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CDL Accident Benefits Newsletter

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Editor in Chief, CDL Accident Benefits Committee

It is a daunting task to select recent decisions that may be of interest to accident benefit practitioners and our readers and this time around is no exception. The following is a brief glimpse into the world of accident benefits since our last edition. A recent case once again reviews a limitation concern that arises with the denial of benefits and a subsequent claim for catastrophic impairment in the area of accident benefits. On judicial review, it would appear that the two year limitation period in the *Insurance Act* is finite. In a rare decision, the License Appeals Tribunal (LAT) agreed with the insurer's finding of exclusion for coverage in considering whether a dirt bike was involved in an accident. If you've ever wondered whether dependency for care encompasses emotional support, there is now further clarification. In a case regarding dependency for care, being principally dependent for care on another for social and emotional support is key. Is a "chronic pain syndrome" sufficient to overcome the minor injury guideline? In a minor injury case, there must be clear objective evidence of a chronic pain diagnosis and a pre-existing condition must be proven to have effect on the claimant's condition. If you have ever wondered whether the two day cooling off period following the signing of a Release and Settlement Disclosure ends at the close of the business day--there is now precedent for the same. As we head into the holiday season, we look back at the year in review. As many practitioners know, 2018 was been busier than ever. With over 800 published decisions from the LAT, more completed hearings not yet released, delays in obtaining a case conference date, motions and preliminary issue hearings and other administrative issues, there are signs that the system is at full if not over capacity. Looking ahead we continue to defend various disputes in accident benefits with no signs of slowing down. Happy Holidays and Drive Safe!

Accident Benefits: The SABS Limitation Period is a Hard Limit

Lisa Armstrong & Shalini Thomas
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The Applicant, Sotira Tomec, sought judicial review of the decision of the Licence Appeal Tribunal in *S.T. v. Economical Mutual Insurance Company*, 2018 CanLII 61170 (ON LAT).

Ms. Tomec was involved in a pedestrian-motor vehicle accident on September 12, 2008. Economical paid attendant care benefits and housekeeping benefits up to the 104-week mark, at which point Economical sent her a letter and Explanation of Benefits, both dated August 26, 2010, containing a refusal to pay further attendant care benefits and housekeeping benefits beyond September 12, 2010. The Explanation of Benefits contained language regarding the dispute resolution process and a warning of the two-year limitation

period to dispute the refusal to pay further benefits. Ms. Tomec did not dispute the refusal to pay further attendant care benefits and housekeeping benefits until more than six years later, on September 20, 2016. In the interim, Ms. Tomec submitted an Application for Determination of Catastrophic Impairment, dated May 13, 2015 and via letter dated November 4, 2015, Economical deemed her catastrophically impaired.

At the Licence Appeal Tribunal, Ms. Tomec argued that the limitation period should not start to run before she was deemed catastrophically impaired, which was when she discovered she had a claim.

In response, Economical argued that the limitation period contemplated by the SABS and the *Insurance Act*, R.S.O. 1990, c. I.8 is triggered by the insurer's refusal to pay a benefit such that the doctrine of discoverability is not applicable to SABS disputes. Economical relied upon the decision of *Kirkham v. State Farm*, [1998] O.J. No. 6459 (leave to appeal refused) in which the Divisional Court adopted the reasons of FSCO's Director's Delegate, David R. Draper.

In the FSCO Appeal Decision, Delegate Draper noted that prior to the 1990 amendments of the *Act*, the no-fault benefit provisions were contained in a Schedule to the *Act,* which required an insured to commence an action or proceeding against the insurer "within one year from the date on which the cause of action arose and not afterwards."

The *Insurance Act* was then substantially amended in 1990, enhancing the role of statutory accident benefits and establishing a dispute resolution system, which required an insured to commence a dispute "within two years from the insurer's refusal to pay the benefit claimed". Delegate Draper noted that the Legislature's amendment clearly established a new triggering event for the SABS limitation period, marking a clear shift away from the cause of action approach. In agreeing with Delegate Draper, the Divisional Court in *Kirkham* found that the SABS limitation provision was precise and unambiguous.

The Tribunal's Vice-Chair followed the decision in *Kirkham,* finding that the principle of discoverability does not apply to accident benefits such that Ms. Tomec was statute barred from proceeding with her claim for attendant care benefits and housekeeping benefits as Economical issued a clear and unequivocal denial of both benefits.

The Divisional Court considered the appropriate standard of review of the Tribunal's decision, noting that the question of whether the discoverability principle applies is a general question of law that goes beyond the expertise of the Tribunal and is a question that must be answered uniformly for all adjudicators deciding cases under the *Insurance Act*. However, ultimately, the Court found that it was unnecessary to come to a definitive conclusion on the applicable standard of review since there was no error, even on a correctness standard.

After considering its own decision in *Kirkham v. State Farm* and the Ontario Court of Appeal's decisions in *Levesque v. Crampton Estate*, 2017 ONCA 455, *Haldenby v. Dominion,* 55 O.R. (3d) 470*, Turner v. State Farm*, (2005) 195 OAC 61 and *Sietzema v. Economical*, 2014 ONCA 111*,* the Divisional Court held:

as found by the Tribunal, the insurer had clearly and unequivocally refused to pay those expenses as of September 12, 2010. Pursuant to the clear words of the limitation period, which ties it to a period of two years after the insurer's refusal to pay the benefit claimed, the claim is time barred."

The Divisional Court confirmed that the limitation period set out in the *Insurance Act* and the SABS fall within the category of "hard" limitations periods, which are triggered by a fixed and known event, as opposed to the day a claim was discovered.

The Divisional Court noted that although it may be considered harsh, there are important policy considerations on both sides:

In the case of the *Insurance Act*, and claims under the SABS, an insurer has no control over when an insured applies for a designation of catastrophic impairment. An insurer would not continually assess a claimant if ongoing expenses are not being submitted. Presumably, the legislature thought it important to provide for a reasonable period, after which an insurer's obligation would be discharged, whether or not meritorious claims may be discovered later.

Leave is being sought to the Court of Appeal.

The Boa Constricts

Michelle Friedman, AB Committee, & Danielle Wilkinson
Aviva Trial Lawyers

In the previous article, we noted the increasingly elastic nature of the arbitral treatment of the definition of an "accident" under the *Statutory Accident Benefits Schedule*. Since that time, two decisions have come out from the LAT suggesting that the boa is constricting once more.

Both decisions narrowly interpret coverage; the Tribunal engaged in statutory interpretation, resolving in favour of the Insurer's interpretation of the legislation.

In the 2018 case of *M.B. v*. *Travellers1*, the applicant was injured driving an off-road vehicle (dirt bike), at a closed course competition sanctioned by Canadian Motorsport Racing Corporation and sponsored by Rockstar Energy Drink.

Travellers denied the applicant's claim for accident benefits on the basis that he was not involved in an "accident" as the vehicle was not an "automobile".

Adjudicator Kowal applied the burden of proof analysis set out in the SCC case of *Ledcor Construction Ltd.* v. *Northbridge Indemnity Insurance Co.*2 as follows:

- Phase I: Onus rests with the applicant in the interpretive phase of establishing coverage
- Phase II: Onus rests with the Respondent in establishing an exclusion
- Phase III: Onus rests with the applicant in establishing the exception to the exclusion

During Phase 1 the applicant must establish coverage under a contract of insurance. He must prove he was involved in an "accident" and that the vehicle is an "automobile". Adjudicator Kowal relied on the test in *Adams v. Pineland Amusements Ltd* 3 to define "automobile". Both parties agreed that the third element of the test was the only applicable question, i.e. does the vehicle fall within any enlarged definition of an "automobile" in any relevant statute?

The Tribunal's decision rested on whether the dirt bike was an automobile required to be insured under any act in section 224(1) of the *Insurance Act,* or if the dirt bike was exempt from mandatory coverage pursuant to section 2(1) of O.Reg.863, a regulation of the *Off-Road Vehicles Act.*

Section 2(1) of O.Reg. 863 designates classes of vehicles exempt from the requirement of

insurance including “off road-vehicles driven or exhibited at a closed course competition or rally sponsored by a motorcycle association”.

The Tribunal was asked to consider two alternative interpretations of section 2(1):

> “Off road-vehicles driven or exhibited at a closed course competition or rally sponsored by a motorcycle association” (i.e.: both closed course competitions and rallies have to be sponsored by a motorcycle association to be exempt from insurance); or
>
> “Off road-vehicles driven or exhibited at a closed course competition **or** rally sponsored by a motorcycle association” (i.e.: closed course competitions are exempt and rallies sponsored by motorcycle associations are also exempt.)

The parties agreed that the Applicant was driving in a closed course competition. They also agreed that it was not sponsored by a motorcycle association.

The Respondent argued that the requirement of sponsorship by a motorcycle association applied only to rallies and not to closed course competitions. The Tribunal accepted the Respondent’s submission that the “Last Antecedent Rule” of statutory interpretation applies: when no comma is present, a qualifying clause only applies to the last antecedent – “sponsored by a motorcycle association” applies only to rallies.

The Tribunal underscored that the purpose and intent of the *ORVA* is to protect the public when off-road vehicles are driven on land that the owner does not occupy and to allow vehicles to remain uninsured if they are being driven on the owner’s land, which would not pose a risk to the public. An exemption from insurance for a closed-course competition is consistent with the purpose and intent of the legislation. Moreover, risks are controlled with rallies sponsored by motorcycle associations and an exemption of insurance in this situation is also consistent with the purpose and intent of the legislation.

Adjudicator Kowal found that the Applicant was not involved in an “accident” as defined by the *Schedule* because he was not driving a vehicle that meets the definition of an “automobile”. The dirt bike was exempt from the requirement of insurance pursuant to s.2(1) of O.Reg. 863 as he was driving an off-road vehicle at a closed-course competition.

In the second recent LAT decision of *OM v. Aviva Insurance Company4*, the Tribunal undertook a contextual and purposive approach to interpret the exclusionary provisions of coverage under s.268(1.1) of the *Insurance Act*.

Subsection 268(1.1), known as the “no crash no claim” provision, excludes coverage for Accident Benefits from those injured while occupants of a public transit vehicle that does not collide with another automobile or object. “Special purpose facilities for persons with disabilities” are excluded from this exemption under s.224(1) of the *IA.*

O.M. was disabled pre-accident: she used a walker, lost vision in one eye, suffered from COPD, emphysema and a knee injury. On the date of loss O.M. was injured from a fall while trying to find a priority seat on a public bus. Aviva denied coverage under subsection 268(1.1). O.M. claimed that she was not excluded from coverage by virtue of the exemption of “special purpose facilities for persons with disabilities” under s.224(1).
The Tribunal agreed with the submissions of Aviva’s counsel, Andy Smith, that “special purpose facilities” required a special service to be provided to persons with a disability.

The Tribunal did not exclude the possibility that “special purpose facilities” could apply to all or just part of a vehicle, but that priority seating on a public bus is not a special service offered to persons with disabilities: all riders pay the same fare and have access to priority seating.

The Tribunal distinguished priority seating from services such as Wheel Trans or DARTS in

Hamilton which place extra requirements on the driver, such as ensuring that riders are secure. Regular transit operators do not have this kind of obligation because priority seating is available to anyone who uses the transit and disabilities are not always apparent by simply looking at a person. The Tribunal found that it was outside the intention of the legislature to place this obligation on all public transit operators.

As a result, Aviva's denial of coverage on the basis of s.268(1.1) was successfully upheld. The License Appeal Tribunal's interpretation of an "accident" in these two recent cases has narrowed coverage in these circumstances. However, it remains to be seen how the Executive Chair will interpret these provisions if either matter is reconsidered.

Applicant v Aviva: Dependency for Care

Shelby Chung, Dutton Brock LLP
AB Committee

In *Applicant and Aviva Insurance Company*, 2018 CanLII 110955 (ON LAT), the Applicant's 48 year old adult child, D.H., was involved in a motor vehicle accident on October 31, 2014, when he was struck as a pedestrian while crossing the road, resulting in a fractured leg. He suffered surgical complications due to his diabetes, resulting in death from his injuries two months post-accident. The Applicant applied for a death benefit under the *Schedule* which was denied by the insurer.

As a preliminary issue, Adjudicator Norris allowed the hybrid (written and teleconference) hearing to proceed where the Applicant failed to submit any initial written submissions and only replied to the insurer's responding submissions, and accepted that the Applicant did not rely on any documents disclosed after the cut-off date and distinguishing the case from *K.K. and Unifund Assurance Company* (2018 CanLII 13159, (ON LAT)) which dealt with written submissions only.

The main issue in dispute was whether the deceased, D.H. was dependent upon the Applicant at the time of the accident. While D.H. had been diagnosed as mentally disabled since approximately four years of age, he was living independently from the Applicant at the time of the accident.

The Applicant took the position that D.H. was principally dependent for care on the Applicant, and the support and services provided by others providers was arranged for and coordinated by the Applicant.

Adjudicator Norris referenced the analysis in *Miller v. Safeco Insurance Co. of America* (1985 CanLII 2022, (Ont. C.A.) in his analysis which required him to look beyond the dependent's financial independence and to consider the ability to provide for one's own basic needs. Other factors referenced by Adjudicator Norris included, from *Intact and MVACF* (2012, www.densemadr.com):

- social and emotional support
- companionship
- protection
- and services such as feeding, clothing, cleaning, and transportation.

Adjudicator Norris also noted the two main factors considered in *Harris and Liberty Mutual Insurance Company* (1998, FSCO):

- the nature of the emotional and physical care provided; and,
- whether in fact the dependent was principally dependent on the applicant for care having regard to the amount and duration of the dependency for care, the needs of the claimant and the ability of the claimant to be self-supporting.

Adjudicator Norris concluded the Applicant was the principal provider of social and emotional support for D.H., noting that the Applicant regularly called D.H. on the telephone during the day, had helped D.H. set up residence in 1987, and set up and participated in the ongoing management of D.H.'s other forms of support through providers. While Adjudicator Norris accepted that service providers, such as Avenue II, provided support in the form of assistance with personal care and organized outings, he found that the evidence showed that the Applicant would help D.H. with household chores, teach him various routes in order for him to walk around and use public transit, monitor his diet, and help with clothing maintenance. Adjudicator Norris found the insurer's counter submissions showing examples of independence did not outweigh the evidence that the Applicant principally satisfied D.H.'s needs for care.

Having found that D.H. was principally dependent for care on the Applicant, Adjudicator Norris did not address financial dependency, and ordered the insurer pay the death benefit of $10,000 along with interest.

Condition vs. syndrome, it's in the terminology

Aly Pabani, Dutton Brock LLP

17-006571 v. TD Home & Auto Insurance Company, 2018 CanLII 115669 (ON LAT)
A recent case indicates that without further clarification or development by an assessor, a "chronic pain condition" is not equivalent to "chronic pain syndrome".

In *Applicant and TD Home & Auto Insurance Company*, the Applicant relied on the report of a chiropractor to argue that his impairments removed him from the MIG. The report outlined that "the applicant suffered serious depressive symptoms and PTSD as a result of the accident, in addition to suffering from a chronic pain condition". Adjudicator Derek Grant found that the physician did not define "chronic pain condition" or equate it to "chronic pain syndrome". In that regard the wording provides no guidance for the basis of the diagnosis or how this "condition" removes the Applicant from the MIG. The report was dismissed.

The Applicant also advanced an argument that he was not subject to the MIG on the basis that a right knee MRI revealed a "small effusion in the suprapatellar joint recess, a flap tear of the anterior horn lateral meniscus which is displaced and a thickening of proximal deep fibers compatible with prior sprain injury". The Applicant contended that the definition of a minor injury does not include a tear. Adjudicator Grant disagreed and held that a minor injury does not include a full tear injury, though a partial tear as is the case here, falls under the definition of a minor injury.

In addition, the Applicant advanced that his pre-existing condition was aggravated as a result of the accident and that this pre-existing condition placed him outside of the MIG. Adjudicator Grant disagreed and held that there is no indication of any worsening of the applicants pre-existing condition. We are reminded that the test to determine that a pre-existing condition removes and applicant from the MIG is that the pre-existing condition must be proven to impact the Applicants recovery time. Though a pre-accident MRI showed

mild degenerative changes, the results are in line with subsequent diagnostic images post-accident.

Ultimately the case is a noteworthy reminder there must be clear, objective evidence, obtained through diagnostic testing or other medical assessment that concludes a person suffers from chronic pain with a diagnosis of “chronic pain syndrome”. It further defines that a flap tear is partial in nature and does not remove an applicant from the MIG, while reminding us of the test for pre-existing medical conditions and MIG removals.

Two Day Cooling Off Period Ends at ?

Shirline Apiou, Dutton Brock LLP
Past-Chair, CDL AB Committee

In the recent LAT decision of *E.P.* and *Sovereign* (November 6, 2018, 17-004529/AABS), Adjudicator Mather considered whether the parties had reached a binding settlement in a preliminary issue hearing. In that case, the applicant was represented by counsel and signed a Release and Settlement Disclosure Notice at a resumption case conference. The applicant then rescinded the settlement by notice to her counsel and to insurer’s counsel after the close of the second business day. The insurer relied on the *Settlement Regulation*, O. Reg. 664 under the *Insurance Act*, R.S.O. 1990, C. I.8. The Applicant argued that she had until midnight on the second business day to rescind the settlement. Adjudicator Mather agreed with the insurer that the regulations made under the *Insurance Act* formed an integrated scheme. However, a business day is not defined under the Settlement Regulation and Adjudicator Mather found that a business day is 24 hours and accordingly the time period for rescission did not expire at the close of the business day on 5:00p.m. The Applicant was allowed to rescind the settlement agreement and to proceed to a hearing for a determination of benefits claimed on the LAT application.

What is the interplay between the **Personal Information Protection and Electronic Documents Act** (PIPEDA), the federal legislation privacy law for private-sector organizations and the insurer’s obligation to produce documentation requested by insureds in the area of statutory accident benefits? Stay tuned for more information and developments on these topics brought to you from Accident Benefits Committee and Canadian Defence Lawyers.

UPCOMING EVENTS

AB Committee Pub Night February 21, 2019
Location: Duke Of Cornwall, 400 University Ave. Toronto 5:30-7:30
Speaker: Devan Marr, Strigberger Brown Armstrong LLP
“New Trends and Issues in Accident Benefits Litigation”

ALL CDL Members Welcome! RSVP to maryellen@cdlawyers.org

Loss Transfer/Priority Disputes Feb 28, 2019 - 9 am **Register now!**
Chaired By: Dan Strigberger, Strigberger Brown Armstrong &
Ashleigh Leon, Miller Thomson

PAST EVENTS

Special Awards, CDL Audioconference, October 11, 2018
Audio recording available to access: **HERE**
Bill C-45: Impact on Insurance Issues, CDL Audioconference July 24, 2018
Audio recording available to access: **HERE**

The CDL AB Committee

The CDL AB Committee supports the Canadian Defence Lawyers and provides resources and continuing legal education in the area of accident benefits for defence lawyers and industry professionals.

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