WCAT Decision Number: WCAT-2010-00645
WCAT Decision Date: March 02, 2010
Panel: Anthony F. Stevens, Vice Chair

Introduction

[1] The worker appeals the June 15, 2009 decision (*Review Decision #R0100796*) of the Review Division of the Workers' Compensation Board (Board). The Board now operates as WorkSafeBC. The review officer who issued that decision confirmed the Board's earlier October 29, 2008 decision, in which a case manager declined to accept multiple chemical sensitivity (MCS) under the worker's claim. In confirming that decision, the review officer noted there was disagreement in the medical community as to the validity of such a diagnosis. The review officer nevertheless also determined it was speculative to conclude the worker suffered from MCS that arose from the occupational exposure for which her claim had been established by the Board.

[2] The worker did not request an oral hearing, and an oral hearing was not arranged during the registration of her appeal. I accept the appeal can be properly considered without an oral hearing as there is no significant factual dispute or issue of credibility involved. Rather, the matter in dispute is medical in nature, or of the type that can be argued by way of written submissions. As such, I have decided the appeal following a review of the claim file, and with regard to submissions provided by the worker's representative, a lawyer, and the respondent employer's representative, a consultant.

Issue(s)

[3] The issue raised by the worker in her appeal is whether she suffers from MCS as a compensable consequence of her 1995 occupational exposure.

Jurisdiction

[4] This appeal was filed with the Workers' Compensation Appeal Tribunal (WCAT) under section 239(1) of the *Workers Compensation Act* (Act).

[5] Under section 250 of the Act, WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent. It must make its decision based on the merits and justice of the case, but in so doing it must apply policies of the board of directors of the Board that apply to the case, except in circumstances as outlined in section 251 of the Act.

[6] The evidentiary standard in this appeal is the balance of probabilities, as modified by section 250(4) of the Act. Section 250(4) of the Act provides that if the evidence

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supporting different findings on an issue is evenly weighted, WCAT must resolve the issue in a manner that favours the worker.

Background and Evidence

[7] In the worker's case specifically, she was one of six MRI technologists who occupied a new building in June 1994. It was subsequently established that the worker was exposed to film processing chemicals until about May 1995 due to the fact a particular MRI machine had not been installed in accordance with the manufacturer's recommendations. The machine involved was shut down once that situation was identified through on-site investigations. It was believed the worker and her co-workers had been exposed over a rather lengthy period of time to the chemicals used in the processor.

[8] The worker completed an application to the Board on June 6, 1995 in relation to an occupational exposure she indicated arose in her employment as a magnetic resonance imaging (MRI) technologist at a hospital. The worker outlined that the occupational exposure caused her to experience itchy eyes, coughing, chest pain, headaches, itchy facial skin, and shortness of breath.

[9] The Board accepted five of the claims for temporary work-caused conditions. The worker's claim was one of the accepted claims. The Board denied one claim entirely. The Board's decisions specific to each of the claims were appealed to the former Workers' Compensation Review Board (Review Board); however, they were transferred to WCAT by operation of law following legislative amendments that included changes to the appeal structure. In considering those appeals, a WCAT panel held an oral hearing that took place over three days in November 2005.

[10] The WCAT panel allowed the appeals launched by the five co-workers (see *WCAT-2006-01155-RB*, *WCAT-2006-01167-RB*, *WCAT-2006-01168-RB*, *WCAT-2006-01164-RB*, and *WCAT-2006-01206-RB*), although to somewhat differing extents based on the actual issues available in each appeal.

[11] In the worker's case, on March 14, 2006 her appeal was also allowed by the WCAT panel. It is appropriate at this point to note the Board accepted the worker's claim for temporary complaints of respiratory irritation, eye irritation, sore eyes, headaches, and chest heaviness. For reasons that I will not repeat here, the WCAT panel concluded (see *WCAT-2006-01218-RB*) the worker developed permanent sensitivities to one or more film processing chemicals. However, the WCAT panel noted the worker's overall symptom experience had broadened since her claim was considered by the Board. The previous WCAT panel also noted the diagnosis of MCS had been posited subsequent to the Board's adjudication of the claims made by the MRI technologists. In concluding she did not have jurisdiction to consider the compensability of the alternative diagnosis of MCS, the WCAT panel said:

> It may be that the technologists have developed conditions involving multiple symptoms to unknown substances as permanent sequelae of their occupational exposures in 1994/95 and afterwards. This is a question, though, that is adjudicated as an issue of compensable consequences.
>
> In view of all of the above, I do not consider that I have the jurisdiction to decide whether the individual technologists have developed multiple chemical sensitivity as a result of their occupational exposures, except where that matter appears to have been considered at the time the decision was made that forms the basis of the appeal.
>
> [all quotes reproduced as written, except as noted]

[12] Insofar as her determination that the worker had permanent sensitivities to one or more film processing chemicals, the previous WCAT vice chair said:

> Based on the opinions of Dr. Yeung [respirologist] and the [Board medical advisor], I find that the worker has developed permanent sensitivities to one or more film processing chemicals.
>
> With respect to skin irritations, in an opinion dated August 21, 1998, the BMA gave his opinion that the worker had developed itchy eyes, itchy skin on the face, coughing, chest pain, shortness of breath and contact dermatitis as a result of occupational exposures. I accept that opinion.
>
> I find the worker continued to suffer respiratory and eye irritations, headaches, itchy skin and chest symptoms beyond September 11, 1998. These are recurring symptoms associated with her permanent chemical sensitivities.

[13] It is also appropriate to note that following the earlier WCAT appeals, further adjudication took place at the Board level, leading to five further appeals to WCAT by the worker's co-workers. Four of those further WCAT appeals involved the issue of whether those individuals developed MCS as a result of their occupational exposure. However, in the fifth further appeal to WCAT, the issue that was determined (see *WCAT-2009-02356*) was in relation to health care entitlement directed to MCS, being a condition that was accepted under that particular claim following a request for review to the Review Division by that individual (I will describe that determination by the Review Division below). In terms of the four other appeals to WCAT, two were denied and one was allowed. The fourth appeal was also denied, although the issue in that appeal was not whether the 1995 exposure resulted in MCS. I can summarize those four WCAT decisions as follows:

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- In *WCAT-2008-01013* the panel who decided all six previous WCAT appeals considered a co-worker's appeal on the issue of whether this individual developed MCS arising from her earlier occupational exposure. The co-worker's appeal was denied. The WCAT panel concluded the medical evidence did not support a diagnosis of MCS. Rather the evidence indicated the worker had a pre-existing allergic tendency that caused her to develop sensitivity to one or more of the x-ray processing chemicals she was exposed to at work. The panel concluded there was insufficient evidence to support a conclusion the worker developed increased sensitivity to non-specific irritants attributable to her workplace exposure to film processing chemicals.

- In *WCAT-2008-02566* a different WCAT panel concluded that another co-worker developed sensitivities to multiple chemicals, which could be equated to MCS. The WCAT panel concluded this condition arose as a compensable consequence of this individual's exposure to film processing chemicals.

- In *WCAT-2009-01251* a different WCAT panel concluded, amongst other things, that it did not have jurisdiction to consider whether another co-worker developed MCS as a result of her 1995 exposure. In short, subsequent to *WCAT-2006-01164-RB* this individual had been provided a decision by the Board that declined to accept MCS under that particular claim; the WCAT panel noted this individual had not disputed that earlier decision by way of a request for review to the Review Division. The WCAT panel also noted the issue in the further WCAT appeal was whether she developed MCS as a result of three exposures in 2007 that were stated to involve scented products, diesel fumes, and perfume. The WCAT panel concluded there was insufficient evidence to establish a work-caused aggravation, activation or acceleration of this co-worker's pre-existing condition.

- In *WCAT-2009-01780* a different WCAT panel reviewed the medical opinions on that particular file, and concluded another co-worker developed MCS as a result of her exposure to film processing chemicals at work.

[14] It is sufficient at this point to note the considerations described above were centred on the following determinations: whether MCS is a descriptive medical term or a diagnosis, the extent each of the individuals involved suffered from pre-existing complaints, the nature and extent of the complaints subsequent to the occupational exposure, and an evaluation of the overall medical evidence regarding causation.

[15] As a consequence of the earlier WCAT appeal it is established that the worker sustained permanent sensitivities to one or more film processing chemicals, with continuing episodic respiratory and eye irritation, headaches, skin itchiness and chest symptoms. The worker is now in receipt of a 5% permanent partial disability award in relation to her residual complaints.

[16] The matter in dispute in the worker's current appeal to WCAT involves the question of whether she also developed MCS that arose as a compensable consequence of the earlier exposure.

[17] According to the medical information on file, the worker had been an active and athletic individual. Her only previous allergic-type of complaint in the past had to do with what was described in the medical reports as a minor reaction to inexpensive jewelry, not involving gold products.

[18] Dr. Yeung, a respirologist, completed a consultation report on May 12, 1997 to note the worker had no family history of asthma or allergies. Dr. Yeung noted that following her exposure the worker experienced wheezing when she ran, and also experienced sore eyes, itchy skin, and a pressure sensation on her chest when she was in proximity to developing chemicals, including those on film that had already been processed. Dr. Yeung concluded there was no doubt the worker was sensitized to one of the chemicals in the processing machine. Dr. Yeung also noted that once someone was sensitized, even exposure to minute amounts of such chemicals could lead to recurrence of symptoms.

[19] When assessed by dermatologist Dr. Morton on September 15, 1997, patch testing revealed that the worker had an immediate reaction to perfume. Dr. Morton considered this to be an interesting finding, given her co-workers had also been found to have that particular sensitivity.

[20] Subsequent medical reports indicated the worker sought medical attention on March 9, 2000 for a neck and upper chest rash that arose when working at another MRI facility, even though there had been no contact with film. She was next seen on October 15, 2003 for headaches, eye redness, and progressive fatigue.

[21] New medical evidence was submitted in the worker's previous WCAT appeal, which included a May 2004 report that had been completed by Dr. Yassi, a specialist in community medicine and occupational medicine, and Dr. Ouelette, a community health medicine resident. That report considered the impact on the MRI technologists that the 1995 workplace exposures may have had. It also included a literature review, including in relation to MCS. This report detailed that although there was a consensus definition for MCS in place since 1999, there continued to be a lack of widely accepted standardized clinical and epidemiological criteria for MCS. The report indicated that four of the MRI technologists had symptoms, medical histories, and exposure histories that met the criteria for the diagnosis of MCS. However, the May 2004 report also noted:

> It should be acknowledged that although MCS is controversial, as the etiology and pathophysiology are unknown and there are no reliable diagnostic tests, it is clearly an illness…
>
> …compensation of affected individuals needs to be case-specific. This is generally a tricky subject, as MCS, although real, is undiagnosable with any degree of certainty, and as the pathophysiology is unknown there is often reluctance to accept this syndrome as a compensable occupational disease….

[22] In a January 6, 2005 medical-legal report Dr. Stark, a specialist in allergy and clinical immunology, commented as follows:

> …It is my opinion that [the worker's] prolonged exposure to x-ray developing chemicals…was of causative significance in her development and worsening of her respiratory, ocular, skin, and fatigue complaints. She had no significant previous problems with these symptoms prior to exposure to the faulty x-ray processing unit chemicals. She has also become more sensitive to other non-specific irritants. I suspected that sulphite allergy may be only one of the types of chemical sensitivities that an x-ray technologist potentially could develop with exposure to sulphur based compounds in the developing chemicals. The WCB Board Medical Advisor was sceptical that sulphites were a significant factor in the MRI technologists development of symptoms. I would agree that sulphites as a single agent would have unlikely been a significant factor in exacerbating [the worker's] symptoms. However, in combination with other chemicals that she was exposed to, this could have been an exacerbating factor. I suspect that glutaraldehyde sensitivity may be more likely to be the major culprit based on subsequent studies that have become available. Although [the worker] did not show any immediate sensitivity on patch testing eight years after her exposure, it is still possible this could have been a significant factor. The developing chemicals that these MRI technologists were exposed to over a prolonged period of time at low concentrations could have caused increased immunological sensitivity and irritant effects. Other examples where low molecular weight chemical compounds can cause exacerbation of her asthma and allergic-like symptoms are in western red cedar asthma as a result of plicatic acid allergy…patients who develop western red cedar asthma appear to remain sensitive to this chemical for most of the rest of their life and may also have non-specific hyper-reactivity of their lungs for years to come…These patients, like the MRI technologists, become more sensitive to non-specific irritants such as dust, cigarette smoke, and perfume….

[23] Dr. Stark expressed the opinion that the worker experienced difficulties associated with having become sensitized to chemicals used in the developing process. However, he also said:

> …She also developed cross-reacting sensitivities to other chemicals and experiences non-specific irritant reactions to other substances. This will likely be a life-long sensitivity.
>
> …will likely continue to have increased sensitivity to developing chemicals and other non-specific irritants in the environment such as perfumes, cigarette smoke, and dust…

[24] In any event, as I noted previously, in the earlier March 14, 2006 decision the previous WCAT panel allowed the worker's appeal by concluding she was permanently sensitized to one or more film processing chemicals, but declined to consider the compensability of her MCS. Thereafter, the worker's representative wrote the Board on October 2, 2008 to request adjudication on whether MCS would be accepted under the claim.

[25] The worker's evidence in her earlier WCAT appeal was to indicate that in addition to complaints associated with exposure to film processing chemicals, her complaints were also triggered with exposures to the following: perfume, cologne, scented products (such as hair products and body/facial creams), some cleaning products, new products (such as furniture, carpets, car interiors, etc.), smoke, smog, and gas stations.

[26] In considering whether to accept MCS under the claim the case manager sought a medical opinion. The Board's internal medicine consultant reviewed the worker's claim on October 20, 2008. He expressed the following opinion:

> Multiple chemical sensitivity is not a recognized disease with demonstrable pathology, but a state of ill health characterized by a multiplicity of symptoms attributed to environmental toxins. No reproducible physical or biochemical abnormalities have been demonstrated for this condition and the mechanism by which symptoms are produced, or even the very existence of this condition, is subject to considerable debate. The preferred term for this symptom complex by many authors is "idiopathic environmental intolerance". The relationship between the symptoms of idiopathic environmental intolerance and the claimed exposure does not fit the basic tenants of toxicity – i.e. dose dependency, reproducibility, consistency, and predictability. Bradford Hills criteria for causality are notable for their absence in this condition. This "illness" has been popularized by practitioners who usually identify themselves as clinical ecologists or specialists in environmental medicine. Clinical ecology is not a recognized medical specialty. Environmental

> medicine and occupational medicine are components of the speciality of preventative medicine but the theories and practices of clinical ecology are not. Critics of clinical ecology charge that (a) multiple chemical sensitivity or idiopathic environmental intolerance have never been clearly defined, (b) no scientifically plausible mechanism has been proposed for it, (c) no diagnostic tests have been substantiated, and (d) not a single case has been scientifically validated. The theories and practices of clinical ecology have been severely criticized by the American Medical Association, the American College of Physicians, the Canadian Psychiatric Association, the International Society of Regulatory Toxicology and Pharmacology, the American Academy of Allergy, Asthma, and Immunology, the American College of Occupational and Environmental Medicine, and several scientific panels that have been convened to investigate them.
>
> The most commonly held opinion likely explaining this symptom complex is that it represents a phobic disturbance with manifestations of a panic disorder. Many experts think that the condition actually represents "olfactory panic".

[27] That opinion was the basis on which the case manager issued the October 29, 2008 decision to deny MCS under the worker's claim. In the request for review, the review officer acknowledged that Dr. Stark's opinion supported work causation. However, the review officer believed Dr. Stark's conclusions were more general in nature, given he also provided comment regarding the co-workers, such that it would be speculative to conclude that the worker had MCS that arose consequential to her workplace exposure. In turn, the review officer preferred the opinion of the Board's internal medicine consultant.

[28] I noted previously that MCS was accepted in one of the co-worker's claims as a result of a successful request for review. Of interest, that request for review was completed by the same review officer who issued the June 15, 2009 decision that is now before me. The employer was involved in that other request for review, and that Review Division decision was otherwise referred to in the submissions provided by the worker in her present appeal. Accordingly, it is not necessary to disclose that decision in advance of completing my determinations regarding the worker's present appeal. That particular Review Board decision (*Review Decision #R0086989*) was issued on September 21, 2007. In considering the co-worker's request for review of the issue of whether MCS would be accepted under that particular claim, the review officer referred to the January 6, 2005 opinion of Dr. Stark for that individual, the May 2004 report completed by Drs. Yassi and Ouelette, and the opinion of the Board's internal medicine consultant that was on the co-worker's claim. In allowing the co-worker's request for review the review officer said:

In denying MCS under the worker's 1995 claim, the adjudicating Board Officer relied, in large part, on the September 2007 memorandum of the [medical advisor] in [Occupational Disease Services]. Stressing there was no reliable evidence in the medical literature to confirm that workplace exposures can cause/aggravate idiopathic environmental sensitivities, otherwise known as MCS, the MA was unable to support or exclude an occupational cause or aggravation of an idiopathic environmental sensitivity. It should be noted that the MA's opinion was a generalized overview of the nature of MCS and the unsettled understanding of its origins. The MA did not specifically reference the worker's medical or claim history.

On the other hand, the January 2005 medico-legal report of Dr. S, a specialist in allergies, immunology, and internal medicine, was grounded in first hand clinical observation and treatment of the worker over nearly a decade. As I understand Dr. S' evidence, occupational exposures like the worker's can leave a patient with permanent hyper-sensitivity to not only the specific irritant (i.e. the film processing chemicals in the worker's case), but also with increased sensitivity to non-specific irritants such as dust, cigarette smoke and perfume. Dr. S' prognosis was that, as a result of the occupational exposure, the worker would likely continue to have increased sensitivity to film processing chemicals (accepted by the Board as compensable) and "other non-specific irritants in the environment such as perfumes, cigarette smoke, and dust." I interpret Dr. S' general comments and specific prognosis for the worker as supportive of a positive causal link between the protracted 1994-5 occupational exposure and the onset of MCS. In considering Dr. S' comprehensive report, I give significant weight to his:

- assessment that the film processing chemicals to which the worker was occupationally exposed overtime may result in increased immunological sensitivity and irritant effects; and

- emphasis on the fact that, prior to the worker's prolonged occupational exposure, she had no significant problems with sensitivities (i.e. coughing, asthma, chronic rhinosinusitis, chronic eye irritation, chronic bowel complaints, sensitivities to sulphite preservatives and MSG in foods) – apart from seasonal hay fever symptoms. I note that this feature of the worker's history, which suggests an important temporal connection between the occupational exposure and subsequent onset of MCS, does not appear to be contradicted or disputed.

In my judgment, Dr. S's case-specific and thorough examination of the worker's claim history warrants greater weight than the more generalized

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and, ultimately, inconclusive September 2007 opinion of the MA. Furthermore, it should be emphasized that policy item #22.00 of the *RSCM* only requires the evidence to support a conclusion that the original injury – or, as in this case, occupational exposure – was a *significant cause* of a later injury or condition. In the worker's case, the weight of evidence persuades me to find that, at a minimum, the compensable occupational exposure of 1994-5 was a significant factor, if not necessarily the only factor, in the subsequent development of MCS. I accept Dr. S' evidence that MCS for the worker takes the form of increased sensitivity to environmental irritants such as perfumes, cigarette smoke, and dust, *et cetera*.

In summary, I find on a balance of probabilities that the onset of the worker's MCS is a compensable consequence of the occupational exposure to film processing chemicals which gave rise to this claim. As a result, I allow the worker's request. The Board must now determine the nature and extent of the additional compensation, if any, which flows to the worker as a consequence of my decision.

[29] In the present WCAT appeal the worker provided copies of material, some of which was already on file, along with a lengthy written submission. I have reviewed that information. The worker submitted that Dr. Stark's opinion and the May 2004 report support a conclusion she sustained MCS arising as a consequence of her 1995 exposure. A further argument was to suggest that MCS is now an accepted diagnosis, and to further suggest the worker's symptoms were consistent with MCS. Also referred to by the worker were the successful WCAT appeals of her co-workers, as well as the successful request for review that I noted above.

[30] The employer referred to *WCAT-2008-01013*, being the decision related to the unsuccessful appeal of one of the worker's co-workers. The employer noted the panel in that appeal concluded that the opinions rendered in favour of work causation had been too general in nature, such as to not be of assistance in determining entitlement under that specific claim.

[31] The worker did not forward a rebuttal submission, although she was provided the opportunity to do so.

Findings and Reasons

[32] The overall evidence indicates that MCS continues to be controversial, at least insofar as establishing universal diagnostic criteria on which such an illness ought to be based, and in terms of fully understanding the pathogenesis of the associated complaints. Nevertheless, I accept the evidence reasonably establishes that MCS is an illness that provokes symptoms that arise due to increased sensitivity to non-specific irritants.

[33] In terms of whether the worker has MCS, I acknowledge there has been no such specific diagnostic label explicitly stated in her case. However, the more general comments of Dr. Stark, together with those of Drs. Yassi and Ouelette in the May 2004 report, discuss the symptom presentations of the MRI technologists with the diagnosis of MCS in mind. Moreover, Dr. Stark offered opinions specific to each of the individuals involved in a series of medical-legal opinions that were completed at the same time. Although not in any way binding on me in terms of the worker's present appeal, I nevertheless adopt the approach in considering whether a diagnosis of MCS has been made that was outlined in *WCAT-2008-02566* with respect to the successful appeal by one of the co-workers. The WCAT panel in that decision said:

> …The May 2004 assessment is not directed at the worker only. It includes information concerning co-workers. It does not provide an opinion about multiple chemical sensitivity, work causation, and the worker. It provides some general commentary, only, about that condition. The document, however, does support the diagnosis of multiple chemical sensitivity in the worker's case.

[34] Also, in discussing Dr. Stark's opinion related to that particular worker, the WCAT panel said:

> I accept this expert opinion to the effect that the worker has developed cross-reacting sensitivities to other chemicals and non-specific irritant reactions to other substances. This set of symptoms has been identified by the occupational medicine specialist, in the assessment referenced above, as multiple chemical sensitivity (see above). Although the immunologist does not use that term, I accept the term as the diagnosis for the worker's symptoms of respiratory and skin allergy problems.

[35] I am in agreement with that approach. As such, although not explicitly stated, I accept that the evidence contained in the May 2004 report and Dr. Stark's January 6, 2005 opinion serves to establish that the worker in the case before me suffers from MCS.

[36] MCS is not an occupational disease that has been recognized by the Board by inclusion in Schedule B or by regulation of general application. Nevertheless, pursuant to item #26.04 of the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I) a disease that has not been previously designated or recognized can be accepted on a case-specific basis.

[37] Moreover, consideration of the worker's MCS was with regard to item #22.00 of the RSCM I, which is the Board's policy in relation to compensable consequences. Item #22.00 of the RSCM I provides that not all consequences are compensable; the test is whether the compensable condition was a significant cause of the subsequent condition.

[38] I acknowledge that in the case of one co-worker the Board issued a decision to not accept MCS, and the individual involved did not dispute that decision of the Board. I also acknowledge the WCAT panel in *WCAT-2008-01013* declined to accept MCS under another co-worker's claim. I do not know the particulars in the case of the first individual. However, in the case of the second individual the WCAT panel outlined in *WCAT-2006-01168-RB* that this individual had a medical history that included positive reactions on testing to orange juice and tomatoes in 1984, as well as known allergies to amoxicillin and erythromycin. Moreover, that individual also had pre-existing strong reactions to grass pollen, alder/birch/cottonwood/oak tree pollens, cat dander and dust mites. She also had known mild reactions to tree/weed pollens, mould, and sulphite. As a result, in denying that particular co-worker's appeal related to MCS, that WCAT panel concluded it was speculative to relate the worker's underlying allergic tendency to her 1995 exposure. That panel also concluded Dr. Stark's opinion on that claim did not specifically address the worker's status.

[39] I contrast that decision to the previous Review Division decision related to one of the other co-workers, and the successful WCAT appeals by two of the other co-workers. As described above, the review officer in that earlier request for review on a co-worker's claim concluded that Dr. Stark's opinion was a thorough, case-specific analysis. Also, in the two successful WCAT appeals the panel in *WCAT-2009-01780* described that this co-worker was known to only suffer mild seasonal hay fever prior to her 1995 occupational exposure. In *WCAT-2008-02566* the WCAT panel noted that particular co-worker was not known to have previous allergic or sensitization conditions, and that Dr. Stark offered an opinion that supported a conclusion she developed such complaints consequential to her occupational exposure.

[40] Such is the situation in the present appeal. The worker had no prior allergic or sensitization conditions, apart from that which was associated with inexpensive jewelry. As noted above, I accept that she now suffers MCS. The overall evidence also supports a conclusion that the worker's MCS arose as a consequence of her workplace exposure. Accordingly, I allow the worker's appeal and vary the June 15, 2009 Review Division decision.

[41] The worker did not request appeal expenses, apart from time loss from work to attend an oral hearing. As an oral hearing was not necessary on this appeal, such appeal expenses did not arise. Accordingly, there appears to be no appeal expenses on which to consider an order for reimbursement.

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Conclusion

[42] I vary the June 15, 2009 Review Division decision.

[43] In summary, I conclude the worker suffers from MCS that arose as a compensable consequence of her 1995 occupational exposure.

Anthony F. Stevens
Vice Chair

AFS/gl