

CLAIM HISTORY AND APPEAL PROCEEDINGS:

The Worker* appeals to this Tribunal seeking recognition that he suffers from compensable stress.

As the Employer is a Federal Crown Corporation, the Worker's entitlement to benefits is determined pursuant to the *Government Employees Compensation Act*, R.S.C. 1985, c. G-8 ["GECA"]. Eligibility for compensation under the provisions of GECA is provided at s.4(1), and pursuant to s.4(2), the rate of compensation and conditions for payment of compensation are determined under the *Workers' Compensation Act*, S.N.S. 1994-95, c.10, as amended [the "Act"].

The Worker is a former miner. He retired from the mining industry in 2001. On October 29, 2001, he filed a claim with the Board for pneumoconiosis, automatic assumption, industrial bronchitis and asthma. He was awarded a 15% permanent medical impairment rating for industrial bronchitis in 2002.

The Board also provided him with vocational rehabilitation assistance, but subsequently terminated the Worker's benefits on the basis that the Worker had been uncooperative in the program. The Worker appealed, arguing that his continuing inability to work was the result of a psychiatric disorder (depression) that, in turn, was related to his industrial disease.

In a July 30, 2003 decision, a Board Hearing Officer reversed the finding that the Worker had been uncooperative in his vocational rehabilitation program. The issue as to the compensability of the Worker's depression was referred back to the Board for adjudication. In a January 14, 2004 decision, an Occupational Disease Adjudicator concluded that the Worker's depression was not related to his occupational disease or inability to work. The Worker appealed. In a decision dated April 15, 2004, a Board Hearing Officer held that the Worker's depression was not related to his industrial bronchitis. The Worker appealed the April 15, 2004 decision to this Tribunal.

Before the Worker's appeal could be heard, the Chair of the Board, on October 6, 2004, invoked his authority under s. 248 of the *Act* to stay all proceedings at the Tribunal which dealt with claims for compensation due to stress that had been filed pursuant to the provisions of GECA. The stay was to allow the Board of Directors an opportunity to consider the adoption of a policy outlining the appropriate test to determine the compensability of stress claims under GECA. The Tribunal advised the participants that it could not proceed with the appeal until the stay had been lifted.

*This decision contains personal information and may be published. For this reason, we have not referred to the participants by name.

On July 27, 2005, the Board of Directors adopted Policy 1.3.6 dealing with the compensability of stress as an injury under GECA. The Policy was effective July 25, 2005.

On September 23, 2005, the Tribunal referred the issue of recognition of stress back to the Board so that the issue of the Worker's entitlement to benefits could first be decided at the Board level [*Decision 2004-193-RTH*]. On October 20, 2005, the Hearing Officer returned the file to the Case Manager for re-adjudication.

This appeal arises out of the subsequent Board decisions. On November 10, 2005, the Board's Occupational Disease Adjudicator found that the Worker failed to establish that he suffered from stress as a result of his compensable claim for industrial bronchitis pursuant to GECA. This decision was confirmed on appeal to the Hearing Officer on March 8, 2006. The Worker now appeals from the March 8, 2006 decision.

The Worker's appeal proceeded by way of oral hearing. The appeal was heard by a panel of three appeal commissioners. The panel heard oral testimony from the Worker and his treating psychiatrist, Dr. Sheard. The Employer participated in the appeal, but presented no evidence. The panel considered submissions from the representatives for the Worker and Employer. The Board did not participate in the appeal. In addition, the panel has considered the decision under appeal and the contents of the Worker's Board files.

ISSUES AND OUTCOMES:

Is there sufficient evidence to find that the Worker suffered a personal injury, in the form of stress, arising out of and in the course of his employment?

No. There is insufficient evidence to establish that work-related factors, including the Worker's lung disease, caused his severe depression.

ANALYSIS:

Causation and Recognition of Compensable Stress under GECA

The Worker seeks recognition that he suffered a personal injury in the form of stress that should be recognized under s.4(1) of GECA.

Board Policy 1.3.6 applies to this appeal. It establishes criteria for the adjudication of stress claims under GECA. Under the Policy, the Board will consider claims for compensation when a worker's condition results from either traumatic onset stress that is a reaction in response to a traumatic event, or gradual onset stress that is a reaction to unusual and excessive work-related stressors over time.

The Policy refers to the American Psychiatric Association's Diagnostic and Statistical

Manual of Mental Disorders - Fourth Edition (DSM IV), at pages 424 and 427 for guidance. The Panel concludes from a review of these excerpts that the Worker's claim to have suffered a traumatic event cannot be sustained.

The evidence does not indicate that the Worker suffered a traumatic event as defined by the Policy. The Worker has not experienced, witnessed, nor was he confronted with, an event that involved actual or threatened death, serious injury, or a threat to the physical integrity of himself or others. Therefore, the Worker's claim will be adjudicated as a gradual onset stress claim. To be compensable, four criteria must be satisfied as outlined in the Policy, as follows:

- (i) the work-related events or stressors experienced by the worker are unusual and excessive in comparison to the work-related events or stressors experienced by an average worker in the same or similar occupation;
- (ii) the worker is diagnosed with a mental or physical condition that is described in the DSM IV;
- (iii) the mental or physical condition is caused by work-related events or stressors; and
- (iv) the condition is diagnosed in accordance with the DSM IV by a health care provider being either a psychiatrist or a clinically trained psychologist, registered with the Canadian Register of Health Service Providers in Psychology.

The critical question in this appeal is whether the Worker's mental condition is caused by work-related events or stressors that are unusual and excessive.

The Worker is entitled to the benefit of the doubt under s.187 of the *Act* on any issue involving compensation. Where there is doubt on an issue and the disputed possibilities are evenly balanced, the issue must be resolved in the Worker's favour.

Any participant disputing an inference raised by the Worker is required to meet a greater burden of proof, the balance of probabilities standard generally required in civil matters. Whether an inference is reasonable is a question of fact that depends upon the circumstances of each case.

Although a causal relationship linking an injury to the workplace must be shown, the Worker is not required to prove causation to a scientific certainty. Common sense may be used to infer causation where appropriate (*Workers' Compensation Board (N.S.) v. Workers' Compensation Appeals Tribunal (N.S.) and Johnstone* (1999), 181 N.S.R. (2d) 247 (C.A.)).

Furthermore, it is not necessary that an injury be solely due to work. The necessary causal link is established where it is shown that "but for" factors arising from work, a worker would

not have suffered an injury. Alternatively, the test is met where work is a materially contributing factor; i.e., more than an insignificant or trifling amount, (*Ferneyhough v. Workers' Compensation Appeals Tribunal (N.S.)* (2000), 189 N.S.R.(2d) 76 (C.A.)).

The Worker's representative submits that this panel should not apply Policy 1.3.6 if it narrows the benefits the Worker would otherwise be entitled under s.4(1) of GECA. He also submits that if the Policy does not benefit the Worker, it should be disregarded under s.183(6A) of the *Act*. Because of the panel's findings in this matter, it is not necessary for the panel to consider the application of s.183(6A) of the *Act*.

For purposes of this appeal, we note that Policy 1.3.6 recognizes the compensability of gradual onset stress under GECA. We also note that the Policy appears to be consistent with recent decisions of the Court of Appeal of Nova Scotia. Policy 1.3.6 was adopted by the Board following the decision of the Nova Scotia Court of Appeal in *Nurnber v. Nova Scotia Workers' Compensation Board et al.* (2004), 224 N.S.R.(2d) 276 (C.A.).

In *Nurnber*, the Court of Appeal overturned a finding by the Tribunal that the Worker had suffered an injury in the nature of stress as a result of his workplace. The Court found the Tribunal had erred in its conclusion that, where there is clear medical opinion evidence available, the question of causation is to be determined exclusively on the basis of the opinion evidence. The Tribunal also concluded that the nature of the workplace incidents and the reaction of other workers to them were irrelevant to the question of the causal link between the workplace and the worker's psychological condition.

The Court observed that incidents should be viewed objectively for purposes of the causal connection to stress. The related question, whether other workers found such incidents stressful, while not necessarily dispositive of the issue of causation, was nonetheless also relevant. The Tribunal had erred by simply dismissing such evidence as irrelevant and refusing to consider it. The Court stated that the Tribunal should weigh all of the relevant evidence and approach causation as a practical question of fact which can best be answered by ordinary common sense.

Policy 1.3.6 adopts a consistent approach. It requires that a mental condition be caused by work-related events or stressors which are unusual and excessive in comparison to the work-related events or stressors experienced by an average worker in the same or similar occupation.

The Worker asserts that he developed stress associated with his lung disease by being forced to work in an environment that was causing him health difficulties. Dr. Sheard supports this assertion. He is of the opinion that the Worker developed gradual, pervasive stress from wanting to work and being forced to work in an unsafe environment with a diagnosis of lung disease. The hypothesis put forward by the Worker is that, in March, 1999, he suffered a breakdown when he realized he could no longer work because of his

lung disease. The Worker has always been concerned about being on a solid footing financially. He wanted to support his family and keep them from financial hardship.

Although the Worker may have experienced severe depression in March of 1999 associated with concerns in relation to his and his family's financial future, the panel is unable to find a causal connection between his lung disease and the development of his severe depression. As discussed below, concerns about having a disabling lung disease rendering him unable to support his family are not borne out by the evidence.

Factual Background

The Worker was employed with Devco from March 3, 1975 until he retired on September 3, 2000 under Devco's Early Retirement Incentive Program. After initially working underground for a period of five years, he successfully completed training to become a journeyman millwright. He worked primarily in the maintenance department from 1979 until he retired. His main occupation was as materials coordinator.

His job changed over time. When he left Devco, he was the assistant maintenance planner. This position required him to work four or five hours a day in an office in the maintenance building and two to three hours a day in an office in the administration building. The maintenance building housed welding, painting, electrical and FAB steel shops.

The Worker testified as to the conditions in the maintenance building. He said he had difficulties due to the environment. He complained to management concerning the working conditions. On March 17, 1997, a memorandum was prepared by Gerard Shaw suggesting changes to the surface foreman's shop. Mr. Shaw recommended replacing an exhaust fan to allow for air exchange because the office did not have either forced air ventilation or windows.

Subsequently, the Worker took another position as a scaleman in the quality control department. This was a part-time position. He worked in this position from September 22, 1997 until October 26, 1998. He was bumped out of the scaleman's position and, on November 2, 1998, returned to his prior job duties as assistant maintenance planner. He was once again located in offices in the maintenance building and the administration building, working four or five hours in one and two or three hours in the other. He remained there until he went off work in March of 1999.

There is a dearth of medical evidence concerning the Worker's lung difficulties during the period 1997 to 1999. The Workers' Compensation Board files indicate the Worker had multiple investigations over the years for various symptoms. In 1986, he was treated for laryngitis. In 1991, he was treated for a deviated nasal septum and recurrent rhinosinusitis. In 1993, he was treated for gastro-esophageal reflux disease. Investigations

include a sleep apnea study, hearing tests and investigations for migraine headaches. His most serious physical problem concerned a diagnosis of fibromyalgia syndrome in 1994 by a rheumatologist, Dr. Hanley. There was some question of depressive symptoms associated with that diagnosis and he was off work for several months concerning this problem. However, there is no evidence that fibromyalgia is associated with, or is relevant to, the Worker's stress under consideration in this appeal.

In the period 1997 to 1999, the Worker had two chest x-rays which appeared to be normal. Dr. Michael, a respirologist, reviewed the two x-rays dated June 26, 1998 and December 5, 1998 in his March 19, 2002 report concerning the Worker's claim for pneumoconiosis. In relation to the December 1998 examination, he noted an improved ability to take a deeper breath. Other observations were noted as normal. The Worker was not referred to a specialist for further treatment until October 2001.

Also critical in the underlining factual analysis are the other medical reports contemporaneous to March 1999.

On July 16, 1999, the Worker's family physician, Dr. Rogers, wrote to the Canada Pension Plan program in support of the Worker's request for CPP disability benefits. He indicated that the Worker was off work due to medical problems and was under the care of a psychiatrist. He agreed with the psychiatrist's opinion that the Worker was unable to enter the workforce and was disabled for the long term. He specifically noted that the Worker battled with fibromyalgia for many years. He associated this with a motor vehicle accident that caused the death of the Worker's wife. He believed that there was some concurrent and progressive element of depression associated with the diagnosis of fibromyalgia and the events of the accident. He enclosed copies of records from specialist consultations over the years confirming the diagnosis and the Worker's ongoing medical problems. He concluded that the Worker "has pushed himself gallantly in the workforce over the years despite exacerbations of his fibromyalgia and no doubt flare-ups of a lingering and grumbling depression".

In a later report dated March 28, 2003, Dr. Rogers recanted his opinion of depression associated with the diagnosis of fibromyalgia. The panel accepts that there was no diagnosis of depression prior to 1999. However, it is relevant to this appeal that Dr. Rogers does not mention anything with regard to the Worker's lung difficulties or lung disease in a report sent in July 1999. Nor would there have been any specialist consultations at that time concerning the Worker's lung difficulties. There were, presumably, only consultations concerning the many other symptoms experienced by the Worker.

On March 4, 1999, at the time the Worker left work, Dr. Rogers referred the Worker to Dr. Sheard for what he described as "some personal difficulties, some stresses in his life".

Dr. Sheard saw the Worker for the first time on April 13, 1999. In a report dated April 13,

1999, he noted that the Worker had been working in the mining industry for many years and that he had been on sick leave for the past few months. The Worker was faced with the uncertainty of the job market, financial pressures and a feeling at age 47 of being washed up with nowhere to go in terms of education, re-training or any future. He had heightened anxiety and an intense sense of depression and despair. Dr. Sheard noted that the Worker had a number of adverse life events to contend with over his life. In particular, at age 8, his father died and the Worker had to go out to work at a young age in the pit because there were children left at home and no one else could work. He also lost his first wife in a tragic accident and was left to raise two young children.

Dr. Sheard diagnosed the Worker with “major depression severe without psychotic features” in the context of psycho-social difficulties and work-related issues.

In an April 24, 1999 report, Dr. Sheard noted that the Worker continued to experience a depressed mood with crying spells, a feeling that there is no future, difficulty in concentrating, difficulty initiating and maintaining sleep and a sense of going nowhere with his life.

In a May 21, 1999 report, Dr. Sheard supported the Worker’s wish for long term disability. He felt that the Worker was still significantly depressed over his situation.

In a subsequent report dated July 22, 1999, Dr. Sheard noted that the Worker was doing quite well until the son of one of his best friends suffered a serious injury in a pool accident. This event brought his mind back to all of the feelings and circumstances of the motor vehicle accident in which his wife was killed. He remained convinced that the Worker was disabled long-term from any and every form of employment. He would write Canada Pension on his behalf.

On August 25, 1999, Dr. Sheard noted that the Worker was still having waves of doom, gloom and despondency thinking about the future, particularly with reference to finances. He noted that the Worker was still too preoccupied with sorting out current financial provisions to be in a position to reflect on the past.

On September 21, 1999, Dr. Sheard noted that the Worker had heard through the grapevine that his CPP was likely to be approved. He referred to this as tremendous news and was a great comfort to him at this stage.

On March 3, 2000, Dr. Sheard noted that the Worker was getting along well, however he had to face the death of his mother. He noted that the Worker was still very agitated over the Devco uncertainty.

On June 8, 2000, Dr. Sheard noted that the Worker was included in the Devco package. This meant he was to get a legitimate pension which would probably eliminate Great West

Life from the equation. He was increasing his Paxil for a two month period to see what it does to his past flashbacks and intrusive depressive thoughts.

No further reports are available from Dr. Sheard until after the Worker consulted a specialist for his lung disease.

A report from Dr. Chokshi, an otolaryngologist, dated December 7, 2000 was provided concerning a consultation for the Worker's recurrent laryngitis. Dr. Chokshi noted no history of cough, headache, heartburn or dysphagia. However, there was a family history of carcinoma of the larynx. The ENT examination was normal.

The Worker was not referred to a specialist with regard to breathing difficulties until 2001. On August 7, 2001, Dr. Rogers referred the Worker to Dr. Kevin McNeil because the Worker was bothered by increasing dyspnea with minimal workload over the preceding year or so. Dr. Rogers noted that the Worker had a "horrendous family history" for coronary artery disease. Both his sister and brother needed bypass surgery.

Dr. McNeil reported his findings on September 24, 2001. He related the history as reported by the Worker. The Worker had heard people comment about his breathing for the past year or so, generally at rest. People told him that his breathing seemed heavy and noisy. He did not notice this himself. He seemed to be short of breath in the spring when pollens are out. Since a teenager, the Worker complained of a runny nose, eyes and some shortness of breath on exposure to pollens. He was never diagnosed with asthma that he could recall.

Dr. McNeil noted that the Worker had PFTs a few years ago and believed they were normal. Commenting on the investigations, Dr. McNeil noted that the August 10, 2001 chest x-ray showed elevation of the right hemi-diaphragm with atelectasis right middle lobe unchanged from November 21, 2000. The chest x-ray at that time showed that these changes were new since January 27, 2000. He thought the PFTs showed some degree of obstructive lung disease unchanged from a prior PFT (presumably, 1987).

Dr. McNeil ruled out cardiac disease. However, he suspected a respiratory/asthmatic flavour to the Worker's history given his symptoms on exposure to pollens and the evidence of airway obstruction on the PFTs. He requested that the Worker undergo a methacholine challenge test at the time he has repeat PFTs.

Following the results of the PFTs confirming asthma, Dr. Rogers wrote to the Board on October 23, 2001. He enclosed a completed application form for an occupational disease claim. The Worker had checked off pneumoconiosis, automatic assumption, industrial bronchitis and asthma.

Dr. Rogers noted the Worker's history with Devco and his significant decrease in lung

function over the last two years. Dr. Rogers added that the Worker had been diagnosed by a methacholine challenge test as having a severe asthmatic reaction.

This diagnosis was confirmed by Dr. McNeil in a follow-up report dated November 8, 2001. He noted that the Worker's symptoms were suggestive of reversible airway disease. The Worker had PFTs on September 28, 2001 showing a further loss of lung volume from February 2000, some hyper inflation, and mild airway obstruction. Given this, he went on to have a methacholine challenge test on October 19, 2001. The test confirmed that the Worker had reversible airway disease (i.e., asthma). He noted, as well, a repeat chest x-ray on September 25, 2001 showing no change. However, a fluoroscopy of the chest on September 27, 2001 showed that the diaphragm moved with respiration. Therefore, the elevated diaphragm was from loss of lung volume from the atelectasis. Dr. McNeil concluded that this could account for some loss of lung volume compared to values in February 2000. He noted that the Worker had numerous questions regarding compensation, silicosis, pension, automatic assumption, etc.

Subsequent to the filing of his compensation claim, the Worker's chest x-rays were reviewed by Dr. Michael. In a report dated March 19, 2002, Dr. Michael ruled out pneumoconiosis. The Worker's claims for pneumoconiosis, automatic assumption and asthma were denied. His claim was, however, accepted for industrial bronchitis as an aggravation of his underlying asthmatic condition based on a report by Dr. Michael dated August 16, 2002.

Dr. Michael saw the Worker on June 27, 2002. In his August 16, 2002 report, Dr. Michael noted (as reported by the Worker) that the Worker started to have breathing difficulties in 1987, at the same time, that co-workers at Devco noticed his problem. He would be short of breath, particularly around dust and fumes. When he was off work, he began to notice that his breathing would improve. His shortness of breath was persistent and became quite progressive, although he did not require regular treatment or hospitalizations for his breathing. In the fall of 2001, he had a full assessment. Tests at that time confirmed the presence of bronchial asthma.

Dr. Michael noted that chest x-rays of December 5, 1998 and January 27, 2000 were normal. He observed that November 21, 2000 chest x-rays showed some abnormality as compared to previous films. He analyzed the PFT results over time and attached a summary of these to his report. The initial PFTs of November 20, 1987 demonstrated normal volumes with mild airflow obstruction with improvement in flow rates following bronchodilator. He concluded that the most recent PFTs done on June 27, 2002 had flow rates in response to bronchodilator compatible with bronchial asthma. He therefore opined that the Worker had bronchial asthma. This was diagnosed in 1987. However, due to progressive symptoms in the fall of 2001, treatment was required.

In making a connection to the workplace, Dr. Michael stated that, in his opinion, the work

environment had been a significant aggravating factor to his underlying disease. He added that "...As can be seen from the PFTs from 1987 to the present time, there has been indeed a progressive increase of residual volume suggesting the development of air trapping as well as increased airflow obstruction documented by the airflow parameters".

In his opinion, the Worker qualified for a 15% disability award. Based upon Dr. Michael's recommendation, the Worker was awarded a 15% permanent medical impairment rating effective June 27, 2002, the date of the studies.

On October 23, 2002, the Worker's family physician wrote to the Board. Dr. Rogers requested the Worker be considered for a loss of earnings because he had to miss time at work due to a cough and shortness of breath. He noted the Worker had left his occupation as a millwright in 1997 to take a part-time job in a clerical capacity. He then had to return to the workplace as a millwright until March of 1999, when he laid off work. This coincided with the closure of Devco. The Worker's chief complaints in 1999 were cough, congestion and dyspnea. Dr. Rogers felt that these symptoms were in keeping with the diagnosis of industrial asthma for which the Worker was now receiving a benefit. In response, the Board awarded the Worker temporary earnings-replacement benefits for periods of time between 1997 and 1999.

A review of the medical evidence during the critical period between 1997 and 1999, as well as the period up to the diagnosis of asthma in 2001, reveals the following: although the Worker had PFTs in 1987, he did not require treatment or further investigations until 2001; there were no specific references to work-related breathing difficulties until he was extensively investigated in the fall of 2001 for increased shortness of breath while he was away from the workplace; there was no connection made between the Worker's depression in March, 1999 and breathing difficulties at work; and, there was no mention the Worker's breathing difficulties were a disabling problem in March, 1999.

The panel concludes, on the whole of the evidence, that the Worker could not have been so concerned about his lung disease in March of 1999 as to have become depressed.

Recognition of Injury

Has the Worker developed gradual onset stress due to unusual or excessive work-related stressors? Dr. Sheard is of the opinion that he did. Dr. Ali suggests that the workplace may have been a precipitating factor.

The assertion of a relationship between the Worker's severe depression and work did not arise in the compensation context until the Board attempted to discuss vocational rehabilitation efforts with the Worker. These discussions took place in the context of an attempt to get him back into the workplace.

The Worker informed his VR counsellor that he did not believe he was capable of returning to work given his mental status. In a decision dated May 16, 2003, the VR counsellor found the Worker non-cooperative with his VR plan. She found that there was no objective clinical evidence that the Worker's current mental difficulties were directly related to his compensable injury. Therefore, she concluded the Worker's inability to participate in VR services was based on non-compensable health problems. This decision was overturned on appeal to a Hearing Officer. The Hearing Officer ordered the Board to adjudicate the compensability of the Worker's psychiatric condition.

At this point in 2003, medical reports, specifically Dr. Sheard's reports, addressed the relationship between the Worker's lung disease and his depression. Dr. Sheard's reports are briefly summarized below.

On March 11, 2003, Dr. Sheard wrote directly to the Worker's VR counsellor and noted that the Worker was referred to him and suffered from severe depressive symptoms in April, 1999 "as a direct result of his inability to work in the mine as a result of his industrial related chest condition". Because of the complete absence of past psychiatric history, Dr. Sheard stated that the condition was most certainly industrial-injury related, i.e., causally linked to the lung disease previously diagnosed.

On June 3, 2003, Dr. Sheard wrote the Board again and stated that, at the time of the Worker's lung disease diagnosis in 1997, he was not suffering from depression. Dr. Sheard added that as a direct consequence of his occupational lung disease and job reclassification, his mood deteriorated. Essentially, for the two years after that, he was reclassified with an alternate occupation paying him significantly less money. His thought content was filled with catastrophic future scenarios of his children starving and his second wife being without support. He truly believed that he was in danger of being on skid row, and the relentless stress of these symptoms in combination with his lung injury led him to go on long-term stress leave in 1999.

Finally, in a report dated January 16, 2004, Dr. Sheard addressed differences of opinion between himself and a psychiatrist who had conducted an independent examination of the Worker at the Board's request, Dr. Ali.

The panel does not find the points of contention between Dr. Ali and Dr. Sheard critical to the central issue on appeal, that is, causation. Both psychiatrists agree on the diagnosis. Dr. Sheard disagreed with Dr. Ali's conclusion that the depressive episode resulting from the Worker's occupational disease could not be clinically substantiated. Dr. Sheard added that the absence of any past symptomatology and presentation when the Worker successfully coped with two prior adverse life events without loss of time at work supported his view. Dr. Sheard felt this demonstrated very clearly that the Worker's subsequent psychiatric and medical morbidity went hand in hand with his sudden absence from the workplace.

Dr. Sheard elaborated on his opinion during his testimony. He suggested the stress associated with the Worker's lung disease and work environment caused emotional difficulties. He noted the Worker's underlying concern about being able to support his family. He acknowledged that the closing of the mine announced in January 1999 was a relevant factor. Dr. Sheard testified that the Worker responded to treatment and has improved, but not enough to permit him to return to work.

The Worker's representative argued that the Worker qualified for benefits under Policy 1.3.6. He relied on Dr. Sheard's opinion as to causation and suggested that the Worker's lung disease was an unusual and excessive stressor in the workplace. The representative asserted that it prevented the Worker from working and making a living, thereby causing severe depression.

The Employer's representative argued that the Worker did not meet his burden to prove gradual onset stress. He acknowledged that the Worker may have had discussions about the workplace environment during the time he was working in the maintenance office, but this was not unusual in the Worker's workplace. He noted that the worry about the future at Devco was intense for everyone at that particular time. There was nothing that brought the Worker outside of the norm for the industry at that time. Nothing was particularly unusual in the workplace, certainly as compared to the numerous events in the Worker's life. Anything work-related was not unusual. He submitted that one could not draw a line of causation between work-related factors and the Worker's depression. The Worker's representative suggested, in response, that any financial troubles the Worker may have had were linked to his inability to work in that environment due to his lung disease.

The panel concludes that the only work-related events which made a material contribution to the development of the Worker's depression related to the uncertain future for Devco and its employees in 1999. These are not unusual or excessive events in that context.

The assertions that the Worker's lung disease, working environment, or concerns over not being employable because of his lung impairment, made a material contribution to the stresses in his life in 1999 were not borne out by the evidence. The Worker did have difficulties with his workplace. He did have symptoms of cough and shortness of breath, but nothing that concerned him to the extent that he required medication, medical treatment or referral to a specialist until two years after he left the workplace. This brings the panel to the inescapable conclusion that the Worker's difficulties, such as they were, and his work environment, such as it was, were not unusual or excessive events or stressors. They would not have caused, even in part, the Worker's severe depression in March of 1999.

Therefore, the Worker is not entitled to recognition that he has suffered a personal injury in the form of stress under s.4(1) of GECA.

CONCLUSION:

The appeal is denied. The Worker has not suffered an injury in the form of stress as a result of work-related factors.