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REVIEW AND SUMMARY OF FSCO ARBITRATION DECISIONS

Addendum to IBC's Submission for Proposed Reform to FSCO ADR Process

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Definition of "Automobile"

1) *Buckle v. Motor Vehicle Accident Claims Fund* (FSCO A10-000010, Arbitrator Kominar, February 3, 2011)

A golf cart was determined to be an "automobile" for the purposes of determining the claimant's entitlement to statutory accident benefits, requiring the Motor Vehicle Accident Claims Fund in this case, or other personal insurers in other cases, to pay for injuries arising in connection with the use of a golf cart.

This hearing arose from an application for the determination as to whether the claimant was injured as a result of an "accident" as defined in s. 2(1) of the *SABS* to determine whether the application for arbitration could move forward on the merits, which involved the question of whether a golf cart is an "automobile."

The claimant was being transported as a passenger on a motorized golf cart, which was illegally being operated on the highway and was not licensed, registered or insured. It was not merely crossing the road as golf carts are commonly known to do, but actually driving down the road as other vehicles do. At some point during the trip, the claimant fell off the golf cart and sustained injuries. No other vehicle was involved in the incident. The claimant had no automobile policy of her own, and as such, she applied to the Motor Vehicle Accident Claims Fund (MVACF) for SABs.

The arbitrator accepted the claimant's position that, irrespective of the common sense acknowledgment that golf carts are really not intended to be driven on public highways at all, and notwithstanding that the *Off-Road Vehicles Act* exempts golf carts from its regulatory requirements, it remains unclear as to what the specific policy reason was for the exemption of golf carts. The arbitrator rejected MVACF's argument that the only compelling inference from the legislation is that golf carts are not regulated and are not required to have automobile insurance, so the incident was not an "accident" for the purpose of the *Insurance Act* and the *SABS*.

Even though no specific submissions were made, the arbitrator took judicial notice of the fact that a golf cart being driven down a highway meets the definition of "motor vehicle" in the *Highway Traffic Act*, and the Compulsory Automobile Insurance Act requires any vehicle being driven on a highway. Rather than accepting MVACF's argument that the only compelling inference from the legislation is that golf carts are not regulated and are not required to have automobile insurance, the arbitrator chose to infer that a golf cart being driven on a highway is required to have automobile insurance.

2) ***Bouchard v. Motors Insurance Corporation*** **(FSCO A09-001616, Arbitrator Ashby, January 7, 2011)**

The arbitrator concluded that a gas-powered miniature motorcycle being operated on the owner's private property was required to be insured, and as a result continued to have the characteristics of an automobile, requiring the payment of SABs by the insurer. This imports a test that cannot be determined at the time of the loss, leaving insureds and insurers without any confident way of knowing whether similar circumstances may have opposite outcomes for entitlement to SABs depending on some former outside usage of the vehicle in question, which is a very unseemly outcome.

The claimant was injured while operating a gas-powered miniature motorcycle (or "pocket bike") on private property, when she collided with another pocket bike. Her claim for SABs made to her own automobile insurer was denied on the basis that a pocket bike is not an "automobile." The arbitrator recognized that a pocket bike is not an automobile in ordinary parlance, but found that it met the definition of an "off-road vehicle" under s. 1(a) of the *Off-Road Vehicles Act*.

The crux of the issue therefore was whether, at the time of use, the pocket bike was not required to be insured within the requirements of the applicable legislation so as to determine whether the claimant was entitled to SABs. As the insurer pointed out, s. 15 of the *Off-Road Vehicles Act* provides that an off-road vehicle is not required to be insured if it is driven on land occupied by the owner of the vehicle. The incident between the pocket bikes occurred on the property occupied by the owner of the pocket bikes. Nevertheless, because the owner of the pocket bike had driven it at her friend's house in the past, the arbitrator held that it was required to be insured and that it met the definition of an "automobile" within the expanded definition of s. 224(1)(a) of the *Insurance Act*. As a result, the arbitrator found that the claimant was involved in an accident, and was therefore entitled to SABs notwithstanding the fact that the incident occurred on lands occupied by the owner.

Definition of Automobile "Accident"

3) ***Whipple v. Economical Mutual Insurance Company*** **(FSCO Appeal P10-00020, Director's Delegate Evans, October 6, 2011)**

The arbitrator found that an injury to a 62 year old inebriated man attempting a headstand on a stripper pole in a moving limo party bus was caused directly by the use or operation of an automobile, thereby constituting an "accident," and requiring the payment of SABs.

The question posed in this case was whether the claimant, who sustained catastrophic injuries as a result of the antics he was engaged in as a passenger while inside a moving limo bus, was injured as a direct result of the use or operation of an automobile so as to be

entitled to SABs payments. The incident occurred in a 24-passenger luxury limousine coach, which was advertised as a "party bus," and included amenities such as a stripper pole with a light above it in the centre of the wrap-around seating of the vehicle. The claimant had requested the limo bus so that its occupants could move about freely and party, which included bringing their own alcohol on board. The incident occurred while the group was fairly inebriated, but the arbitrator found that the level of intoxication did not concern the driver. The claimant's injuries were sustained after he attempted a headstand on the stripper pole in the limp bus while it was in motion.

The arbitrator found that the claimant's headstand attempt met the purpose and causation tests of an "accident," and although his use of the limo bus was unprecedented, it was in keeping with the context of the group's activities in the vehicle. According to the arbitrator, there was no break in the chain of causation because in this context, the headstand flowed naturally from the increasingly creative activities around the pole, which was an integral part of the vehicle. The arbitrator also found that the motion of the party bus itself directly contributed to the claimant's injuries, although the driver's evidence was that it was a smooth ride.

The Director's Delegate supported the arbitrator's findings, and concluded that the claimant's actions occurred "in the course of the ordinary and well-known activities of that particular limo bus." Although he admitted that the performance of a headstand on a stripper pole was unusual, the pole was an invitation to the forms of activities that occurred on the night of the incident. As such, he failed to find that the headstand fell so far outside of what was expected in an insurance contract that it does not meet the *Amos* use and operation test, and concluded that the arbitrator did not err in making such a finding.

4) *Webb v. Wawanesa Mutual Insurance Co.* (FSCO A10-001986, Arbitrator Miller, May 12, 2011)

This case involved a claimant who was injured after she parked her vehicle on a residential street, exited it, locked the door, walked around to the front of it and put her foot on an icy sidewalk, causing her to slip and fall backwards. Notwithstanding the remoteness of the events with the direct use or operation of the claimant's vehicle, the arbitrator found that the claimant was in the process of disembarking her vehicle when the fall occurred, requiring her automobile insurer to pay SABs as a result.

On February 8, 2009, the claimant went to visit a friend, and parked her vehicle on a residential street. She exited from the driver's side, walked around to the front of the vehicle, and attempted to go to the sidewalk through an access point at the front of her vehicle. When she put her foot onto the access point, she slipped on ice and fell backwards. The question at issue in this FSCO arbitration hearing was whether the injuries she sustained as a result were due to an "accident."

The arbitrator found that it was an "accident" because disembarking from a motor vehicle is a normal activity required by the use or operation of a vehicle. She refused to accept Wawanesa's argument that the disembarkation process had ended as she stepped onto the access point, and found that the access point was part of the roadway that the claimant had to traverse before she got to the curb. To the arbitrator, this went beyond the ordinary risk faced by anyone who disembarks from a vehicle onto a roadway, and it did not constitute an intervening event. By the time that she fell, the claimant had not safely and completely disembarked from her vehicle.

This decision appears to be contrary to the Director's Delegate's decision is *Webb v. Lombard General Insurance Company of Canada*, which found that a claimant who disembarked from a taxi in a hotel driveway and slipped and fell on ice behind the taxi while walking toward the hotel entrance had not been injured in an "accident."

Catastrophic Impairment

5) *Aviva Canada Inc. v. Pastore*, 2011 CarswellOnt 3187 (Div. Ct.)

The Director's Delegate was found to be wrong in making a decision that was not supported by objective evidence, data or analysis, and by misstating the purpose of the legislation as being one without concern for the impact on premiums. The Divisional Court also pointed out that the Director's Delegate ignored evidence that provided context to the particular *SABS* section at issue in the case.

Aviva appealed the decision of a FSCO Director's Delegate, which upheld the arbitrator's decision that the claimant met the decision of "catastrophic impairment" under s. 2(1.1)(g) of the *SABS*. In overturning the decision of the Director's Delegate, the Divisional Court majority was particularly critical of FSCO's interpretation and application of the *SABS* in this regard. They noted that the arbitrator's and the Director's Delegate's interpretation ignored a consideration of the secondary sources that form the background of the SABS and which provide the context of the SABS as a whole, as well as the "surroundings that colour the words" of the particular section at issue.

The Divisional Court also pointed out that the Director's Delegate relied on assertions that were not supported by objective evidence, data or analysis, such as the one that if a marked impairment in one area of functioning is not accepted for the definition of catastrophic impairment, it would deprive the victims "most likely in the greatest need." In its criticism of the Director's Delegate's reliance on such assertions, Justice Lederer for the Court stated (at paras. 48, 51, 53 & 54):

> **The assertion is simply what the Director's Delegate believes is right. To me, this is the imposition of a moral absolute. Unhappily, it is not so easy to balance who will receive these additional benefits against the cost**

> **… Rather than adhere to this understanding of the use of the Guides, the Director's Delegate treated it as a free-standing text to be re-interpreted, independent of its origins, to suit a separate and distinct Ontario model for the treatment of catastrophic impairments.**
>
> **The interpretation of the Guides was undertaken, by the Director's Delegate, as if it bore no relationship to, and was independent of, the document that was incorporated into the SABS. This perspective allowed the Director's Delegate to see the Guides as inherently inconsistent with *SABS* rather than as part of it… where the *Guides* were inconsistent with the purpose of the legislation *as he perceived it* (that is to say, without concern for the impact on premiums) the Director's Delegate did not feel bound to find an interpretation which harmonized the words of the Guides with the words of the SABS.**

6) *Kusnierz v. Economical Mutual Insurance Company*, 2010 ONSC 5749 (CanLII)

Whereas many FSCO arbitrators who had previously considered the issue of the catastrophic impairment definition in cases since *Desbiens* had received guidance from medical experts on how the SABS ought to be applied, Justice Lauwers recognized an interpretation of the SABS regarding catastrophic impairments which adheres to what the legislature has required. In addition, contrary to numerous FSCO arbitration decisions which relied on a literal approach to interpreting the SABS, Justice Lauwers relied on a purposive analysis to statutory interpretation in coming to his conclusion.

Before coming to the conclusion that physical and mental/behavioural impairments cannot be combined for the purposes of determining which claimants fit the definition of catastrophic impairment, Justice Lauwers reviewed a long line of cases which found otherwise, beginning with *Desbiens v. Mordini* (2004 CanLII 41166, ON SC).

Whereas many arbitrators and judges who had previously considered this issue in cases since *Desbiens* had received guidance from medical experts on how the SABS ought to be applied, Justice Lauwers cautioned that to defer to or adopt expert opinion on this legal issue was not the proper approach, given that the entire regulatory context must be considered.

7) *Jaggernauth v. Economical Mutual Insurance Company* (FSCO A08-001413, December 20, 2010, Arbitrator Feldman)

Despite the ruling in *Kusnierz* noted above, the arbitrator in this case specifically declined to follow the Superior Court's decision, and instead chose to apply a more general

interpretation criticized in *Kusnierz* and applied within FSCO. This decision raises important concerns about how the concept of *stare decisis* is actually being applied by FSCO arbitrators.

In determining the issue of whether the claimant met the statutory definition of catastrophic impairment in the SABS, the arbitrator in this case declined to follow the Divisional Court's decision in *Kusnierz* on the basis that he felt bound by the Director's Delegate's decision in *Mrs. G. v. Pilot Insurance Company* (FSCO Appeal P06-00004, September 4, 2007), which adopted the *obiter dicta* by Justice Spiegel in *Desbiens v. Mordini* (2004 CanLII 41166, ON SC). This decision is currently under appeal by the Director's Delegate at FSCO.

8) *T.S. v. Allstate Insurance Company of Canada* (FSCO A07-001223, November 15, 2011, Arbitrator Wilson)

The arbitrator also chose to apply a more general interpretation to determining catastrophic impairment which was specifically rejected in *Kusnierz* and applied within FSCO. He allowed the hearing to proceed sporadically over a two and a half year period so that the self-represented claimant could determine whether she wanted to obtain additional evidence in support of her position. He concluded that the claimant, who took a paralegal course in order to represent herself at the hearing, was markedly impaired in all four areas, which was unsupported by any of the conclusions made by the assessors in the case.

The motor vehicle accident in this place was in November 2001, and the FSCO arbitration hearing took place sporadically between April 2008 and October 2010. The arbitrator remarked that the claimant "bravely undertook" to represent herself at a hearing which required the consideration of technical wording with respect the determining catastrophic impairment, and noted that she took a paralegal training course offered by a vocational college so as to prepare for the hearing.

The arbitrator accepted all documents offered by the claimant at the outset of the hearing as evidence, despite the procedural requirements set out by FSCO. The documents accepted as evidence included reports which, for the most part, no experts were called to testify about. The only experts who attended the hearing to testify were the claimant's treating psychologist, and two CAT DAC insurer's examination assessors. The arbitrator found that, despite certain challenges in the evidentiary presentation at the hearing, the evidence adduced was sufficient to allow him to render a decision on the issues raised.

The arbitrator concluded that the CAT DAC assessors did not take a proper, open-minded approach by not following the one specifically criticized in *Kusnierz* and relied on within FSCO, and that the claimant met the definition of catastrophic impairment on the basis of his own assessment of the evidence presented, rather than based on the conclusions of the catastrophic impairment assessors.

9) *Mr. C. v. Coachman Insurance Company* (FSCO A09-000167, October 21, 2011, Arbitrator Miller)

Although the assessor's report in this case only concluded that the claimant had a marked impairment in one out of four areas, the arbitrator rounded up various other evidence and concluded that the impairment rating should have been higher. In doing so, she found a level of impairment that was well beyond anything alleged by the parties or assessors involved in the case.

The Arbitrator's efforts in rounding up evidence put forth by the applicant to make a determination that he met the definition of catastrophic impairment in the *SABS* was done despite the fact that the catastrophic assessment report obtained by the applicant found a marked impairment in only one to two areas. The arbitrator took it upon herself to increase the impairment ratings used by the applicant's assessor in his report:

> **Moreover, I find that if Dr. Rosenblat had the additional detailed, credible evidence that was presented at the hearing, Dr. Rosenblat's rating should have been higher than one "marked impairment."**
>
> **…I find that taking into consideration the observations of Mr. C.'s treatment providers, who have observed him over a long period of time, as well as the credible evidence of Mr. and Mrs. C., as noted below, I have increased Dr. Rosenblat's ratings on my findings on the four domains of mental or behavioural impairments. (emphasis added)**

In doing so, the arbitrator took a case which, on the basis of the claimant's evidence, could not succeed in accordance with the recent Divisional Court decision, *Aviva v. Pastore*, *supra*. She made new findings of fact, and put the case together much stronger than the claimant's own evidence demonstrated.

10) *Augello v. Economical Mutual Insurance Company* (FSCO A07-001204, Director of Arbitrators, Draper, December 4, 2007)

Confronted with a controversial legal issue requiring resolution by an appellate Court, the Director declined to direct a reference to the Divisional Court as contemplated by the *Insurance Act*. This resulted in a delay of nearly four years before that issue could be dealt with at the appellate Court level.

The Legislature grants the power and jurisdiction to a Director to state a case in writing for the opinion of the Divisional Court upon any question that in his or her opinion is a question of law via the *Insurance Act*. Despite the fact that the insurer's request to do so

did not require any factual determinations to be made, the Director of Arbitrations refused, even though it would have allowed the proceeding to move forward in the most cost-effective and efficient manner.

In this case, the insurer asked the Director of Arbitrations at FSCO to direct a reference to the Divisional Court on the issue of whether the claimant sustained a catastrophic impairment pursuant to s. 2(1.1)(f) or (g) of the *SABS*, and specifically, whether it is correct to assign a percentage value to psychological impairments under clause (g) and combine that percentage value with the physical impairment ratings under clause (f).

The Legislature grants the power and jurisdiction to a Director to state a case in writing for the opinion of the Divisional Court upon any question that in his or her opinion is a question of law through s. 285 of the *Insurance Act*, R.S.O. 1990, c. I.8. The Divisional Court must then hear and determine the stated case. The opinion on the particular question of law in this case does not require any factual determinations that may be at issue. Referring such an issue to the Divisional Court would have allowed it to be addressed at the appellate level directly, instead of taking the less cost-effective and expedient approach of proceeding through FSCO's Director's Delegate and then to the Divisional Court.

Nonetheless, the Director of Arbitrators denied this request on the basis that the proper recourse would be to pursue the matter through the process at FSCO, and then apply for judicial review. Instead of referring the question so as to resolve the question of law on a cost-effective and expedient basis, the Director compelled the parties to follow the FSCO process, which is a much longer, costly and time-consuming route.

Special Awards

11) *Sinnapu v. Economical Mutual Insurance Company* (FSCO Appeal P11-00012, Director's Delegate Blackman, November 1, 2011)

In cases dealing with entitlement to statutory accident benefits, insurers are frequently being punished by way of special awards for making ordinary claims handling decisions in accordance with the *SABS*. This punishment seems to arise solely from the particular arbitrator's difference of opinion than that of the insurer with respect to ordinary claims handling decisions.

The arbitrator in this case granted a special award in the amount of 40% of the benefits outstanding plus interest, regardless of the fact that there was no evidence of malice or ill-intention on the part of the insurer. FSCO arbitrators' wide discretion to make such awards places a significant risk on insurers who may be exposed to astronomical monetary penalties, especially in situations where it is not the insurer's malicious conduct but the vulnerability of the claimant that is the determining factor.

Following the claimant's motion for interim benefits, the arbitrator ordered Economical to pay the claimant income replacement benefits until the matter was ultimately resolved. Economical paid the IRB arrears, and consented to an order for payment of ongoing IRBs. This settled all issues in dispute, other than a special award claim under s. 282(10) of the *Insurance Act*, which was the subject of the arbitration hearing. The arbitrator's decision to make a special award of 40% of IRBs at the time they were finally resolved for "unreasonably withholding benefits" was upheld by the Director's Delegate, who refused to find that the arbitrator erred in doing so because there was evidence that the insurer relied on the conclusions of its own assessor to withhold IRBs from the claimant (see p. 10):

> **I am thus not persuaded that the Arbitrator erred in improperly exercising his discretion in finding that the Appellant unreasonably withheld payment of IRBs. I am not persuaded that the Arbitrator granted a special award simply on the basis that the Appellant was incorrect in terminating benefits. Accordingly, I am not persuaded that the Arbitrator erred in law in his finding that the Respondent was entitled to a special award.**

Similarly, by reference to FSCO arbitration decisions speaking to lump sum special awards, the Director's Delegate refused to disturb the arbitrator's finding as to the amount of the special award as a high-range percentage rather than a lump sum. The Director's Delegate found that, as an appeal officer, his role was not to "second guess" the arbitrator or fine-tune the special award as he might have viewed the evidence. On the basis that he was able to find comparable lump sum figures for special awards, he refused to find that the special award granted by the arbitrator was so excessive in furthering the goals of punishment and deterrence or so disproportionate to the facts of the case so as to constitute an error of law.

12) *Cowans v. Motors Insurance Corporation* (FSCO A09-003237, Arbitrator Wilson October 15, 2010)

In a further example of how special awards are being used to punish insurers for ordinary claims handling decisions, the arbitrator granted a special award of 40% of the outstanding benefits owing and interest based on the claimant's vulnerable financial position, which was reduced from 50% based on the insurer's reinstatement of a benefit and the claimant's counsel's lack of delivery of reports in a timely basis. Despite the lack of intention on the part of the insurer to withhold benefits, the arbitrator granted the award on the basis that the insurer unreasonably failed to sufficiently consider the claimant's medical evidence.

The hearing which gave rise to this arbitration decision also dealt with the issue of a special award only, as the parties had resolved all other issues before the arbitration. The

insurer had terminated income replacement benefits on the basis of a determination that the claimant did not meet the post-104 week test for entitlement to benefits, which the claimant argued constituted unreasonable conduct by the insurer.

In reprimanding the insurer for relying on the conclusions of its insurer's examination assessors, the arbitrator stated that the insurer's efforts of delegating the investigation, unsupervised, to what seems to have been an assessment mill, and merely reciting the summary of the assessment before terminating benefits, was not a "reasonable and competent investigation" on the part of the insurer. According to the arbitrator, the insurer's decision to terminate benefits was not only "wrong" but "unreasonable," and the finding of such an unreasonable withholding of benefits "automatically" attracted a special award. By virtue of his finding that the claimant was vulnerable as a result of financial distress, he ultimately found it suitable to make an award of 40% in light of the insurer's "egregious" withholding of benefits.

Compliance with SABS Forms

13) *Jetty v. ING Insurance Company of Canada*, (FSCO Appeal P08-00012, Director's Delegate Blackman, October 10, 2008)

In this case, the arbitrator refused to uphold a settlement effected between the parties where the insurer's lawyer signed the Settlement Disclosure Notice – a form mandated for use by FSCO.

In this case, the parties entered into a settlement at a FSCO mediation. The insurer's counsel subsequently forwarded a document that is required to be provided by the insurer to the claimant, a Settlement Disclosure Notice, which had an electronic signature by the insurer's lawyer on it as opposed to a true signature by a representative of the insurer.

The Director's Delegate upheld the arbitrator's decision that the insurer did not comply with s. 9.1(2) of the SABS Settlement Regulation regarding a signed Settlement Disclosure Notice, nor with s. 9.1(3)2 regarding a description of benefits under the *SABS*. As a result, he found that the claimant was entitled to rescind the settlement after the two-business day period set out in s. 9.1(4).

14) *Huynh v. Allstate Insurance Company of Canada* (FSCO A98-001309, Arbitrator Killoran, November 21, 2000)

Conversely, where the claimant filed the wrong FSCO form and did not file the appropriate and up-to-date FSCO form until after the applicable limitation period had expired, the arbitrator allowed the claimant to proceed to arbitration anyway. This demonstrates an internal inconsistency when it comes to rendering arbitration decisions

which deal with the issue of whether a party has properly complied with the forms mandated to be used by FSCO.

This preliminary issue hearing dealt with whether the claimant was precluded from commencing arbitration because the proper FSCO form was not filed within two years after the insurer's refusal to pay benefits. The claimant had counsel at the FSCO mediation, who reportedly did not act for the claimant thereafter. An Application for Arbitration was filed on behalf of the claimant within the two-year limitation period, but it was completed on an older form that had been replaced by FSCO. As such, it could not be processed. Through an error made by FSCO's administrative staff, the claimant was not contacted about the defect in the form.

Based on the reasoning that the claimant had no opportunity to remedy the defect before the limitation period expired, the arbitrator found that the claimant was entitled to proceed to arbitration, despite not having filed the proper form on time.

Production Issues

15) *Certas Direct Insurance v. Gonsalves*, 2011 CarswellOnt 6643 (Div. Ct.)

Although this dispute called for adjudication on competing views over whether certain treatment was "reasonable and necessary," the Director's Delegate forced the insurer to arbitration without an opportunity to respond to the claimant's evidence, which was served hastily before the hearing commencement date. This amounted to substituting his own discretion for the arbitrator's and allowing for a "trial by ambush," which violates the fundamental tenets of basic procedural fairness.

This decision, released in July 2011, involved a situation where the claimant's counsel served two orthopaedic opinions concluding that she qualified for non-earner benefits under the *SABS* one month before the arbitration hearing was to commence. Certas requested an adjournment and an Order that the claimant attend an insurer's examination pursuant to the *SABS*, which was granted by the arbitrator. The claimant refused to attend the insurer's examination and appealed to the Director's Delegate, who overturned the arbitrator's decision. Certas then applied to the Divisional Court for judicial review.

In finding that the Director's Delegate's decision constituted an error of law, the Divisional Court held that such a decision was unreasonable and could not stand. If the arbitration were allowed to proceed without an insurer's orthopaedic examination, the insurer would be denied the fundamental right to make a full response, which is contrary to the requirements of basic procedural fairness. According to the Divisional Court, to hold otherwise would be to allow for a "trial by ambush."

By finding that the arbitrator erred in law in not applying a consideration of extraordinary circumstances or an unavoidable delay, the Divisional Court held that the Director's Delegate unreasonably fettered the discretion of the arbitrator by requiring these considerations as conditions precedent to the adjournment. According to the Court, the Director's Delegate essentially heard the matter de novo and substituted his own discretion for that of the arbitrator. As such, the Court found it appropriate to allow the insurer's application and hold that the arbitration proceed on its merits after the claimant attends the insurer's examination.

16) *Uka v. Aviva Canada Inc.* (FSCO Appeal P08-00036, Director's Delegate Evans, July 16, 2009)

In this case, the arbitrator ordered that an insurer's reserve amounts were producible under fairly routine circumstances. Despite many court decisions that say otherwise, the arbitrator used a very broad and far-reaching test of relevance, which was criticized by the Director's Delegate.

Following a hearing on the preliminary issue of whether Aviva was required to disclose to the claimant information regarding the setting of its reserve amounts in respect of Mr. Uka's claim for accident benefits, the arbitrator ordered that it was. In the order, the arbitrator did not include any time limits restricting the breadth of the reserve amounts to be produced. The arbitrator took the position that reserve information is relevant regarding the insurer's investigation and assessment of a claim, and therefore should be produced.

Prior to making her order, the arbitrator applied a very broad test of relevance: that is, whether there was a "reasonable possibility" that reserve information was relevant.

The Director's Delegate pointed to a number of court decisions which found otherwise, and take the position that evidence about reserves does not have a semblance of relevance except in rare and exceptional circumstances (e.g., *Osborne v. Non-Marine Underwriters, Lloyd's of London*, 2003 CanLII 7000, 68 O.R. (3d) 770, Sup. Ct. J.). The Director's Delegate saw no reason why arbitration decisions should differ from Court decisions with respect to the production of reserve information. He ultimately found that the arbitrator erred in law, and refused to allow the arbitrator's order to stand.

17) *Vaitheeswaran v. State Farm Mutual Automobile Insurance Company* (FSCO A09-002295, Arbitrator Murray, July 26, 2010)

The rules on the production of an insurer's file are generally that it must be produced up until the date that the Application for Mediation is filed. Yet in this case, the arbitrator took it upon herself to extend the production date until the date of the outgoing letter from FSCO to the insurer notifying it of the Application, which was significantly delayed. This is an example of FSCO arbitrators finding a way to circumvent FSCO's internal deficiencies, which in turn has a significant impact on the insurer.

This decision arose from the preliminary issue of whether the insurer is required to produce its file beyond the date of the Application for Mediation to the claimant. The arbitrator found that litigation privilege attached to the insurer's file on the date that the insurer received FSCO's letter notifying it of the Application for Mediation. There was nearly a three month gap between FSCO's date stamp on the Application and the date of the letter from FSCO notifying the insurer of the application.

The arbitrator held that production of the insurer's entire file was relevant to the date of FSCO's notification letter, even though the only issue at arbitration was the claimant's entitlement to housekeeping and home maintenance benefits.

Despite the significant delay by FSCO in notifying the insurer, the arbitrator found that the insurer did not anticipate litigation until it received notice from FSCO that the applicant applied for mediation. Following the insurer's receipt of the Application for Mediation, the documents in the insurer's file had the dual purpose of settlement and defence/litigation. The arbitrator's justification for her departure from previous FSCO arbitration decisions that privilege commenced on the date of the Application for Mediation was based on the distinguishing feature that there was significant delay by FSCO to notify the insurer of the claimant's Application for mediation.

Settlements/Assignments

18) *D'Ettorre v. Coachman Insurance Company* (FSCO Appeal P09-00029, Director's Delegate Evans, July 28, 2010)

The law on assignments for third party tort actions is clear that Court Orders can only ban them when some sort of a trial or assessment of damages has taken place. Although there was a Court Order made on consent only, the FSCO arbitrator refused to allow Coachman's motion to prevent the assignee of the claimant's SABS benefits from bringing the proceeding in the claimant's name. As the Director's Delegate noted, the arbitrator also erred in finding that the motion constituted a collateral attack on the Court's decision.

This case involved a claimant who assigned his *SABS* claims against Coachman to Nordic Insurance in settlement of his third party tort action against Nordic's insured. Nordic pursued arbitration in the claimant's name against Coachman pursuant to the assignment. Coachman brought a motion to prevent Nordic from proceeding in the insured's name, which was dismissed by the FSCO arbitrator.

On appeal, the Director's Delegate overturned the arbitrator's decision on the basis that the arbitrator erred in finding that a consent Order was a general ban on assignments since it was a Court Order, given that no trial on the assessment of damages had even taken place. He also disagreed with the arbitrator's finding that Coachman's motion

constituted a collateral attack on the Court's decision, and concluded that Nordic was precluded from proceeding in the claimant's name.

19) *Klimitz v. Allstate Insurance Co. of Canada* (FSCO Appeal, Director's Delegate Evans, March 16, 2010)

In response to the claimant's allegations that a settlement had been effected with the insurer at a FSCO mediation, the arbitrator improperly placed the onus on the insurer to prove that a settlement had not occurred, rather than on the claimant to prove that a settlement had occurred. The arbitrator also specifically ignored evidence in support of the insurer's position that nothing had been done to enforce the alleged settlement, and placed undue weight to the claimant's allegation that an offer had been made by an insurer, which had the effect of prejudicing the insurer's position.

The Director's Delegate in this case rescinded an arbitrator's decision to enforce a settlement between the insurer and the claimant following a report of mediator which recorded an offer to settle of $0, and an alleged unrecorded offer to settle of $17,000. According to the Director's Delegate, the arbitrator unjustifiably reversed the onus of the claimant to prove that a settlement had taken place, and gave weight to evidence that either should have been ignored or given little weight. The arbitrator also completely ignored other crucial evidence, such as the fact that nothing was done to enforce the settlement.

The Director's Delegate also found that, in addition to the difficulty in the arbitrator's logic, the arbitrator's position was contrary to other case law at FSCO (e.g., *Mouriopoulos and Citadel General Insurance Company*, (OIC A-002166, March 23, 1993). He found that the arbitrators should have considered evidence prior to the pre-hearing in determining whether there was indeed a settlement, and by going beyond her discretion to simply give insufficient weight to evidence to giving no weight to important evidence, which the Director's Delegate determined to be an error of law.

Policy Cancellation

20) *Walker v. Aviva Canada Inc.*, (FSCO A09-001079, Arbitrator Richards, February 28, 2011)

The *Insurance Act* and Statutory Conditions provide for strict rules allowing an insurer to unilaterally terminate a contract of automobile insurance in limited circumstances, including non-payment of premium. Despite the insurer's actions in following these rules in strict accordance with the statutory provisions, the arbitrator found that the policy cancellation was not valid because the insurer could not prove that the claimant had "actual knowledge" of the termination. "Actual knowledge" is not required by the statutory provisions, and this ruling appears to be contrary to case law established from

the highest court in Canada as well as decades of approved practice and procedure in the insurance business.

This case dealt with the issue of proper notice of cancellation of a claimant's automobile insurance policy. The fact scenario was that the claimant purchased insurance and authorized automatic withdrawals so as to correspond with her ODSP payments, and subsequently left the country with her children, leaving her eldest son in charge of her affairs. When the insurer attempted to withdraw the first payment, it was returned "NSF." The insurer sent a termination letter by registered mail, which was marked "unclaimed" and returned. When the claimant subsequently reported a claim under the *SABS*, the insurer denied it on the basis that the policy had been cancelled.

In determining whether the cancellation was valid, the arbitrator held that an insurer has a duty to ensure that the insured had "actual knowledge" of the termination. However, the arbitrator failed to refer to any case law in support of his decision, nor did he refer to the applicable Statutory Conditions under Ontario Regulation 777/93 to the *Insurance Act*, R.S.O. 1990, c. I.8. Given that the insurer was unable to prove that the claimant had "actual notice" of the termination, the arbitration found that the claimant had "no reason to believe that she was driving without insurance."

The arbitrator's decision is contrary to case law from the Supreme Court of Canada and other levels, which has held that it is well-established law that the insurer is only required to establish that a cancellation notice was sent by registered mail to the post office associated with the claimant's address recorded on the policy. This requirement also adheres to the applicable Statutory Conditions (seem for e.g., *Lumbermen's Mutual Casualty Co. v. Stone* [1955] S.C.R. 627 and *Masters v. Mohammed* (2007 CarswellOnt 9546, Sup. Ct. J.), and many years of what has been the approved practice and procedure in the insurance industry.

Workplace Accidents

21) *Balendra v. Security National Insurance Co.* (FSCO Appeal P10-00011, Director's Delegate Evans, September 2, 2011)

After being injured as a result of a workplace accident, the claimant applied to WSIB for benefits, and then also applied to his automobile insurer for SABs on the same basis. Despite the general legal principle that a claimant is not entitled to bring multiple proceedings in respect of the same issue, the arbitrator held on a preliminary issue hearing that the claimant was not prevented from doing so. The decision was overturned by the Director's Delegate as a "patent absurdity."

The claimant was working as a parking lot attendant when a car hit his booth. He applied for workers' compensation benefits. After doing some investigation, the WSIB denied his claim on the basis that he had no medical documentation showing that he sustained a

personal injury as a result of the accident. He also applied for SABs from his automobile insurer, who denied the claim for the reason that it was not obliged to pay benefits where the claimant is entitled to receive WSIB benefits pursuant to s. 59(1) of the *SABS*.

The arbitrator found that the WSIB's letter to the claimant denying benefits for his failure to submit sufficient medical documentation to prove a personal injury was a "final appealable order" denying his entitlement to WSIB benefits. As the Director's Delegate pointed out, had the claimant turned to FSCO after failing to prove an impairment in the court system, his arbitration proceeding at FSCO would have been immediately dismissed. Unlike the arbitrator, he saw no reason for why this case should be treated any differently.

Given that the claimant commenced multiple proceedings without an explanation, and then having failed to prove his claimed before the WSIB, the Director's Delegate refused to allow the arbitrator's order allowing him to seek SABs at FSCO to stand. Although the risk of inconsistent results is a fundamental criteria in refusing to allow for multiple proceedings, the arbitrator was prepared to allow the claimant to proceed to arbitration at FSCO anyway.

Deductibility of Collateral Benefit Payments

22) *Scott v. State Farm Mutual Automobile Insurance Company* (FSCO A01-001288, Arbitrator Muir, May 15, 2003)

The arbitrator refused to allow the insurer to deduct payments received under a pension obtained through her employer by the claimant from income replacement benefits it was paying to her under the *SABS*, despite the fact that it otherwise met the test for a temporary disability plan or an income continuation plan as required by the *SABS*.

In this case, the claimant began to receive a disability pension plan entitled "Hospitals of Ontario Pension Plan" (HOOPP) in June 2000. The pension was calculated on the projected weeks of contributory service the claimant would have accumulated to age 65 (or 35 years of service) had she not become disabled from working, subject to a maximum established by Revenue Canada. The plan also provided for death benefits in the form of a lump sum payment to a beneficiary if there was no spouse.

The claimant's position was that the plan was akin to a CPP disability pension and was not deductible from income replacement benefits. The insurer took the position that it was more akin to a temporary disability plan or an income replacement plan, and that it was therefore deductible from the claimant's income replacement benefits pursuant to the requirements of the *SABS*.

The basis of the arbitrator's reasoning for refusing to allow the insurer to deduct the payments received by the claimant under her pension plan was that the claimant opted to pay into the pension plan, and that she did not have to show economic loss in order to

demonstrate entitlement to the benefits. She paid a portion of the premium, while the remainder was paid by her employer. The arbitrator found that it was not as clearly tied to her employment as it was to disability.

23) *Lee v. Certas Direct Insurance Company* (FSCO A03-00004, Arbitrator Alves, June 15, 2006)

Similar to the above decision, the arbitrator found that the amount received by the claimant for payments made to her under a disability policy for the same accident was not deductible from income replacement benefits paid to her under the *SABS*, by requiring that no waiting periods must be present in order for payments from collateral benefits to constitute benefits from income continuation plans. This decision has been subject of judicial criticism by the Superior Court.

The claimant was injured after she slipped and fell on some icy steps of a bus. Her automobile insurer paid her income replacement benefits pursuant to the SABS up to the 104-week mark, but deducted $72,000, the amount she received under a disability insurance policy with Independent Order of Foresters.

Her insurer took the position that it was entitled to deduct the disability plan benefits under s. 7(1)1.i of the *SABS* as "net weekly payments for loss of income that are being received by the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan," which the claimant disagreed with.

The arbitrator found that because there was no stated intent to pay income security for loss of wages or any indication that the amount of the benefit was designed to follow the claimant's pay at the time of her disability, it was not deductible under the *SABS*. The arbitrator found that, because of a four month gap between the onset of her disability and when the pension plan benefit began, the policy was likely a "financial cushion" which the claimant arranged for herself in the event of disability which lasted for longer than five months, rather than a policy tied to her earnings.

The arbitrator also reasoned that because the disability plan provided for the payment of monthly benefits, rather than weekly benefits, the insurer was not entitled to deduct them under s. 7(1)1.i of the *SABS*.

The arbitrator's reasoning in this decision was specifically criticized by the Superior Court in the 2009 decision of *State Farm v. Ramalingam*, given that it had the effect of allowing the claimant to "double dip" for both income replacement benefits and benefits she received from a disability or income continuation plan.

24) *Codling-Mokoena v. CAA Insurance Company* (FSCO 04-000017, October 17, 2006, Arbitrator Leitch)

The arbitrator in this case went one step further than the arbitrator in *Lee* by holding that a collateral benefits policy with a short waiting period meant that the policy was not an income continuation plan, and could not be deducted from income replacement benefits as provided for by the *SABS*. Similar to the arbitrator's decision in *Lee*, this decision has been the subject of criticism by subsequent Court decisions.

The question to be decided by the arbitrator at a preliminary issue hearing was whether the claimant's entitlement to income replacement benefits ought to be reduced by her receipt of benefits under a disability insurance policy she purchased before the accident from Crown Life Insurance Company. If the Crown Life policy constituted an "income benefit continuation plan" in accordance with the definition mandated by the *SABS*, such benefits would be deductible from the claimant's income replacement benefits.

The policy purchased by the claimant prior to the accident from Crown Life was called a "dignity disability income policy," with the stated purpose of paying the monthly income benefit upon due proof of the total disability of the insured. The policy provided that she would receive the monthly income benefit for a two-year period, even if, during that period, her disability only prevented her from performing her pre-disability occupation as opposed any other gainful occupation. The policy also provided that the monthly benefits were payable after a 60 day waiting period.

According to the arbitrator, the 60 day waiting period removed payments under the policy from the ordinary meaning of an "income continuation plan," and as a result, were not deductible from the claimant's income replacement benefits under the *SABS*. His reasoning for this was that a claimant who receives no collateral benefits for a 60 day period has plainly not had his or her income continued during that period, and may suffer serious financial consequences as a result.

In essence, the arbitrator imposed a requirement of an unbroken stream of income, despite the fact that continuation includes the idea of stopping and starting again, which applies equally to the payment of benefits.