at least six times and complained of additional symptoms, namely, a recurrent feeling of fullness when chewing, persistent sore throat, nasal congestion and headaches. The doctor diagnosed a middle ear infection and continued to prescribe antihistamines and decongestants. He did not have an audiogram or other hearing test performed, despite the fact that the equipment to do so was readily available on the military base where it was used to test pilots' hearing.

[12] In February of 1973, Ms. Sloan began to experience facial numbness. On her own initiative, she consulted the base dentist on February 20, 1973, who concluded that her symptoms were not dental in origin and referred her back to the base doctor for further investigation. Ms. Sloan saw the

base doctor on the same day and complained to him that she was suffering from facial numbness, dizziness and pain in her right ear. Between February and December of 1973, Ms. Sloan saw the base doctor eight times, each time complaining of right ear pain, dizziness, facial numbness and hearing loss. Once again, the diagnosis of ear infection remained unchanged, and the base doctor continued to prescribe decongestants and antihistamines (and added eardrops as a further treatment). No hearing test was conducted. During this period, Ms. Sloan was in such pain that she even complained of the symptoms to her gynaecologist and to an ophthalmologist, whom she consulted. Eventually, she and her husband begged and then insisted that the base doctor refer her to an ENT specialist. He eventually agreed to do so at the end of 1973.

[13] Ms. Sloan saw the ENT specialist in December 1973, and he immediately performed an audiogram. It showed significant hearing loss in her right ear. Thereafter, the specialist had an X-ray taken, and, based on these investigations he made a diagnosis of a right acoustic neuroma (or tumour in the ear). Shortly thereafter, Ms. Sloan was referred to Drs. Hill Britton and Hitselberger in the United States, who were leading specialists in treatment of tumours of this nature. In March of 1974 they conducted surgery to remove the tumour and, as noted, due to its size, Ms. Sloan experienced permanent hearing loss and permanent facial paralysis, which, in turn, led to a speech impediment. In 1990, Ms. Sloan developed a corneal abrasion as a further complication from her surgery, which resulted from impairment to her tear ducts that were damaged in the surgery.

[14] The uncontradicted evidence before the VRAB was to the effect that the primary symptoms of acoustic neuroma are pain, hearing loss, facial numbness and dizziness, and that this was known in 1971. The evidence also established that Ms. Sloan's tumour was a fast-growing one, having

increased in size from 2.5 to 3 cm in diameter in January of 1974 to 3.5 to 4 cm in diameter in early March of 2004.

[15] Several of the medical reports before the Board indicated that, had the tumour been diagnosed earlier, it is possible that the complications Ms. Sloan suffered might have been avoided or have been less severe. Several of the medical reports also suggest that the base doctor's treatment of Ms. Sloan did not meet the standard one would expect.

[16] In this regard, Dr. Hitselberger opined as follows:

> … the delay from May of '72 to December of '73 would perhaps be considered an unreasonable delay before referral to an Otolayrngologist specialty since... [Ms. Sloan's] symptoms were no better and, in fact, had gotten worse. I would certainly say that this might have made a difference in [Ms. Sloan's] ultimate outlook.… The difficulty that anyone has in evaluating the situation is what we're talking about here occurred over twenty years ago. It is very hard to apply the standards that we have a 1994 to those that existed back in 1972. There have been many advances made in the diagnosis of these lesions and I'm not sure, but at that particular point in time, [Ms. Sloan was] in the framework of reasonable care and treatment for a patient with [her] symptoms … I may be a little hasty in stating that [Ms. Sloan] should have gotten to an otolaryngologist a little sooner. It does seem that a year and a half delay before referral to an otolaryngologist was perhaps a little long especially since [Ms. Sloan's] symptoms seemed to be getting worse, or certainly no better during this period of time.

[17] Dr. Sévigny was much more forceful in his opinion. He concluded that prior to 1972 Ms. Sloan's symptoms did not suggest the presence of an acoustic neuroma. However, he opined that as of 1972, the neuroma ought to have been diagnosed, once Ms. Sloan began to complain of hearing loss. He wrote in this regard:

Par contre, votre cliente a commencé à se plaindre de surdité droite en 1972. Je suis étonné de ne pas retrouver d'audiogramme au dossier avant celui demandé par l'oto-rhino-laryngologiste en décembre 1973. À l'époque et même maintenant, l'audiogramme demeure un examen essentiel dans l'évaluation des problèmes otologiques. Chez les patients présentant un problème infectieux qui persiste malgré le traitement médical, l'audiogramme est utile pour permettre d'exclure une atteinte plus sévère de l'oreille moyenne ou encore de l'oreille interne. Dans le cas de votre cliente, le médecin qui la suivait aurait dû demander un audiogramme on aurait découvert la perte auditive relativement rapide s'étant développée en moins de 3 ans. Il faut comprendre que même si le médecin traitant avait demandé un audiogramme dans le but d'évaluer un problème infectieux, l'atteinte neuro-sensorielle aurait été découverte.

À l'origine de la présente expertise, vous me demandiez si le délai dans l'investigation et le diagnostic a pu causer préjudice à votre cliente. Les documents disponibles confirment que l'évolution de la lésion s'est faite très rapidement, les symptômes étant apparus essentiellement dans l'année qui a précédé

However, your client began complaining of hearing loss on the right side in 1972. I am surprised to not find an audiogram on her file before that requested by the otolaryngologist in December 1973. Then and even now, an audiogram is an essential diagnostic tool in the assessment of otolaryngolic ailments.
For patients presenting with infections that continue despite medical treatment, audiograms allow the exclusion of more serious conditions of the middle or inner ear. In the case of your client, had the treating doctor requested an audiogram, the client's loss of hearing that had occurred relatively rapidly in less than 3 years would have been discovered. It must be understood that even if the treating physician had ordered an audiogram to evaluate an infection, the patient's neuro-sensory problems would have been discovered.

In the present opinion, I was asked whether the delays in the evaluation and diagnosis caused harm to your client. The available documents confirm that the tumour developed very rapidly, and that symptoms began appearing in the year preceding the otolaryngolic assessment. The tumour thus developed significantly during this period; the patient's normal audiogram when she enlisted, as well as the rapid development of symptoms in

l'investigation oto-rhino-laryngologique. La lésion a donc évolué de façon significative durant cette période; l'audiogramme normal à l'enrôlement ainsi que l'évolution rapide des symptômes durant la dernière année confirment la croissance de la tumeur.

Il est évident que les risques et complications chirurgicales augmentent avec la grosseur de la lésion. Chirurgicalement, un neurinome acoustique est enlevé morceaux par morceaux et les structures anatomiques normales disséquées progressivement. Plus la lésion est grosse, plus la dissection est longue. Dans le cas de votre cliente, l'atteinte du nerf facial en est le témoin. Si votre cliente avait subi un audiogramme lorsqu'elle s'est plainte de trouble otologique, il y aurait eu de fortes chances d'éviter l'atteinte faciale puisque l'intervention chirurgicale aurait été pratiquée un an ou un et demi plus tôt.

that last year confirm the tumour's growth.

It is evident that risks and surgical complications increase with the size of the tumour. In surgery, an acoustic neuroma is removed piece by piece and healthy anatomical structures are increasingly impacted. The larger the tumour, the longer the surgery. In your client's case, the injury to the facial nerve is evidence of this problem. If your client had had an audiogram when she first complained of hearing problems, there is a strong chance she would have avoided facial paralysis because her surgery would have been performed a year to a year and one half earlier.

[Unofficial translation]

[18] Even the Canadian Armed Forces doctor, Dr. Slaunwhite corroborates these points to a certain extent. She notes that the Armed Forces' medical files documented 25 recorded clinical assessments "in which plausible symptoms of an early acoustic neuroma were being described", prior to the point at which the referral to the ENT specialist was made. Dr. Slaunwhite goes on to note that it is "of concern" that Ms. Sloan felt compelled to raise the symptoms with her gynaecologist. She further opined that:

> It is not possible to know with certainty if the symptoms in 1971 in 1972 were unrelated or not. We can be more sure that the facial numbness described in 1973 was a clear sign of nerve involvement, and would have been sufficient reason to pursue close follow-up, re-evaluation and specialist referral if the symptom did not fully resolve. The chart notes (dental and medical) do not indicate that this symptom prompted a serious evaluation at that time. In a worst case scenario, if LCol Sloan did possess a fast-growing neuroma (capable of doubling its volume in six months to a year), then the time taken to go from facial numbness to definite x-ray, hearing tests and diagnosis in Dec73, to surgery Mar74, may have resulted in a greater likelihood of irreversible symptoms…. It is also, on the surface, somewhat puzzling to count 24 medical visits for ENT related symptoms and these did not, of their own account, trigger referral to look for other underlying causes at an earlier point in time.
>
> In summary, it cannot be said that this CF General Practitioner or General Dentist practiced below a Canadian standard from 1971 until 1973. Certainly there was a missed opportunity to act on the more ominous symptom of facial numbness that was first presenting in Feb 1973, and other practitioners might have made more definitive evaluations of this symptom. … Earlier referral, diagnosis and surgical treatment were possible, and … it is possible there could have been less severe surgical consequences. It is my opinion that it can be said that some linkage exists between the treatment received and the surgical outcome. While we cannot say with certainty that there was bad medical practice, the missed occasion to pursue the symptoms of nerve involvement in Feb 1973 remains unexplained.

II. <u>THE VRAB's DECISIONS</u>

[19] In the first of the trilogy of the decisions at issue here, which was issued on October 29, 2009, the Entitlement Appeal Panel of the VRAB applied decision I-25 of the Pension Review Board and held that, in order for a pension claim to succeed, there needed to be evidence showing that the "accepted legal and professional standard of care was not observed", which could be demonstrated by showing that there was the duty of care owed to the claimant, a failure to meet that required standard of care, and a disability that occurred as a direct result of the failure (at page 9 of the decision). In a single paragraph at the very end of its decision, the VRAB applied this test to the

facts of Ms. Sloan's case, concluding that there was no medical mismanagement and, accordingly, that Ms. Sloan was not entitled to a pension. The conclusion regarding lack of medical mismanagement hinged entirely on Dr. Slaunwhite's comment that it could not be said that the Canadian Forces general practitioner or general dentist practiced below a Canadian standard. The VRAB concluded that, while the medical evidence "… suggest[ed] that there is a possibility that an earlier referral diagnosis and surgical treatment could have resulted in less severe surgical consequences, …it cannot be said with certainty that there was medical mismanagement". The Board did not give any weight to the several contradictory statements made in the medical reports, cited above, nor did it consider the impact of section 39 of the VRAB Act in resolving the conflicting views contained in the medical reports.

[20] As noted, Ms. Sloan sought reconsideration of the October 29, 2009 decision of the VRAB Entitlement Appeal Panel. In both of her reconsideration applications, she argued that the Board had not properly applied section 39 of the VRAB Act, which creates certain evidentiary and legal presumptions in favour of pension claimants. The section provides:

39. In all proceedings under this Act, the Board shall (a) 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; (b) accept any uncontradicted evidence	39. Le Tribunal applique, à l'égard du demandeur ou de l'appelant, les règles suivantes en matière de preuve : a) il tire des circonstances et des éléments de preuve qui lui sont présentés les conclusions les plus favorables possible à celui-ci;

presented to it by the applicant or appellant that it considers to be credible in the circumstances; and	b) il accepte tout élément de preuve non contredit que lui présente celui-ci et qui lui semble vraisemblable en l'occurrence;
(c) 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.	c) il tranche en sa faveur toute incertitude quant au bien-fondé de la demande.

[21] In its decision of April 22, 2010 on the first reconsideration application, the VRAB applied decision I-25 and, while mentioning the evidentiary presumptions contained in section 39 of the VRAB Act, held that "section 39 requires a logical explanation as to why a panel rejected evidence that the applicant may have considered favourable but it does not require a favourable decision". The Board then went on to reject the reconsideration application, and did not consider how section 39 applied to the various statements in the medical reports that supported Ms. Sloan's position.

[22] As noted, this reconsideration decision was quashed by the Order of Mr. Justice Zinn, in which Justice Zinn held that the VRAB committed a reviewable error in failing to draw the proper inferences from the evidence in light of the facts in the record and section 39 of the VRAB Act.

[23] The matter was then remitted back to the VRAB for reconsideration in accordance with the terms of Justice Zinn's Order, and the Board issued the October 3, 2011 decision, that is the subject of the present application for judicial review. The reasoning in the October 3, 2011 decision is substantially similar to that contained in the April 22, 2010 decision of the Board, despite the

direction contained in Justice Zinn's Order. In this regard, in its October 3, 2011 decision, the VRAB held that decision I-25 required a pension claimant to prove medical mismanagement, the elements of which are the existence of a duty of care owed to the claimant, a failure to exercise the standard of care expected and the occurrence of a disability as a direct result of the failure. In applying the test to the evidence, the VRAB held that "the medical reports may have suggested a possibility that earlier referral, diagnosis and treatment may have led to a better result, but there was no evidence that treatment fell below an accepted standard, or outside of a reasonable care and treatment framework" [emphasis added]. It also held that the VRAB had not premised its October 29, 2009 Entitlement Appeal Panel decision on an incorrect interpretation of section 39 of the VRAB Act in that the Board did not require Ms. Sloan to establish "with certainty" that medical mismanagement had occurred but, rather, had used the term "with certainty" only as reference to Dr. Slaunwhite's report.

[24] With respect, this reading of the October 29, 2009 decision is completely untenable. The only possible way in which to read the decision is that it turns on the determination that Ms. Sloan has not established "with certainty" that medical mismanagement has occurred. As is discussed below, such a finding flies in the face of section 39 of the VRAB Act.

[25] Moreover, the Board's statement that there was "no evidence that treatment fell below an accepted standard or outside of a reasonable care and treatment framework" directly contradicts the evidence before the VRAB. The above-cited portions of the reports of Drs. Hitselberger, Sévigny and Slaunwhite all either state, suggest or imply that Ms. Sloan's treatment fell below an accepted standard of care and outside a reasonable care and treatment framework.

III. ANALYSIS

[26] The claims that the VRAB improperly fettered its discretion and issued inadequate reasons may be disposed of quickly.

[27] Counsel for Ms. Sloan advances the proposition that VRAB fettered its discretion in adopting and applying the reasoning in Decision I-25, asserting that administrative tribunals cannot follow their earlier decisions (or treat them as decisive authority) without improperly fettering the discretion they possess. No authority is cited in support of this proposition, and it is clearly without merit. While the principle of *stare decisis* does not apply to administrative tribunals, it is both commonplace and highly desirable that tribunals follow and consistently apply their previous awards so as to thereby develop a predictable and coherent body of case law. Indeed, the courts have recognised that tribunals may properly engage in tribunal-wide policy discussions to develop consensus on important policy interpretations and do not thereby improperly compromise individual members' independence (see e.g. *IWA v Consolidated-Bathurst Packaging Ltd*, [1990] 1 SCR 282, 68 DLR (4th) 524 at paras 47, 51).

[28] The position advanced regarding the inadequacy of the VRAB's reasons amounting to a violation of the principles of natural justice must be given similarly short shrift. The recent decision in *Newfoundland Nurses* firmly settles that, provided some reasons are given, their alleged shortcomings cannot amount to a failure of natural justice. According to Justice Abella, writing for the Court:

> It strikes me as an unhelpful elaboration on *Baker* to suggest that alleged deficiencies or flaws in the reasons fall under the category of a breach of the duty of procedural fairness and that they are subject to a correctness review… where…there *are* reasons, there is

> no…breach [of the duty of procedural fairness] (*Newfoundland Nurses* at paras 21-22).

[29] Insofar as concerns the other assertions regarding the VRAB's assessment of the evidence and application of section 39 of the VRAB Act, the applicable standard of review is that of reasonableness (*Boisvert v Canada (Attorney General)*, 2009 FC 735 at para 36). The reasonableness standard of review is a deferential one and requires that the Court not intervene unless it is satisfied that the reasons of the Board are not "justified, transparent or intelligible" *and* that the result does not fall "within the range of possible, acceptable outcomes which are defensible in respect of facts and law" (*Dunsmuir v New Brunswick*, 2008 SCC 9, [2008] 1 SCR 190, at para 47). Where the ground of review involves a challenge to a federal tribunal's factual determinations, the content of the reasonableness standard is enshrined in paragraph 18.1(4)(d) of the *Federal Courts Act,* RSC, 1985, c F-7 [FCA], which provides that findings of fact may be set aside only if they are made in a perverse or capricious manner or without regard to the material before the tribunal. A finding for which there is no evidence before the tribunal is subject to being set aside under paragraph 18.1(4)(d) of the FCA because such a finding is made without regard to the material before the tribunal (see e.g. *Gannon v Canada (Attorney General)*, 2006 FC 600 at paras 29-31, 292 FTR 280; *Canadian Union of Postal Workers v Healy*, 2003 FCA 380 at para 25, [2003] FCJ No 1517).

[30] In my view, the Board's decision is unreasonable in two respects: first, in its erroneous conclusion that there was no evidence that the treatment Ms. Sloan received fell below an accepted standard and, second, in its consideration of section 39 of the VRAB Act, which the Board effectively ignored. In short, in light of the evidence before it and the requirements of section 39 of

the VRAB Act, the only reasonable conclusion open to the Board was to grant the reconsideration and award Ms. Sloan the disability pension. Indeed, that is precisely what Justice Zinn's Order contemplated would occur.

[31] This Court has on many occasions quashed decisions of the VRAB in circumstances similar to the present. In *Metcalfe v Canada* (1999), 160 FTR 281, [1999] FCJ No 22 [*Metcalfe*], the VRAB had found that the evidence before it did not establish with certainty a causal link between the applicant's deafness and his military service, notwithstanding medical opinions stating that there was a strong possibility or likelihood that the disability was the result of noise exposure during service. Justice Evans concluded that the Board "could only have reached its conclusion by misdirecting itself on the effect of section 39 of the Veterans Review and Appeal Board Act" (para 17). He reasoned that while "no one can be certain whether a causal link exists between the noise to which the applicant was exposed while on military service and his present deafness…the applicant produced sufficient credible evidence about the cause of his hearing loss that, if the Board had complied with the directions contained in section 39, it must in law have upheld his claim" (para 22). The Board's decision was thus quashed.

[32] Similarly, in *Schott v Canada (Attorney General)*, [2001] FCJ No 126, 199 FTR 225, Justice Hansen found that the VRAB had misconstrued the evidence before it by finding the medical opinions to be speculative, when in fact they had indicated that a misdiagnosis by the original treating doctors was "certainly a factor" in the delay in detecting the applicant's cancer, leading to aggravated disability and discomfort (see paras 20-22). As in *Metcalfe*, Justice Hansen concluded at para 26 that "the VRAB could have reached its conclusion only by ignoring the evidence of [the

medical experts], misconstruing their evidence, or misdirecting itself as to the effect of section 39 of the Act, in the face of credible and trustworthy evidence".

[33] In *Smith v Canada (Attorney General)*, 2001 FCT 857, 209 FTR 172, Justice MacKay quashed a decision of the Board because it required a "definitive medical opinion" and thereby failed to have regard to section 39 of the VRAB Act (paras 29 and 38). As Justice MacKay put it at para 33, "[t]he Board failed to recognize that the medical opinions provided on behalf of the applicant present only one possible diagnosis with only one plausible cause".

[34] Turning to the present case, as noted, the Board's conclusion completely ignores several passages in the medical reports of Drs. Hitselberger, Sévigny and Slaunwhite, all of whom either actually state or suggest that the base doctor ought to have conducted hearing tests or made a referral to a specialist much earlier, which would have resulted in the surgery taking place when the tumour was much smaller, thereby lessening the risk of complications. All these statements support a finding of medical mismanagement.

[35] In addition to ignoring key elements of the evidence before it, the Board engaged in an unreasonable interpretation of section 39 of the VRAB Act. That section provides that any benefit of the doubt in weighing of the evidence must be resolved in favor of the claimant. In this case, there was conflicting evidence before the Board regarding whether or not medical mismanagement had taken place: on one hand, there is the bald statement in Dr. Slaunwhite's report to the effect that she could not conclude that the base doctor had practiced below a Canadian standard; on the other hand, there is the opposite statement in Dr. Sévigny's report, stating that the treating physician had

failed to administer an essential diagnostic test, as well as the multiple indications in all three of the doctors' reports, noting that the standard tests were not conducted and that there was an unreasonably long delay in referring Ms. Sloan to the ENT specialist.

[36] This case is distinguishable from the facts before the Federal Court of Appeal in *Canada (Attorney General) v Wannamaker*, 2007 FCA 126, 361 NR 266 [*Wannamaker*], cited by the respondent. In *Wannamaker*, the Court of Appeal overturned this Court's holding that a VRAB decision was unreasonable because it gave insufficient attention to section 39. In rejecting that argument, Justice Sharlow noted:

> "The Board was faced with contradictory evidence about whether Mr. Wannamaker suffered back injuries in 1959 and 1961 as he claimed. The only direct evidence came from Mr. Wannamaker himself… Mr. Wannamaker's evidence is also contradicted by the contemporaneous medical records. Thus, this is not a situation that engages paragraph 39(b), which requires the Board to "accept any uncontradicted evidence" presented by the applicant that the Board considers "credible in the circumstances."" (para 29).

In contrast to the situation in *Wannamaker*, here the Board did not face contradictory evidence of this nature. The Board had a series of medical opinions which all contained indications that the care received by the applicant did not meet standard levels of care at the time. In face of this evidence and the requirements of section 39 of the VRAB Act, the only possible reasonable conclusion open to the Board was to uphold Ms. Sloan's claim.

IV. CONCLUSION

[37] In light of the foregoing, the decision of the VRAB, dated October 3, 2011, will be set aside and Ms. Sloan's reconsideration application will be remitted to the VRAB for re-determination by a differently constituted panel of the Board.

JUDGMENT

THIS COURT'S JUDGMENT is that:

1. This application for judicial review of the decision of the VRAB, dated October 3, 2011 is granted and the decision is set aside;
2. Ms. Sloan's reconsideration application is remitted to the VRAB for re-determination by a differently constituted panel of the Board; and
3. Ms. Sloan is entitled to her costs of this application in accordance with Tariff B of the *Federal Courts Rules*, SOR/2004-283, s. 2.

"Mary J.L. Gleason"

Judge

FEDERAL COURT

SOLICITORS OF RECORD

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