Financial Services Commission of Ontario

Ontario

Commission des services financiers de l'Ontario

Appeal P14-00046

OFFICE OF THE DIRECTOR OF ARBITRATIONS

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Appellant

and

DAVID JAZEY

Respondent

BEFORE:	Delegate Lawrence Blackman
REPRESENTATIVES:	Mr. Robert S. Franklin, Ms. Victoria Anteby and Mr. Jonathan Schrieder for the Appellant, State Farm Mutual Automobile Insurance Company Mr. James Virtue and Ms. Rasha M. el-Tawil for the Respondent, Mr. David Jazey
HEARING DATE:	November 11, 2015 and June 16, 2016

APPEAL ORDER

Under section 283 of *Insurance Act*, R.S.O. 1990, c.I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Regulation 664, R.R.O. 1990, as amended, it is ordered:

1. Paragraphs 1, 2(a), (b) and (c), 3 and 4 of the Arbitrator's December 9, 2014 Order are confirmed.

2. Paragraph 2(d) of the Arbitrator's December 9, 2014 Order is rescinded. It is replaced by a new order that the Appellant shall pay the Respondent $30,090.49 for occupational therapy and ergonomic equipment, including HST.

3. The stays ordered in my March 24, 2015 Preliminary Issue Appeal Decision are lifted.

4. The Appellant shall pay the Respondent, David Jazey, his arbitration legal expenses fixed in the amount of $95,633.79, inclusive of all fees, disbursements and taxes.

5. The Appellant shall pay the Respondent his legal expenses of this appeal fixed in the amount of $24,179.67, inclusive of all fees, disbursements and taxes.

Lawrence Blackman
Director's Delegate

July 29, 2016
Date

REASONS FOR DECISION

I. BACKGROUND AND NATURE OF THE APPEAL

The Respondent, Mr. David Jazey, was injured in a September 9, 2008 motor vehicle accident. As a result, he applied to the Appellant, State Farm Mutual Automobile Insurance Company, his first-party insurer, for statutory automobile accident benefits under the *1996 Schedule.*[1]

The parties disagreed on the Respondent's entitlement to benefits payable under the *1996 Schedule*. Mediation held December 6, 2012 failed to resolve these disputes. The Respondent filed for arbitration on January 30, 2013. A four-day arbitration was held before Arbitrator Henry of ADR Chambers (the "Arbitrator") in June 2014, followed by written and oral submissions. The Arbitrator's December 9, 2014 decision held that the Respondent was entitled to:

1. Attendant care benefits of $4,027.21 for the period October 20 to December 31, 2009.

2. Medical and rehabilitation benefits of:

   (a) $15,931.90 for the purchase and installation of a hot tub under a January 24, 2011 OCF-18 prepared by Ms. E. Fox;
   (b) $1,500.64 and ongoing incurred sums for massage therapy under a February 14, 2012 OCF-18 prepared by Ms. A. Buffone, subject to a deduction for Mr. Jazey's wife's workplace extended heath benefit plan;
   (c) $1,008.70 for the balance for psychological counseling under a November 30, 2011 OCF-18 prepared by Dr. J. McKillop; and,
   (d)) $38,176.10 for occupational therapy treatment and the current cost of ergonomic equipment under a May 26, 2011 OCF-18 prepared by Ms. N. Gowan, OT.

3. Interest under subsection 46(2) of the *1996 Schedule*.

4. A special award of $32,852.07 under subsection 282(10) of the *Insurance Act*.

5. His arbitration legal expenses.

[1] *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996,* Ontario Regulation 403/96, as amended.

The December 23, 2014 Notice of Appeal appealed all of the Arbitrator's orders. The Appellant further sought, under subsection 283(6) of the *Insurance Act*, a stay of the Arbitrator's Order. My March 24, 2015 Preliminary Appeal Decision, for the reasons provided:

1. Stayed, pending resolution of the appeal, payment under the Arbitrator's order of (a) $15,931.90 for the hot tub, (b) $11,547.35 of the ergonomic equipment cost, and (c) the $32,852.07 special award.

2. Ordered the balance of the Arbitrator's Order paid forthwith.

2. Deferred the question of the legal expenses of this preliminary appeal decision to the conclusion of the appeal.

At the November 11, 2015 oral appeal hearing, the Appellant proposed that should I find that any of the Arbitrator's findings required a new determination, that I make that determination or determinations. I noted *Personal Insurance Company v. Hoang*, 2014 ONSC 81 (CanLII), a judicial review decision of a FSCO appeal decision, where the Divisional Court held:

> Having determined that the Delegate's decision to uphold the grant of a special award was reasonable, I turn now to the Delegate's decision to refer the issue of quantum of that award to arbitration. Counsel for both the Applicant and the Respondents urged the court to fix the quantum of the special award if this court upheld the grant of the special award. The court was advised at the hearing that the original arbitrator has retired and all aspects of Christopher's tort claim have been determined by a court. Thus, another arbitration before a different arbitrator would unduly prolong the proceeding and add considerable expense.
>
> The court has been provided with the complete appeal record that was before the Delegate as well as the transcripts of the hearing before the arbitrator. Given the unusual circumstances of this case and the fact that both counsel wish this court to determine the amount of the special award, I agree that we should do so.

The Respondent's November 17, 2015 letter agreed with the Appellant that should I decide or direct one or more issues on appeal be returned to an arbitrator for re-hearing, that I make that decision or decisions "rather than start afresh at the arbitration level."

I am agreeable to the parties' joint request for the following reasons:

1. As in *Hoang*, the request is on consent.

2. It is now more than three years since mediation failed, more than four years from the initial October 27, 2011 Application for Mediation. Some issues have been in dispute for more than six years. As in *Hoang*, to send the matter back to arbitration would unduly prolong the proceeding and add considerable expense.

3. The arbitration hearing was transcribed. The transcripts have been filed, including oral argument. The Appellant did not call any witnesses. The documentary evidence is before me as well as extensive arbitration written submissions. I am, therefore, at less of a disadvantage from an adjudicator at first instance.

4. One downside to making first-level decisions at the appellant level is that to do so is to deny the parties a level of appeal. However, both parties consent to this process. Further, this level of appeal is being abolished. Should the matter be referred back to arbitration, once a further decision is issued at first instance, an internal appeal process may no longer exist.

5. In conclusion, as in *Hoang*, there are unusual circumstances in this case that warrant the unusual step of having the redetermination at this stage.

I will now turn to an analysis of each of the Arbitrator's awards.

II. ANALYSIS

(1) Attendant Care

Paragraph 16(5)2(i) of the *1996 Schedule* provides:

> 2. If the accident occurred on or after October 1, 2003 and the optional medical, rehabilitation and attendant care benefit referred to in section 27 has not been purchased and does not apply to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,
>
> i. $3,000 per month, if the insured person did not sustain a catastrophic impairment as a result of the accident, or
> ii. $6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident.

The Appellant submits that the Arbitrator erred in awarding $4,027.21 in attendant care benefits for a two-month period for the following reasons, set out at paragraphs 7 to 9 of its February 18, 2015 written appeal submissions:

1. The Arbitrator improperly calculated the amount of attendant care. Only $3,217.21 should have been awarded on the basis that for non-catastrophic attendant care, paragraph 16(5)2i of the *1996 Schedule* requires the maximum allowed to be prorated to a daily maximum.

2. The Respondent failed to submit a Form 1 in a timely fashion (advising of his intention to apply 19 months after his surgery) without an explanation. The Arbitrator's failure to consider the Respondent's lack of compliance with subsection 39(1) of the *1996 Schedule* constitutes an error of law. Further, the Arbitrator "conflates" OCF-6s with Form 1s on page 10 of his decision.

3. The Respondent failed to provide sufficient evidence as to the specific frequency and duration of the attendant care services and provide supporting documentation as requested by the Appellant. Part 2 of the OCF-6 states "Attach all bills and receipts. If a bill or receipt is not available, please explain." The Arbitrator erred in finding that Ms. Gowan, O.T., had interviewed Ms. L. Bushan-Jazey, the Respondent's wife.

The Appellant's oral appeal submissions conceded it had no case law in support of its argument that prorating the monthly maximum was a reasonable interpretation of the legislation.

I am not persuaded by the Appellant's argument. Following *Sullivan and Driedger on the Construction of Statutes,* Fourth Edition (Markham Ontario, Butterworths, Canada Ltd. 2002), at page 383, I find that the *1996 Schedule* is remedial in the "obvious sense" to protect a vulnerable group, victims of motor vehicle accident. Further, subsection 64(1) of the *Legislation Act*, 2006, SO 2006, c 21, states that an "Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects."

Paragraph 16(5)2i unambiguously states the maximum is $3,000 *a month*. I am not persuaded to read into paragraph 16(5)2i further restrictions as to weekly, daily or hourly maximums.

The Appellant also argued that the Arbitrator had failed to consider the Respondent's alleged non-compliance with subsection 39(1) of the *1996 Schedule* that an application for attendant care benefits be in the form of an Assessment of Attendant Care Needs. However, at pages 11 and 12 of his decision the Arbitrator does address subsection 39(1) and the applicable case law. The Arbitrator states, in part, that "State Farm agrees that the failure of an Applicant to forward a Form 1 to the Insurer before the attendant care services are provided is not a complete bar to retroactively claiming attendant care."

The Appellant further argued regarding the attendant care benefit that the Arbitrator confused OCF-6s (Expense Claim Forms) with Form 1s (Assessment of Attendant Care Needs), failed to address Part 2 of the OCF-6 that requires an explanation if a bill or receipt is not available and erred in finding that Ms. Gowan, who prepared a May 30, 2011 attendant care assessment report, interviewed one of the care providers. The Arbitrator stated in his decision:

> While there was a lack of definitive evidence by Ms. Gowan as to the specific frequency and duration of the attendant care services provided by Mr. Jazey's wife and mother, the medical evidence supports her report to be credible and uncontradicted. I find that Mr. Jazey's wife and mother cannot be penalized for not diarizing what care they provided to Mr. Jazey. State Farm did not provide me with any regulatory or legal requirement that detailed notes must be kept of what care was provided. Further, State Farm did not obtain and provide its own experts' opinion to indicate that the Attendant Care Benefits sought by Mr. Jazey were unreasonable. State Farm had already paid for assistive devices which Mr. Jazey required for mobility and safety after his operation, yet it denied the requested Attendant Care Benefits. I find this contradiction in State Farm's actions unfathomable.

Regarding the question of insufficient evidence, in *Liberty Mutual Insurance Company and Young*, (FSCO P03-00043, June 20, 2005), application for judicial review dismissed, 2006 CanLII 7286 (ON SCDC), Delegate Evans cited Delegate McMahon in *Lombardi and State Farm Mutual Automobile Insurance Company*, (FSCO P01-00022, February 26, 2003):

> …errors of law include findings of fact made in the complete absence of supporting evidence, made on the basis of conjecture, or made on the basis of a misapprehension of the evidence caused by a misdirection on a legal principle. The vital distinction is between a conclusion that there was "no evidence" to support a finding and a mere "insufficiency of evidence."

Subsection 282(1) of the *Insurance Act* restricts internal appeals to issues of law. I am not persuaded that there was a complete absence of evidence to support the Arbitrator's decision regarding the Respondent's entitlement to $4,027.21 in attendant care for the period October 20 to December 31, 2009. Accordingly, the Arbitrator's order in this regard is confirmed.

(2) The Hot Tub

The Appellant argues at paragraphs 11 and 12 of its February 18, 2015 appeal submissions that the Arbitrator erred in ordering payment of the purchase and installation of the hot tub because:

1. The Arbitrator failed to address the Respondent's failure to submit an application for the benefit and treatment plan prior to incurring the expense as mandated by section 38 of the *1996 Schedule*. The Appellant relies on *Mostajo and Wawanesa Mutual Insurance Company*, (FSCO A99-000984, January 16, 2001), upheld on appeal (FSCO P01-00011, October 25, 2002), where no treatment plan was submitted. It also relies on *Bowler and Pafco Insurance Company*, (FSCO A12-001507, December 3, 2013), where expenses were not payable because a treatment plan was not submitted in advance of the purchase.

2. There was an absence of supporting evidence. The Appellant submits, in part, that the Arbitrator failed to note that Ms. Fox, the author of the OCF-18 for the hot tub, had no idea the Respondent already had an indoor hot tub at his residence and that she herself conducted no investigation or research as to the cost of the requested hot tub. The Arbitrator also failed to mention that Dr. C. Bailey prescribed the hot tub almost a year after the Respondent had already purchased and installed the outdoor hot tub.

I agree with the Appellant that the Arbitrator failed to address its argument that the Respondent had not complied with subsection 38(1.1) by having purchased and installed the hot tub over a year prior to submitting his OCF-18 Treatment and Assessment Plan. Subsection 38(1.1) of the *1996 Schedule* provides:

> An insurer is not liable to pay any expense in respect of medical benefits or rehabilitation benefits that was incurred before the insured person submits an application for the benefit that satisfies the requirements of subsection (2)

> unless the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates.

The case law provided by the Appellant is not helpful.

In *Mostajo*, Arbitrator Leitch found at page 16 of his decision that the insured had not submitted a treatment plan. On appeal, Delegate McMahon held that neither the insured person nor the treatment provider provided any explanation for this failure. That is not the case here. In *Bowler*, Arbitrator Fadel found that the insured person "chose not to pursue his claim for the mattress by not submitting a treatment plan." Again, that is not the case here.

In resumed oral submissions on June 16, 2016, the parties had an opportunity to speak to the decision of *Kelly and Guarantee Company of North America*, (FSCO A12-006663, August 7, 2014). In that decision, Arbitrator Wilson stated:

> While a Form 1 may be a pre-condition to payment of attendant care expenses, I do not accept that requiring an injured person in every circumstance to complete all the paperwork including a Form 1 before incurring any attendant care expenses is congruent with the scheme of the *SABS* as we know it. Indeed, Ms. Kelly's case demonstrates the folly of such an approach.
>
> A Form 1 has now been issued. Ms. Kelly's claim is not frivolous. Her injuries were serious and life-threatening. It would appear that the calculation of the amounts claimed for attendant care has been made in accordance to the necessary formula. Why should these amounts not be payable?

Kelly followed *T.N. and Personal Insurance Company of Canada*, (FSCO A06-000399, July 26, 2012). In that decision, Arbitrator Bayefsky stated:

> This does not, in my view, mean that an insured forfeits their right to attendant care benefits, or that an insurer is released of any obligation to pay attendant care benefits, prior to the Form 1 being submitted. In my view, significantly stronger statutory language would be required to effect this purpose. The section as it now reads simply ensures the orderly determination of a person's need for attendant care (in accordance with a proper attendant care needs assessment), and protects an insurer from having to determine what it should pay in the absence of a specific and legitimate attendant care needs assessment.

I agree with Arbitrators Bayefsky and Wilson. I am persuaded that subsection 38(1.1) means that an insurer becomes liable to pay an expense in respect of medical or rehabilitation expenses, even if incurred, only when an insured person submits an application for that benefit that satisfies the requirements of subsection (2) (that includes a treatment plan). A treatment plan is not required for emergency-based treatment within five days after the accident.

To find that the provision means that a treatment plan must always precede an incurred expense would result, as an example, in an insured person in any post 5-day emergency after an accident being automatically denied coverage unless he or she endured long enough to first obtain and submit a completed OCF-18 treatment plan. To quote Arbitrator Bayefsky, "significantly stronger statutory language would be required to effect this purpose."

Such a finding would also be contrary to the general approach of the *1996 Schedule* set out in section 31(1). That provision states that a person's failure to comply with a time limit set out in Part X, that includes subsection 38(1.1), does not disentitle the person to a benefit if the person has a reasonable excuse.

Subsection 38(1.1), however, speaks to timing, not a time limit. What is crucial is that there be a treatment plan to which an insurer can respond before being required to pay. That is the submission of the Appellant itself at page 219 of the September 4, 2014 arbitration submissions. That a treatment plan is submitted after the expense is incurred may go to the reasonableness or necessity of the expense.

The Appellant's second ground of appeal is the alleged absence of supporting evidence for this benefit. The Arbitrator provided five pages of reasons for allowing this claim. In summary, in finding the hot tub reasonable and necessary, the Arbitrator held:

1. The Respondent testified that the therapeutic hot tub was effective in relieving his tension headaches, soothing his sore knotted muscles, relieving muscle tension and dizziness and improving his sleep. This improved his ability to work. The Respondent used the hot tub five to seven times a week. Friends and neighbours did not use the hot tub. It was not a "party hot tub." Family members rarely use it.

2. Before purchasing the hot tub, the Respondent obtained the support of both his physiotherapist, Ms. Fox, and his orthopaedic surgeon, Dr. Bailey.

   Dr. Bailey testified that he fully supported this acquisition to treat the Respondent's chronic pain. Dr. Bailey's prior May 12, 2010 report prescribed the hot tub to improve the Respondent's residual symptoms, specifically stiffness for myelopathy (spinal cord injury) stiffness and post-operative neck-stiffness producing headaches.

   The Arbitrator preferred this opinion over that of the Appellant's expert, Dr. G.S. Conn. Dr. Conn's June 2011 IME report opined that "from a strictly orthopaedic perspective, the installation of a hot tub would not … be considered reasonable and necessary." Dr. Bailey testified that Dr. Conn was not a specialist in spinal orthopaedics and spinal rehabilitation. The Arbitrator accepted Dr. Bailey as a specialist in spinal injuries.

   The Arbitrator accepted that Ms. Fox had 18 years' experience as a physiotherapist with a special interest in aquatic rehabilitation along with considerable experience working with complex orthopaedic trauma victims. Ms. Fox testified that, in her expert opinion, based on the available evidence, purchase of the hot tub was a very reasonable expense and definitely beneficial for the Respondent's rehabilitation to return him as close as possible to his pre-accident level of functioning.

   Ms. Fox also concurred with the Respondent's evidence concerning the hot tub's larger size and the greater ability to be immersed, the strength, number and arrangement of the jets, and the higher and constant temperature.

3. The Arbitrator noted that Dr. K. Sequeira, an expert in physical medicine and rehabilitation, disagreed with Dr. Conn. Dr. K. Sequeira was of the view that Dr. Conn missed the point. The issue was treatment modalities that allowed the Respondent to maintain his work and function. Dr. Sequeira testified that, in his opinion, the hot tub was a significant and necessary aid in pain management and enhanced functionality, thereby allowing the Respondent to continue working and remain active.

4. The Respondent was able to purchase the hot tub at a significant discount and had a friend do the electrical installation work.

5. A hot bath was not as effective. The hot tub allowed the Respondent to move around and to utilize different jets on different parts of his body. Further, the hot tub allowed him to immerse himself up to his chin. As well, the hot tub maintained its high temperature.

As held in *Young* and in *Lombardi*, errors of law include findings of fact made in the complete absence of supporting evidence. Errors of law do not include an alleged insufficiency of evidence. I am not persuaded there was a complete absence of evidence supporting this award. I am, therefore, not persuaded that the Arbitrator erred in law in this regard.

The Appellant submits that the cost listed in the Report of Mediator is $15,768.86 for the hot tub, not the $15,931.90 awarded. The February 4, 2011 OCF-18 notes the cost of the hot tub as $15,616.90. Where is the further $315?

$15,616.90 includes a $6,300 component for the cost of installation as set out in a November 23, 2009 statement of G & R Contracting London Inc., also set out at Tab A2 of Exhibit 1. The $15,616.90 in the OCF-18 does not set out any amount for taxes. The November 23, 2009 invoice (also at Exhibit 1, Tab A2) includes $315 for GST. I confirm the entire $15,931.90 allowed by the Arbitrator for the hot tub, including $315 for GST as noted.

(3) Massage Therapy

The Appellant submits, at paragraphs 13 and 61 of its February 18, 2015 written appeal submissions that the Arbitrator erred in awarding $1,500.64 and ongoing incurred sums (subject to collateral benefit deduction) for massage therapy recommended in a February 14, 2012 OCF-18 Treatment and Assessment Plan by Ms. Buffone, on the basis the Arbitrator accepted Dr. McKillop's evidence on a subject the psychologist was not qualified to opine.

As stated in my March 24, 2015 preliminary issue appeal decision, in addition to the evidence of Dr. McKillop and the Respondent himself, the Arbitrator noted his reliance on the evidence

of Dr. Sequeira, an expert in physical medicine and rehabilitation, and Dr. Bailey, an orthopedic surgeon specializing in spinal cord injuries. The Appellant does not challenge the qualifications of these medical practitioners to opine on the question of massage therapy.

Again, as held in *Young* and in *Lombardi*, errors of law include findings of fact made in the complete absence of supporting evidence. I am not persuaded there was a complete absence of evidence supporting this award. I am, therefore, not persuaded that the Appellant has raised an issue of law under subsection 282(1) of the *Insurance Act*. Accordingly, the Arbitrator's order in this regard is confirmed.

(4) Psychological Counselling

The Appellant submits, at paragraphs 14 and 62 to 64 of its February 18, 2015 submissions, that the Arbitrator erred in awarding $1,008.70 for the balance for psychological counseling under Dr. McKillop's November 30, 2011 OCF-18 "despite the evidence." It argues that at the end of the 8 of 15 sessions it had approved, Dr. McKillop decided not to submit another treatment plan as the Respondent did not require it. The Appellant also argues, but without any statutory or case law in support, that the further psychological treatment was not incurred and, therefore, is not payable.

Dr. McKillop testified at pages 25 and 26 of Volume V of the transcript, that if the remaining 7 sessions had been approved, he would have continued treatment. I am not persuaded that Dr. McKillop's testimony regarding resubmitting his plan for approval went to the reasonableness or necessity of the remaining 7 sessions. The Appellant does not argue that resubmitting the November 30, 2011 treatment plan was a prerequisite to payment.

Kennelly and Wawanesa Mutual Insurance Company, (FSCO A99-000139, January 21, 2000), (pertaining to the *1993 Schedule*) awarded a claimant the cost of treatment on the basis that not awarding the missed but necessary treatments would encourage insurers to "deny payment of needed services with impunity, believing that an arbitrator will not later order them to pay for the treatments, however reasonable, because they can no longer be of benefit to the applicant." Arbitrator Baltman continued:

> Nor am I persuaded that this amounts to a windfall for Ms. Kennelly. She was deprived of a service that she was entitled to by statute. The termination of therapeutic support delayed her recovery, increased her frustration over her impairments, and caused her to lose some of the gains she had made over the previous year. Moreover, the insurer has had the benefit of these monies throughout the time that they should have been dispensed to Ms. Kennelly.

Belair Insurance Company v. McMichael, 2007 CanLII 17630 (ON SCDC), (dismissing the application for judicial review of the arbitration decision upheld on appeal) held that attendant care expenses had been incurred although the insured did not actually receive the monetary benefit or the care to which he was entitled. *Monks v. ING Insurance Company of Canada*, 2008 ONCA 269 (CanLII), held:

> The courts, however, have rejected a narrow construction of the word "incurred" as used in accident benefits schedules. In Belair Insurance Co. v. McMichael … when considering the meaning of "incurred" in the context of the attendant care provisions of the SABS, the Divisional Court cited with approval the following statement in Wawanesa Mutual Insurance Co. v. Smith (Committee of) (1998) …:
>
>> A purposive and remedial interpretation requires that the legislation be read so as not to require an insured person to finance, or to pledge her credit, in order to secure the very benefits for which she is insured. . . .
>
> I conclude that an insured . . . need not actually receive the items or services or spend the money or become legally obliged to do so. It is sufficient if the reasonable necessity of the service or item and the amount of the expenditure are determined with certainty before the end of [the specified time limit under the applicable benefits schedule]...

The Arbitrator found $1,008.70 for the remaining psychological counselling reasonable and necessary based on the evidence of the Respondent and Dr. McKillop, the treating psychologist specializing in rehabilitation psychology. I am not persuaded there was a complete absence of evidence to support this award. As in *Kennelly*, the Respondent was deprived of a service to which she was entitled by statute.

The Arbitrator stated that the Appellant provided no reasons for its decision. The amount was determined with certainty. I am not persuaded the Arbitrator erred in law in granting this award. Accordingly, I confirm the Arbitrator's order regarding psychological counselling.

(5) Occupational Therapy and Ergonomic Equipment

The Appellant argues at paragraphs 10 and 51 to 53 of its February 18, 2015 appeal submissions that the Arbitrator erred in allowing the Respondent's increased claim of $11,547.35 served on the Appellant two days prior to the start of the arbitration hearing. The increased claim was submitted to be based on current cost estimates of Ms. Gowan's May 29, 2014 treatment plan in the amount of $26,628.75. The Appellant argues that this circumvented the mandatory requirement for mediation under section 280 of the *Insurance Act*.

The Appellant also argues that the Arbitrator misstated the Respondent's oral testimony. Citing lines 6 to 10 at page 114 of the Volume 2 of the arbitration transcript, the Appellant submits that the Respondent testified (1) he had no knowledge of any of Ms. Gowan's recommendations (2) he had no knowledge of whether any of the items in question would have assisted him (3) he never tested the recommended equipment before keeping it, and (4) he did not want or need the recommended equipment, all of his work equipment being in meticulous working order.

As my March 24, 2015 Preliminary Issue Appeal Decision stated, the Appellant's recitation of the Respondent's testimony does not correspond with lines 6 to 10 at page 114 of the second volume of the transcript referenced by the Appellant. Rather, the Respondent's transcribed evidence was:

> If you like, I'll help clarify it [in response to the Respondent's question about how long he has had his office station]. I assume you're referring to my equipment and my work stations. Over the, I don't know, 25-plus years I've been in business I've been accumulating equipment. Specifically I don't know exactly when each piece or how old each piece is. They're all very well kept and they're all in fine, functioning shape.

My prior decision also noted pages 128 to 132 of Volume 2 of the transcript, where the Respondent notes his evidence from the prior day about getting "anything to get me in a more upright, ergonomically correct position is going to assist in any of my duties and tasks." He further testified at pages 125 to 126 of Volume 1 of the transcript that Ms. Gowan:

> … was in my shop for over two weeks, just assessing the shop and learning about the work, and her girl was with me for quite a while, and we were

> gathering the information with everybody who was involved. So it's not all to do with my particular memory regarding it, as I was drugged up pretty good, and it has a lot to do with the people involved in it as well as what I could remember …
>
> She – she was – she wasn't in there eight hours a day for two weeks, but she was – she was taking measurements, she was taking pictures to see how – would come back the next day and ask more questions and pore over catalogues of what could be an assisting device, what could be useful, what is overkill, what is really more necessary things, then poring over what she could do to improve my situation through mechanical means, as I was unable to at my work station work comfortably any more, and still am unable to work comfortably.

The Appellant did not respond to this either in its May 25, 2015 reply appeal submissions or in its November 11, 2015 oral submissions. I agree with the Respondent's submission at paragraph 86 of its written appeal submissions that the issue at arbitration was not whether the Respondent's equipment was adequate for his pre-accident condition but whether it was adequate to accommodate his post-accident injuries and limitations. The Respondent notes his evidence, in part, at page 193 of Volume 1 of the arbitration transcript:

> It would – these items are – are designed to off load the mechanical – like they – they're devices that are used to go from having me use sheer strength and determination to complete a task smarter, with less impact on my body, being therefore able to maybe work longer and when I'm done working to having less pain, which then makes it so I can work again the next day. The devices are meant to off-load stress and pressure to my body, to sit me up straighter, to sit me up smarter and to help me complete my tasks with less pain.

Further regarding entitlement to the rehabilitation expenses sought, my prior decision stated that the Arbitrator noted weaknesses in the reports of the Appellant's medical examiners, Ms. L. Hisey, OT , and Dr. A. Kertesz, neurologist. The Arbitrator noted that neither was called to give evidence. The Arbitrator also relied on the evidence of Ms. Gowan, OT, as well as Dr. Sequeira, an expert in physical medicine and rehabilitation, who opined that if Ms. Gowan's recommendations were not implemented, the Respondent was at risk of quickly deteriorating.

The Arbitrator also relied on the evidence of Ms. Fox, who had 18 years of experience as a physiotherapist with considerable experience working with complex orthopedic trauma victims, as well as the evidence of Dr. Bailey, an orthopedic surgeon specializing in spinal cord injuries.

Following both *Young* and *Lombardi*, I am not persuaded that there was a complete absence of evidence supporting the Arbitrator's finding of entitlement to this benefit. I am, therefore, not persuaded that the Appellant has raised an issue of law under subsection 282(1) of the *Insurance Act*, regarding entitlement to the ergonomic equipment in question.

I now turn to the question of the quantum of this benefit award.

Relying on *Attavar v. Allstate Insurance Co. of Canad*a, 2003 CanLII 7430 (ON CA), the Respondent argues that interest does not provide compensation where the cost of items has significantly increased, nor is that the purpose of an award of interest. Rather, interest is intended to compensate insureds for the delay in obtaining the benefit, to encourage insurers to pay the accident benefits promptly and ensure insurers are not benefiting from their own denials.

As stated above, Ms. Gowan's initial May 26, 2011 OCF-18 treatment plan for occupational therapy and ergonomic equipment was in the amount of $26,628.75. The Arbitrator awarded $38,176.10. My March 24, 2015 preliminary issue appeal decision stayed payment of the difference of $11,547.35, the quantum to which the Appellant objected.

Ms. Gowan's May 26, 2011 OCF-18 entered zero in the line for taxes. The Respondent's May 5, 2016 letter states that of the $11,547.35, $3,479.65 is HST. The Appellant does not dispute this. I am allowing $3,461.74 for HST, plus interest thereon, as the June 15, 2011 OCF-18 does not include tax. This leaves $8,067.70.

Exhibit 9 sets out an amount of $7,075.03 that the Respondent submits are increased expenses for items set out in Ms. Gowan's May 26, 2011 OCF-18. Including HST, the amount is $7,994.78. The Respondent argues that because of the delay in payment, the proposed expense had increased significantly.

The Arbitrator references Exhibit 9 at page 16 of his decision. He notes that at the start of the arbitration hearing he made an order allowing the Respondent to claim the increased current cost of the ergonomic equipment and interventions. The Arbitrator did not provide any reasons in his decision for allowing the amendment. Nor did he provide any oral reasons in the transcript.

Paragraphs 65 to 90 of the Respondent's April 15, 2015 written submissions set out his arguments regarding the ergonomic equipment. The Respondent argues that the Arbitrator did not err in law in failing to provide reasons for this order.

I disagree. The Arbitrator's failure to give any reasons for allowing the Respondent to amend his claim by some $8,000 is an error of law. *R. v. Walker*, 2008 CSC 34 (CanLII), citing *R. v. Sheppard*, 2002 SCC 26 (CanLII), held:

> *Sheppard* holds that "[t]he appellate court is not given the power to intervene simply because it thinks the trial court did a poor job of expressing itself" … Reasons are sufficient if they are responsive to the case's live issues and the parties' key arguments. Their sufficiency should be measured not in the abstract, but as they respond to the substance of what was in issue. The "trial judge's duty is satisfied by reasons which are sufficient to serve the purpose for which the duty is imposed, i.e., a decision which, having regard to the particular circumstances of the case, is reasonably intelligible to the parties and provides the basis for meaningful appellate review of the correctness of the trial judge's decision"

Normally, this issue would be returned to arbitration. The parties have agreed that, to save further time and expense, I should make determine any such issues.

The Application for Arbitration was filed with the Commission on January 30, 2013. The pre-hearing was held August 22, 2013. The parties agreed to complete production exchange within sixty days of the pre-hearing, that is, by October 23, 2013. The pre-hearing arbitrator set a four-day hearing to start six-months later, on February 25, 2014. The Appellant's May 27, 2014 letter states that at the Respondent's request, the hearing was put over to June 2014.

Rule 39.1 of the *Dispute Resolution Practice Code* (Fourth Edition – Updated January 2014) (the "*Code*") provides that all documents to be introduced at a hearing by either party must be served on the other party at least thirty days before the first day of the hearing. Rule 39.2 states that in extraordinary circumstances a party may seek an arbitrator's permission to serve a document less than thirty days before the first day of the hearing.

The hearing in this matter commenced June 9, 2014. Ms. Gowan's April 7, 2014 report, two months before the start of the arbitration hearing, sets out recommended ergonomic

work equipment and the cost of same. However, it is not readily clear from this report why certain items are more expensive.

Ms. Gowan's May 29, 2014 Treatment Plan is included in the Respondent's 3-volume medical brief dated June 6, 2014, or three days before the start of the hearing. It is in the amount of $71,189.76. This Treatment Plan, by itself, does not make clear what items are new and what are old, but at a higher cost. Exhibit 9, introduced at the arbitration hearing on June 11, 2014, is a somewhat confusing summary of increased, and some decreased, expenses.

With the benefit of Exhibit 9 introduced at the arbitration hearing, and the evidence and submissions at arbitration and further submissions received on appeal, it is now possible to dissect the components of the Respondent's further ergonomic claim. This, however, is hardly fair to the Appellant, where the Respondent had more than nine months from the pre-hearing to prepare his case, to file into evidence at arbitration a report he provided to the other side a handful of days before the hearing.

However, in any event, I am not persuaded as to the merits of the claim for increased costs. Ms. Gowan testified, at page 60 of the June 11, 2014 transcript, that, in costing items, she takes an average of the quotes obtained to determine a reasonable monetary figure. There are six components to the Respondent's claim of an extra $8,000 for ergonomic equipment:

1. $3,085, plus HST for a total of $3,486.05, for a jeweller work bench.

   Both Ms. Gowan's May 26, 2011 Occupational Ergonomic Assessment (Exhibit 1, Tab A10) and her April 7, 2014 Occupational Home and Work Assessment (Exhibit 2C, Tab H6) have two quotes from the same two suppliers.

   Each quote consists of three components. The only difference between the two reports regarding the jeweller work bench is that in the first report the quote from IDM Solutions does not have an amount for an "SMII Inspection Elite Universal Stand." A price of $720 is given in the quote received from Melnick Custom Design.

It may be that the $3,486.05 difference is due to Ms. Gowan having made an arithmetic error in her first report in averaging the two quotes. It may be that part of the difference is due to Ms. Gowan omitting a component in her original plan. I am not persuaded that the claimed price increase for this item is due to the Appellant's delay in paying for this benefit as the Respondent argued (exclusively at paragraph 134 of his July 29, 2014 closing written submissions) at arbitration and on appeal. Accordingly, this aspect of the increased claim for ergonomic equipment is denied.

2. $1,479, plus HST for a total of $1,671.27, for a polishing workbench and polishing hoods.

   Again, each of Ms. Gowan's reports has two quotes. The actual quotes in both reports are identical, except that the second quote from Melnick adds a drawer for a cost of $299.

   Again, the difference of $1,671.27 may be due to an arithmetic error or to omitting a component in the original assessment. I am again not persuaded that the increase is due to an increase in pricing, as argued by the Respondent. Accordingly, this aspect of this claim is also denied.

3. $935.97, plus HST for a total of $1,057.65 for a jeweller chair.

   For this item, Ms. Gowan obtained three quotes. Two of the quotes ($764 and $595) remained the same in her two reports. The third quote went from $850 to $1,243, an increase of 46%. It is unclear why two suppliers would have a zero increase and a third would have almost a 50% increase over the same time period. It is unclear why the third supplier's price is so much higher than that of its competitors. In any event, my calculator shows that the average price has gone up from $736 to $867, an increase of $131, not $935.97 as claimed. I am not, however, persuaded as to the reasonableness of even the $131 increase. This aspect of the increased ergonomic equipment claim is also refused.

4. $113, including HST, for an office chair.

5. $339, including HST, for a John Deere tractor/snow blower.

6. $1,175, plus HST for a total of $1,327.75 for an office desk.

   In this case, the Melnick quote increased from $4,844.99 to $5,040.00, plus HST. The IBM Solutions quote increased from $3,335 to $4,310. That increase is due entirely to adding $975 for a binder holder that Ms. Gowan omitted in her initial report although $975 is including for a binder holder in the Melnick quote. The first report includes a third quote that is not included in the second report. The amount (including HST) that may be due to increased prices would be $110.18.

Therefore, of the some $8,000 the Respondent' additionally claims (net of the sum of $3,479.65 allowed above for HST), I find that the Respondent's best case, including HST, is $562.18. In his December 9, 2015 letter, the Respondent calculates, based on Ms. Gowan's initial May 26, 2011 cost of ergonomic equipment of $26,628.75, $38,299.26 in interest, for a total of $64,917.01. I am not persuaded of the reasonableness of a further $562.18 as an estimate for the increased cost of the ergonomic equipment due to delay in payment. Accordingly, this part of the claim for ergonomic equipment is denied.

I allow $30,090.49 for occupational therapy and ergonomic equipment. That amount, as noted, consists of Ms. Gowan's initial $26,628.75 Treatment Plan allowed by the Arbitrator that I am not persuaded was an error of law, plus HST of $3,461.74 on that $26,628.75.

(6) Pre-Judgment Interest

The Appellant argues, at paragraphs 17 and 75 to 76 of its February 18, 2015 submissions that the Arbitrator erred "in ruling that the insurer is responsible for undue delay and must pay interest on all outstanding benefits." It submits that it has not caused any undue delay and the Arbitrator erred in not considering the Respondent's undue delay in failing to pursue his claims in a diligent and timely fashion despite having the benefit of legal representation.

The Appellant cites in support the decisions of Delegate Makepeace in *Virk and Liberty Mutual Insurance Company of Canada* (FSCO P04-00027, July 5, 2005), and Delegate Evans in *J.C.*

and Progressive Casualty Insurance Company of Canada, (FSCO P04-00036, February 15, 2005), that it submits relied on *Attavar v. Allstate Insurance Co. of Canad*a, 2003 CanLII 7430 (ON CA).

Section 46 of the *1996 Schedule* provides:

OVERDUE PAYMENTS

> 46. (1) An amount payable in respect of a benefit is ***overdue if the insurer fails to pay the benefit within the time required under this Part***.
>
> (2) ***If payment of a benefit under this Regulation is overdue***, the insurer ***shall*** pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly. [Emphasis added]

I find that the Arbitrator erred in law if he required as a pre-requisite to the payment of interest that there be "undue delay" by an insurer. I agree with Delegate Makepeace in *Cole and Allstate Insurance Company*, (FSCO P01-00016, May 23, 2003), that:

> Commission adjudicators have frequently reaffirmed that interest under the SABS is mandatory, compensatory, and flows from late payment of overdue benefits. ***There is no need for a finding of insurer misconduct***. Accordingly, upon a finding of entitlement, interest flows even though the insurer had legitimate reasons for questioning the claim or requiring more information.
> [Emphasis added]

In *Attavar*, Justice Laskin, in looking at the underlying policy of section 68 of the *1993 Schedule* that required the insurer to pay interest on overdue payments of benefits from the date the amount became overdue at the rate of 2 per cent per month compounded monthly, stated:

> Although the amount of interest provided for in s. 68 is above the bank rate, I, like several arbitrators, regard s. 68 as compensatory, not punitive. The provision is designed to compensate insureds for the time value of money and to encourage insurers to pay accident benefits promptly. Without a provision like s. 68, insurers would have an incentive to delay paying benefits properly owing, thus forcing insureds to litigate their claims. I agree with the comments of Arbitrator McMahon in Urquhart v. Zurich Insurance Co., [1998] O.I.C.D. No. 34 at para. 14:
>
> > In addition to the specific intent of compensating the insured for the delay in obtaining the benefit, it cannot be ignored that

> the interest provisions are part of a larger scheme designed to encourage Insurers to pay benefits in a prompt fashion. In many cases insured persons are not in a position to pay for supplementary treatments or services out of their own resources.

And, with the similar comments of the Director's Delegate Naylor in *Canadian Surety Company and Sebastian*, (OIC P96-00032, July 28, 1998):

> Canadian Surety characterised the interest rate as punitive, designed to punish insurers for reprehensible behaviour. In my view, the interest component in the benefits scheme should be seen as remedial. It is designed not only to compensate applicants for the value of money withheld but to further the system's fundamental goal of ensuring prompt payment of benefits for an injured person's medical and vocational rehabilitation, their care or their day-to-day financial support.

Laskin J. noted the trial judge's comment that "failing unusual circumstances brought on by the complexity of the action and/or the applicant's own behaviour 'it is the insurer not the insured who must bear the consequences of a decision not to pay benefits that are found later to be owing.'" I do not see Laskin J. endorsing adjudicators having discretion to depart from the mandatory wording of the interest provision.

I am not persuaded that the Arbitrator erred in law in his Order that the Appellant pay the Respondent interest pursuant to subsection 46(2) of the *1996 Schedule*.

The Arbitrator did err in the body of his decision law in saying that the interest payable is 2% per month on all outstanding benefit payments. First, the rate is 2% per month *compounded monthly*. Second, the interest is payable *for each date the amount is overdue*, overdue meaning from the failure of the Respondent to pay the benefit within the time required under Part X of the *1996 Schedule*.

(7) Special Award

Subsection 282(10) of the *Insurance Act* provides:

> If the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the *Statutory Accident Benefits Schedule*, shall

> award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*.

In determining that the Respondent was entitled to a special award, the Arbitrator stated:

> Pursuant to section 282(10) of the *Insurance Act,* I find that State Farm has unreasonably withheld or delayed payments to Mr. Jazey in denying treatments and withholding payments; State Farm accepted the opinions of its medical advisors to support its routine denials of benefits; and it should have been aware that these denials would cause Mr. Jazey undue stress and financial hardship and reduce the opportunity for him to recover from his injuries.

The Arbitrator noted the Respondent's schedule attached to his closing submissions that the maximum amount calculated for a special award was $131,408.27. The Arbitrator held:

> Considering all the relevant factors in this matter, I agree with Mr. Jazey's contention that State Farm has acted unreasonably and Mr. Jazey is entitled to a special award.
>
> The *Insurance Act* states that an Arbitrator shall award a lump sum of up to 50% of the amount to which the person was entitled, etc. It does not set a quantum but leaves it to the Arbitrator to determine whether that amount should be one dollar or the maximum of 50%. In this matter, because State Farm has provided some benefits to Mr. Jazey and Mr. Jazey has been able to return to his self-employment, albeit to a limited degree compared to his pre-accident ability, and Mr. Jazey has failed to provide some specific documentation to State Farm, I am fixing the special award at 25% of the amount to which he claims entitlement.
>
> I hereby order that State Farm shall pay a lump sum to Mr. Jazey of 25% of the amount to which he is entitled, which amount shall be $32,852.07.

My March 24, 2015 Preliminary Appeal Order stayed part of the Arbitrator's benefit orders. As the Arbitrator's special award was based, in part, on these benefits, I was persuaded to also stay payment of the special award pending resolution of this appeal.

I noted, however, that as interest would continue to accrue on the benefit orders that were stayed, if a special award was upheld, there may be a question whether the 25% the Arbitrator awarded should be applied against a higher amount.

The Respondent argued that a special award was warranted, in part, because the Appellant:

1. Acted unreasonably in denying treatment and withholding benefits.
2. Routinely adopted, without careful scrutiny, the perfunctory and unpersuasive opinions of its medical advisors to support its routine denials of benefits.
3. Stretched these medical opinions to support a specious causation defence that did not and does not bear scrutiny.
4. Acted in a stubborn and unyielding manner by preferring its own assessors' reports that were questionable at best in the face of volumes of medical reports and medical opinions to the contrary.
5. Failed to support the Respondent in his efforts to return to his pre-accident condition.

The Appellant argued at paragraph 175 of its August 12, 2014 responding arbitration submissions that it was not to be held to a standard of perfection in how it responded to a claim. While it submitted that its "decisions in approving or denying a benefit were made following a thorough and comprehensive consideration of all of the medical evidence available," no evidence was cited in support. Submissions are not evidence.

The Appellant's February 6 and 18, 2015 appeal submissions set out the following grounds for appealing the Arbitrator's special award:

1. The Arbitrator ignored the Respondent's failure to comply with Arbitrator Garbutt's pre-hearing order that the Respondent provide particulars of his claim for a special award within 30 days. However, at the November 11, 2015 oral submissions the Appellant conceded that Arbitrator Garbutt never made any such order.

2. The Respondent's failure to provide particulars of his claim for a special award prior to the arbitration hearing prevented the Appellant from answering this claim.

Arbitrator Garbutt's August 22, 2013 pre-hearing letter confirmed as an issue in dispute the Respondent's claim for a special award. The pre-hearing letter set a 30-day deadline for the parties to confirm production undertakings. The Appellant, at page 16 of the June 9, 2014

transcript, stated that it had requested particulars of the Appellant's claim for a special award on May 15, 2014. That is almost nine months after the pre-hearing letter.

The Respondent presented four days of oral evidence. In addition to his own testimony, the Respondent called his wife, his mother, Dr. Sequeira, Ms. Gowan, Ms. Buffone, Ms. Fox and Dr. Bailey. It is not disputed the Respondent's adjuster attended the arbitration hearing. The Respondent's May 29, 2014 letter, prior to the arbitration hearing, stated it intended to call a number of witnesses, including its named adjuster as well as Dr. Conn and Dr. Kertesz. It chose, in the end, not to call anyone.

In addition to closing oral submissions held more than two months after the close of evidence, the parties also filed written submissions. I am not persuaded that the Arbitrator's decision should be set aside on the basis that the Appellant did not have a reasonable opportunity to respond to the Respondent's claim for a special award.

3. The Arbitrator erred in failing to consider the undue delay by the Respondent in not pursuing his claims in a diligent and timely fashion, despite having the benefit of legal counsel. However, as noted above, the Arbitrator specifically took into consideration in determining the quantum of a special award that the Respondent had failed "to provide some specific documentation to State Farm."

4. The law regarding a special award does not preclude insurers from relying on their own medical assessors. *Brazier and RBC General Insurance Company*, (FSCO A07-001290, May 28, 2009), held that an insurer is not held to a standard of perfection. Nor is a special award granted merely because the insurer incorrectly interpreted or failed to comply with a provision of the *Schedule*.

However, Arbitrator Shapiro, in *Arruda and Western Assurance Company*, (FSCO A13-003926, July 7, 2015), cited *Cowans and Motors Insurance Company* (FSCO A09-003237, October 15, 2010), for what is noted as the well-established principle that an insurer has an ongoing duty to assess and reassess a claim as new information is available. At paragraph 211 of his July 29, 2014 arbitration submissions, the Respondent cited the following excerpt from *Cowans*:

> Simply "papering" a termination by obtaining a compliant report from an assessor is not necessarily a protection against a special award if an insurer closes its mind to other information potentially available to it that might have cast its decision or actions in doubt.

Brazier held that "the question of whether an insurer's delay or failure in paying a benefit is "unreasonable" is fact driven and highly dependent on the arbitrator's view of the evidence." Again, Delegate Evans held in *Young* that errors of law include findings of fact made in the complete absence of supporting evidence, not a mere "insufficiency of evidence." I am not persuaded there was a complete absence of supporting evidence for the Arbitrator's award of a special award.

The OCF-9 (Explanation of Benefits) form provides a box for the insurer to provide reasons for expenses not being payable or being stopped. There is a check-off box to be ticked if additional sheets are attached.

The Appellant's June 17, 2011 OCF-9 regarding the hot tub states:

> As per enclosed Section 44 report(s) dated 06/07/11, your Treatment and Assessment Plan (OCF—18) dated 1/24/11 and /0-4/04/11 is deemed not reasonable and necessary, therefore, the proposed treatment is not payable.

The OCF-9 does not note any other ground for denial. The OCF-9 specifically does not note any failure by the Respondent to comply with subsection 38(1.1) of the *1996 Schedule* as a basis for refusal to pay this benefit.

Dr. Conn's June 13, 2011 Insurer's Medical Examination ("IME") report, following a June 7, 2011 assessment, sets out at page two the question to be answered as whether the treatment plans "are appropriate for and consistent with the severity of Mr. Jazey's injury or impairment sustained as a result of the motor vehicle accident of September 9, 2008." This is repeated at page 22 of his report as a question the Appellant posed to him.

Subsection 14(2) of the *1996 Schedule* provides that the insurer shall pay for "all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident." The Appellant set out a different test to its medical expert.

Dr. Conn states that the Respondent did "have significant degenerative changes evident prior to the accident" that aggravated "pre-existing cervical cord and root compromise." At page 13 of his report Dr. Conn cites Dr. Sequeira that the Respondent's symptoms were "materially contributed to by the September 9, 2008 accident."

Dr. Conn does not directly dispute this. Rather, he opines that the accident was "a relatively minor rear-end collision" with apparently less than $2,000 to the vehicle that was drivable. Dr. Conn does not say how the amount of property damage is relevant to the "reasonable and necessary" statutory test. Nor does he say what expertise, if any, he possesses in relating the quantum of property damage to the degree of impairment.

Dr. Conn does opine that "from a strictly orthopaedic perspective, the installation of a hot tub would not, in my opinion, be considered reasonable and necessary." A warm bath, or a hot tub, might be helpful, but was not "an orthopaedic requirement" and, therefore, not reasonable or necessary.

However, the hot tub was not submitted as an "orthopaedic requirement." The question was pain management. I agree with Dr. Sequeira, as noted above, that Dr. Conn missed the point.

As Ms. Fox's prior April 26, 2011 report stated, the "goods included are a hot tub for long-term pain management and improved sleep." The orthopaedic surgeon, Dr. Bailey, stated in his prior May 12, 2010 report that he prescribed the hot tub to improve the Respondent's residual symptoms, specifically stiffness for myelopathy (spinal cord injury) stiffness and post-operative neck-stiffness producing headaches. Dr. Sequeira's prior June 10, 2010 report specifically noted the issue of pain management:

> The continued use of some medication is essential for him. In particular, Amitriptyline nighty helps him to sleep and manage his pain. The Amitriptyline may need to be increased to 80 mg., based on side effects and efficacy. Mr. Jazey currently uses Advil, four times a week, for pain and this helps to some extent. Continuation with Advil or Tylenol Extra Strength is reasonable for this purpose. However, if Mr. Jazey's pain persists, a change to a low dose of long acting narcotic such as Tramadol XL would be appropriate. In addition, Lyric may be helpful if Mr. Jazey's pain becomes more neuropathic in nature (i.e. burning, tingling) …

To quote the Appellant's own August 12, 2014 arbitration submissions, unreasonable behaviour includes imprudent behaviour. Imprudent means rash or lacking judiciousness. In this case, the Appellant set out a different test than the statutory requirement and then relied on its medical expert addressing a different consideration than pain management upon which the benefit was sought. This is an unreasonable withholding of benefits.

The Appellant submits that it had a legitimate defence regarding the hot tub under subsection 38(1.1) of the *1996 Schedule*. It maintains, but without citing evidence in support, that it raised this defence at the August 22, 2013 pre-hearing discussion. Even if that is correct, and I have no evidence it is, that is still more than two years after the Appellant's June 17, 2011 OCF-9 denying the hot tub claim solely on the basis of Dr. Conn's report. It is not reasonable for an insurer to deny a benefit based on a reason it does not deny it did not state for at least two years to which its first-party insured, to whom it has a duty of utmost good faith, could not respond.

Regarding the claimed ergonomic equipment, Ms. Hisey, OT, prepared an August 17, 2011 IME report in respect of the then $26,628.75 claim. At page 18 of her report, Ms. Hisey states that "there is no objective medical information identifying that Mr. Jazey's neurological complaints stem from the motor vehicle accident and would warrant the proposed goods and services."

Rule 4.1 of the *Rules of Civil Procedure* codifies common sense and the common law that experts have a duty to provide opinion evidence that is "fair, objective and non-partisan" and to provide evidence that is related only to matters that are within the expert's area of expertise. That would apply equally to an insurer having a duty of utmost good faith to its first-party insured. I have no evidence as to this occupational therapist's additional expertise in neurology.

Ms. Hisey notes that post-accident, the Respondent underwent surgery for cervical decompression, fusion for cervical radiculopathy as well as cord myelopathy. She opines that "additional medical information is warranted to provide a concise determination as to the percentage of the motor vehicle accident-related injuries in question as it relates to his reported neurological signs, which the evaluee states prevents him from completing some of his home and work-related tasks." I have no evidence as to Ms. Hisey's legal expertise to opine that one looks to the "percentage of the motor vehicle accident-related injuries in question."

Arbitrator Wilson in *Sohi and ING Insurance Company of Canada*, (FSCO A03-001125, July 15, 2004) cited and applied the Supreme Court of Canada decision in *Athey v. Leonati* [1996] S.C.J. No. 102:

> This appeal involves a straightforward application of the thin skull rule. The pre-existing disposition may have aggravated the injuries, but the defendant must take the plaintiff as he finds him. If the defendant's negligence exacerbated the existing condition and caused it to manifest in a disc herniation, then the defendant is a cause of the disc herniation and is fully liable.

Arbitrator Wilson further cited the Ontario Court of Appeal in *Cotic v. Gray*, 33 O.R. (2d) 356:

> Because of the so-called "egg-shell" or "thin-skull" principle, the defendant has to take his victim as he finds him, a psychologically vulnerable individual. It must also be assumed that the jury were satisfied, on a preponderance of the evidence, that the accident, while not necessarily the sole cause, was a direct and substantial cause without which the suicide would not likely have happened.

This was not new law in 2004. I had stated earlier, in *Hearn and Allianz Insurance Company of Canada*, (FSCO A97-001667, August 17, 1999):

> … this Commission has adopted the long-standing "thin skull rule" which, in the context of statutory benefits, means that one is not to be denied weekly benefits because one's pre-accident physical, psychological or emotional condition makes one more vulnerable to disability than might normally be the case.

As with Dr. Conn, the Appellant asked Ms. Hisey whether the treatment plan was "appropriate for and consistent with the severity of the insured's injury or impairment sustained as a result of the motor vehicle accident." Again, this is not the statutory question. Ms. Hisey replies:

> It is this therapist's opinion that confirmation of etiology of any motor vehicle accident- related neurological symptoms or any residual motor vehicle accident-related neurological impairments, if present, are determined and the proportion of which, are attributed to the subject motor vehicle accident-related injuries … Until the, there is limited medical evidence to confirm the appropriateness or necessity of the proposed Treatment and Assessment Plan in question.

Ms. Hisey's November 3, 2001 report states that Dr. Kertesz' October 19, 2011 neurological IME report states that the abnormalities shown on the MRI are related to pre-existing documented cervical spondylosis. Ms. Hisey opines that it was unlikely that a "minor rear-end

collision would produce such abnormalities. The fact that Mr. Jazey became symptomatic after the motor vehicle accident suggests some contribution but not causation by the whiplash."

Subsection 15(1) of the *1996 Schedule* states that an insurer shall pay for reasonable and necessary measures undertaken by an insured person to reduce or eliminate the effects of any disability resulting from the impairment or to, amongst other things, facilitate the insured person's reintegration into the labour market.

It is unclear how it is reasonable for an insurer to rely on an occupational therapist's report that, while commenting on matters outside of her expertise, omits an opinion presumably within her expertise as to whether the requested ergonomic equipment, or any part thereof, was reasonable and necessary in facilitating the Appellant's first-party insured's continued employment.

Dr. Kertesz, in answering the Appellant's questions, stated that it was "unlikely that a minor rear end collision would produce such abnormalities. The fact that he became symptomatic after the MVA suggests some contribution but not causation by the whiplash." Dr. Kertesz concluded that the $26,628.75 treatment plan was "not consistent with the impairment of the severity of Mr. Jazey's injury sustained in the subject accident. It is unlikely that such an extensive purchase of equipment and occupational therapy intervention 3 years after a minor accident, and 2 years after neck fusion would be improving his neurological status and it is not required from the neurological point of view."

The Arbitrator, at page 16 of his decision, held that he found Dr. Kertesz' opinion to be unsubstantiated, that Dr. Kertesz was not present at the hearing to explain why he should be considered as an expert in the implication of motor accidents upon an individual's body. I am not persuaded that there was no basis to the Arbitrator's finding.

Further, as with Dr. Conn, the issue was not orthopaedic or neurological necessity or improvement, but what was reasonable and necessary in facilitating the first-party insured's continued employment. Again, it was not reasonable for the Appellant to deny this benefit on the basis of its own threshold for entitlement and a different basis for consideration than that submitted by the Respondent.

Regarding the recommended psychological treatment, the Arbitrator stated at page 28 of his decision that the Appellant gave no reason for its decision to pay for only part of the recommended psychological treatment.

However, the Appellant did have the January 16, 2012 IME opinion of Dr. Corbin. Again, the Appellant asked specific questions. Dr. Corbin answered that the Respondent had not reached pre-injury status and had not reached maximum medical improvement. The Appellant also asked whether "the current and/or recommended Treatment and Assessment Plan dated November 30, 2011 [is] appropriate for and consistent with the severity of the insured's injury or impairments sustained as a result of the motor vehicle accident."

To Dr. Corbin's credit, he did change the question to whether the treatment plan was reasonable and necessary. However, he then answered that question by saying that eight sessions "should probably suffice" because the Respondent was doing relatively well psychologically. This ignores Dr. Corbin's prior statement at page 4 of his report that the treating psychologist was continuing to help the Respondent come to terms with his limitations and accept that he cannot work at the same standards he was used to prior to the accident. It is difficult to see how this report was a reasonable basis upon which to deny the remaining seven sessions.

The Appellant's February 9, 2012 OCF-9 stated that the Respondent's January 21, 2012 OCF-18 in respect of massage therapy would remain declined pending the results of the Appellant's Insurer Medical Examination ("IME"). Dr. K. Hamilton's April 2, 2012 IME report stated that the massage therapy would not "have a long-lasting benefit" and was unlikely to improve the Respondent's functional capacity. Dr. Hamilton, however, acknowledged "that these treatments initially and for a short time alleviate the claimant's various aches and pains within the affected regions of his body."

The Appellant also asked Dr. R.J. Wahby whether the treatment plan was "appropriate for and consistent with the severity of the insured's injury or impairments sustained as a result of the motor vehicle accident." Dr. Wahby was of the view that the treatment was not appropriate as the "massage therapy might give instantaneous relief, it would be very short lived and not curative."

However, the argument that medical and/or rehabilitation treatment are neither reasonable nor necessary solely on the basis that they do not cure medical injuries has long been rejected. As Arbitrator Alves stated in *Violi and General Accident Assurance Co. of Canada*, (FSCO A98-000670, August 20, 1999):

> No one has been able to offer Mr. Violi a cure for his pain. What he seeks is pain relief. The premise of the DAC report is that the treatment claimed must promote recovery to be reasonable and necessary. In the case of *State Farm and Walker*, [*State Farm Mutual Automobile Insurance Company and Walker* (OIC P96-000036, December 3, 1996] Director's Delegate Draper held that the *Schedule* does not require the insured person to establish that she would not have recovered if the item were not provided. Pain relief is one of the reasons people frequently consult medical practitioners, and I find the relief of pain in and of itself to be a legitimate medical and rehabilitative goal. For these reasons I reject the premise in the DAC's report that treatment which relieves pain but which does not also promote recovery, is unreasonable and unnecessary.

As noted above, the Arbitrator held that regarding the requested attendant care benefits, the Appellant did not obtain and provide its own experts' opinion that they were unreasonable.

The Appellant filed four large volumes of medical documents at arbitration. The material is overwhelming forthcoming from the Respondent, consisting of continuing Treatment Plans, Reports, Disability Certificates, clinical notes, test results and consultation reports. None of this massive documentation caused the Appellant to reverse its refusal papered (using the *Cowans* terminology) on inherently faulty IME reports. As the Appellant states both at paragraph 174 of its August 12, 2014 arbitration submissions and paragraph 69 of its February 18, 2015 appeal submissions, unreasonable behaviour includes behaviour that is stubborn and/or inflexible.

The Appellant objects to the Arbitrator's use of the word "routine" in describing its denials when it submits it did pay for some things. Paragraph 173 of the Appellant's August 12, 2014 arbitration submissions state it had paid the Respondent $48,757.12 to date. The Appellant's June 14, 2012 letter, at Tab 15 of Volume 2 of Exhibit 5 states that of the $41,135.29 paid to date, $14,569.21, or more than a third, had gone for examinations and assessments.

I take the Arbitrator's use of the word "routine" not to mean occurring in every instance in the entire adjusting of the file, but, as set out in *Merriam Webster's Collegiate Dictionary*,

Tenth Edition (1993), mechanical in the above-noted instances in dispute in this proceeding.

As stated above, *R. v. Sheppard* held that "[t]he appellate court is not given the power to intervene simply because it thinks the trial court did a poor job of expressing itself." Following *Young* and *Lombardi*, I am not persuaded that there was no evidence upon which the Arbitrator made a special award.

In the alternative, if the matter should have been returned to arbitration for a new consideration on the basis of an insufficiency of reasons, given the agreement of both parties that I decide the matter and for the reasons set out above, I am persuaded that a special award is warranted based on a finding of that the Appellant unreasonably withheld the benefits in dispute.

Turning to the amount of the special award, the Appellant submits:

1. The Arbitrator erred in calculating the special award.

2. As stated in *Persofsky*, the special award should be based solely on the benefits that were unreasonably withheld or delayed. The Arbitrator erred in failing to differentiate between those benefits he found had been "unduly delayed" and those that were simply owed.

The Respondent's July 29, 2014 arbitration submissions included two schedules setting out the mathematical calculations of a maximum special award that it calculated as $131,408.77.

The Appellant's August 12, 2014 responding arbitration submissions consist of 182 paragraphs. Two, at page 40 of 41 pages, pertain to the quantum of a special award. Neither objects to the Respondent's mathematical calculation. It states only that the special award should be based only on the benefits that were unreasonably withheld or delayed and the principles of rationality and proportionality should be applied.

The Appellant's September 4, 2014 oral submissions are equally silent on the mathematical calculation of the maximum available special award. It did not provide its own calculation.

Neither the Appellant's February 18, 2015 appeal submissions nor its May 25, 2015 reply appeal submissions object to the Respondent's mathematical method of calculation.

I note that subsection 282(10) does not restrict the maximum special award to a percentage of the benefits unreasonably withheld. Rather, it states that the mathematical calculation is against "the amount to which the person was entitled at the time of the award." If the Legislature had wished to restrict the multiplicand (the figure against which a multiplier is multiplied to find a product, the product in this case being the special award) to payments that were unreasonably withheld, it would have said so. Rather, the Legislature has set out the unreasonable withholding or delay of payments as a pre-requisite to a separate, carefully stated, mathematical formula.

Reading in restrictions on that mathematical equation is inconsistent with the consumer protection intent of the legislation stated by the Supreme Court of Canada in *Smith v. Co-operators General Insurance Co*., [2002] 2 S.C.R. 129. It runs counter to subsection 64(1) of the *Legislation Act*, 2006, S.O. 2006, c. 21, that an "Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects." In this case, however, the benefits to which the Respondent has been found entitled were all unreasonably withheld.

The Appellant's December 9, 2015 report of Jarvie & Company Inc. sets the maximum possible special award as $110,296.59 based on the December 9, 2014 date of the Arbitrator's decision. The Respondent provided a December 9, 2015 report that set the maximum special award at $197,638.25 as of the beginning of December 2015.

Part of the arithmetic difference is that the parties have calculated the special award to a different date. A further minor difference is the amount allotted to the principle cost of the hot tub. Another minor difference is that the parties are off by a few days on when interest begins running. The Respondent's May 25, 2016 letter states that the major difference is "a different manner of interest calculation for the special award."

The Appellant has the onus of establishing that the Arbitrator erred in law in calculating the maximum possible special award. The Appellant provides 11 pages of figures based

on its accountants' assertion that its calculations are "in accordance with the SABS" and "in accordance with subsection 282(10) of the Insurance Act." That is of no assistance in establishing an error of law.

The Arbitrator's maximum possible special award of $131,408.27 was based, in part, on ergonomic equipment of $38,176.10. I have allowed $30,090. On the other hand, interest under the *1996 Schedule* and the *Insurance Act* continued to accrue. In the case of the stayed $15,931.90 for the hot tub, interest has accrued for a further year and a half from the Arbitrator's December 9, 2014 decision. I am persuaded that any fine-tuning of the maximum possible special award would leave an amount close to the $131,408.27 determined by the Arbitrator.

The Arbitrator had before him the Respondent's July 29, 2014 written arbitration submissions that, at pages 62 to 63, set out the following cases where special awards had been previously granted:

1. *Singh and Commercial Union Assurance Company*, (FSCO A99-001160, September 11, 2001), upheld on appeal by Director Draper in *Commercial Union Assurance Company and Singh*, (FSCO P01-00042, June 12, 2002), awarded $61,829.52 (half of the $123,659.04 maximum). Arbitrator Miller made this determination based on the insurer terminating benefits "when it did not have any meaningful medical evidence on which to base its termination" and "refused to adjust the amount" of the benefit although it had the information to do so and "refused to re-evaluate or adjust [the] claim in the face of overwhelmingly significant and material evidence which substantiated her claim." This unreasonable conduct created a great deal of harm to the insured and to her family.

2. Arbitrator Wilson, in *Thangarasa and Gore Mutual Insurance Company*, (FSCO A02–001360, August 9, 2005), granted a special award of $39,295 (the maximum available award in that case being $56,136). The insurer had argued that it was entitled to rely on the officially sanctioned Designated Assessment Centres that supported its decision, and that it could not be faulted for such reliance. Arbitrator Wilson found other information, including an Occupational Therapist who had worked closely

with the insured in trying to integrate him into work that strongly disagreed with the insurer's opinion there were no cognitive impairments.

3. Arbitrator Sampliner, in *Henderson and Lombard General Insurance Company of Canada*, (FSCO A97-001019, March 31, 2000), (appeal by the *insured person* dismissed in *Lombard General Insurance Company of Canada*, (FSCO P00-00027, January 7, 2002), granted a special award of $65,000 (approximately 40% of the maximum available special award of $160,000). The insurer argued that the entire dispute arose out of a novel point of law. Arbitrator Sampliner found as a mitigating factor that the insurer had made some payments but that it had also, in part, "neglected its duty to evaluate and respond" to the claims of its insured.

4. Arbitrator Murray, in *Federico and State Farm Mutual Automobile Insurance Company*, (FSCO A08-001138, December 10, 2012), granted a special award of $58,000 (some 20% of the withheld benefit payments). She held that the insurer persisted in its position that its insured was not entitled to benefits, despite the medical information it had.

Again, section 15 of the *1996 Schedule* provides that the insurer shall pay an insured person who sustains an impairment as a result of an accident a rehabilitation benefit that shall pay for:

> … reasonable and necessary measures undertaken by an insured person to reduce or eliminate the effects of any disability resulting from the impairment or to facilitate the effects of any disability resulting from the impairment or to facilitate the insured person's reintegration into his family, the rest of society and the labour market.

The Respondent's position regarding the benefits in question is perhaps best summed up in his own evidence on page 193 of Volume 1 of the arbitration transcript, noted above, that he would be "able to maybe work longer and when I'm done working to having less pain, which then makes it so I can work again the next day."

As stated by the Appellant itself, at paragraph 70 of its February 18, 2015 appeal submissions, citing my decision in *Wawanesa Mutual insurance Company and Melchiorre*, (FSCO P07-00014, April 25, 2008):

> The purpose of a special award is to deter first party insurers from unreasonably withholding or delaying payments, reinforcing their duty of *uberrimae fides*, that is, utmost good faith, towards their own insureds.

What I take from the Arbitrator's decision is acknowledgement of an insured person trying his best to reintegrate himself, especially in the labour market, with reasonable and necessary measures to reduce the effects of his disability resulting from his accident-related impairments, including pain, and an insurer's stubborn and unyielding position, seized upon by selected experts, that the monies in dispute were not consistent with a minor rear end collision with less than $2,000 property damage and/or that the items in dispute were not orthopaedic or neurological requirements or would not cure his impairments.

In *Persofsky*, Director Draper stated that "[r]ationality refers to the need to relate the particular facts of the case to the underlying purposes of the legislation. In other words, what amount is large enough to further the goals of punishment and deterrence, but no larger than is needed to serve that purpose." Proportionality, he stated, "refers to the need to ensure that the consequences imposed on the insurer are rationally related to the misconduct at issue."

The Appellant's actions in this matter undermine the major intent of this legislation of rehabilitating victims of motor vehicle accidents. Deterrence regarding this prime principle is directed not only to the insurer in question, but to all first-party automobile insurers. I am not persuaded that there was no basis in terms of either rationality or proportionality upon which the Arbitrator found the Appellant liable to pay a special award of $32,852.07.

In the alternative, if the matter should have been returned to arbitration for a new consideration on the basis of the Arbitrator providing insufficient reasons, given the agreement of both parties that I decide the matter, based on the principles of rationality and proportionality and considering the prior cases provided by the Respondent, I am persuaded that a special award of $32,852.07 is warranted on the particular facts of this case to support the major rehabilitative intent of this legislation and that such an amount, if not more, is necessary to serve the goal of deterrence.

Accordingly, this aspect of this appeal is dismissed.

III. ARBITRATION LEGAL EXPENSES

The Arbitrator's December 9, 2014 decision awarded the Respondent his legal expenses of the arbitration. The Arbitrator, however, failed to give reasons for this award. The Arbitrator's failure to give any reasons whatsoever for his expense determination was an error in law.

Normally this matter would return to arbitration for a redetermination. However, as noted, the parties agreed that rather than return any matters to arbitration, in the interest of justice, expeditiousness and cost-effectiveness, I should decide any issues requiring a new determination.

The Appellant submits that if successful on appeal, each party should bear their own arbitration legal expenses. It, nonetheless, submits an Arbitration Bill of Costs of $31,647.32. This includes 376.6 hours at the legal aid rate. The Appellant's Bill of Costs at full indemnity rates is $64,706.69.

The Respondent seeks $107,936.10 in arbitration expenses. This includes 329.3 hours at up to $150 an hour. It also encompasses, with supporting documentation, $28,875.53 in disbursements, including $13,099.33 for medical reports and records and $11,161 for witness attendance.

Subsection 12(2) of R.R.O. 1990, Reg. 664 (the "*Expense Regulation*") sets out the criteria to be considered in awarding legal expenses. I am persuaded that the Respondent is entitled to his reasonable arbitration legal expenses for the following reasons:

1. Most importantly, the first criterion of the *Expense Regulation*, "each party's degree of success in the outcome of the proceeding."

   The Respondent, being required to proceed to a hearing to obtain payment of statutory benefits, was overwhelmingly successful at arbitration. I am not persuaded by the Appellant's argument that each party should bear their own arbitration legal expenses or, in the alternative, the Respondent's arbitration legal expenses should be reduced because he was not 100% successful. Such a result would frustrate the goal of insured persons having access to justice against much wealthier insurers.

2. The second criterion of the *Expense Regulation* is whether there were any written offers made in accordance with the *Code*. The Respondent submits that the arbitration result was a total of $165,680.90 ($93,496.62 in benefits plus interest) plus legal expenses. Under my interim appeal decision allowing a partial stay of the Arbitrator's Order, the Respondent paid $79,815.32 in respect of benefit and interest orders not stayed.

   The Appellant's June 5, 2014 offer to settle the issues in dispute was in the amount of $17,708.70 for benefits and interest, plus $2,291.30 for legal expenses. This was far below what the Respondent ultimately obtained. The Respondent's May 29, 2014 offer to settle the treatment plans in dispute for $32,500, plus interest and legal expenses, was far less than he received in a final award.

   The Appellant's June 3, 2014 offer to settle was for $46,500, on a full and final basis. This was still far less than the Respondent's award. However, this offer was not in accordance with the *Code* as the Respondent's entitlement to *all* statutory accident benefits was not being decided in this arbitration. Rather, only discrete issues were in dispute. To consider this offer is to compare apples to oranges.

   I am not persuaded by the Appellant's argument that it should be given credit for its "compromising settlement strategy." Rather, the Appellant would have been wise to have accepted the Respondent's June 4, 2014 full and final offer of $50,000, plus interest and legal expenses.

3. Criterion 3 of the *Expense Regulation* is the conduct of a party or of a party's representative that tended to prolong, obstruct or hinder the proceeding.

   Regarding the Appellant's conduct, the Respondent's May 31, 2014 letter confirmed his offer to settle some of the smaller issues in dispute. The Appellant's position was "that it was all or nothing – we could settle all of the issues, but not some of the issues." As the Respondent submits, the Appellant required that he prove every issue. It objected even to his request to withdraw the issue of $515.69 for an X-Box for yoga instruction.

Rule 41.1 of the *Code* requires each party to provide, at least thirty days before the first day of the hearing, the names of witnesses it intends to call or requires to attend for cross-examination. The Respondent argues, as an example of the Appellant prolonging, obstructing or hindering the proceeding its May 15, 2014 letter (less than 30 days before the start of the arbitration hearing) that it may call 20 witnesses, including 10 doctors.

The Appellant's May 29, 2014 letter indicated it might call two of its expert witnesses. The Respondent submits, and the Appellant does not contradict, that only after three or four days into the hearing did the Appellant advise of its intention not to call any witnesses.

However, the Respondent's May 9, 2014 letter required "all of [the Appellant's] witnesses to be in attendance [at the arbitration hearing] and reserve the right to cross examine them on their evidence."

The Respondent submits that the Appellant "ultimately capitulated on this issue" only before closing submissions. I am persuaded by the Respondent that the Appellant's position required him to call experts to speak to this issue.

The Appellant does not respond to the Respondent's May 5, 2016 expense submissions, at paragraph 37, that the Appellant served documents, requested months before, less than five days before the start of the hearing.

Turning to the Respondent's conduct, I would not label the Respondent's increased claim for ergonomic equipment set out in Ms. Gowan's second report and her new OCF-18 an "ambush." In my reading of the transcript, argument on whether to allow this amendment was comparatively brief. However, along with the Respondent's late service of Dr. Sequeira's May 26, 2014 report just a week before the hearing, this is hardly best practices. I am not, however, persuaded that this is sufficient reason to deny the Respondent its legal expenses of the arbitration proceeding.

The Appellant also submits that the Respondent failed to produce his CCAC file.

Rule 32.1(a) of the *Code* provides that a party, at least ten days before the pre-hearing discussion, must establish reasonable time frames for the exchange of any remaining documents. Under Rule 33, a major purpose of the pre-hearing discussion is making orders and setting time lines for the exchange of outstanding productions.

The initial pre-hearing was held August 22, 2013. The Respondent responds, and the Appellant does not dispute, that the Appellant's CCAC request came less than 30 days before the June 2014 hearing, and that he did not receive the CCAC file in time. I find that any hindrance in this regard was caused by the Appellant, not the Respondent.

The Appellant submits that the Respondent did not provide particulars of his claim for a special award prior to the arbitration hearing. There are numerous Rules in the *Code* that speak to parties' pre-hearing responsibilities to be completed at least thirty days before the start of the arbitration hearing. The August 22, 2013 pre-hearing letter included a claim for a special award as an issue. The Respondent states, and the Appellant concedes at paragraph 5 of its June 10, 2016 expense submissions, that the Appellant only requested particulars of a special award claim on May 15, 2014, three weeks before the start of the arbitration hearing, eight months after the pre-hearing.

Regarding the quantum of arbitration legal expenses, I am persuaded:

1. The Respondent's claimed 329.3 hours is reasonable in light not only of five hearing days but the written and extensive submissions required. The Appellant cites *P.B. and State Farm Mutual Automobile Insurance Company*, (FSCO A09-003232, April 22, 2015):

   > The general approach with respect to fees is to take a pragmatic, broad-strokes approach, with a view to fixing an amount that is reasonable. This includes taking into account the length of the proceeding and the complexity of the issues, and frequently involves applying a ratio of pre-hearing preparation time to hearing time in the range of 1:1 to 4:1.

   I agree with this general approach. However, in this case, a pragmatic, broad-strokes approach makes the 4:1 usual upper limit insufficient considering, amongst other things, the extensive post-oral hearing written submissions.

Again, there were four hearing days in June 2014, followed by written submissions and oral submissions heard September 4, 2014, followed by further written submissions. The parties agree that the long hearing days were long, starting at 9:00 or 10:00 a.m. and going until 5:00 or 6:00 p.m.

The Appellant cites *Henri and Allstate Insurance Company of Canada*, (OIC A-007954, August 8, 1997) for the proposition that a "line by line" inquiry is not appropriate. I also with agree with this proposition. In accordance with this precept, I am not persuaded by the Appellant's arguments that the Respondent's hours for preparation of written arbitration submissions is excessive when, overall, the Appellant claims a total of 376.6 hours versus the Respondent's 329.3 hours.

2. The Respondent's senior counsel was called to the Bar in 1977, less senior counsel in 2008. I find the claimed $150 an hour for senior counsel (for 7.5 hours) and $130 for less senior counsel (172.9 hours) is more than reasonable.

   I am not persuaded by the Appellant's argument that the Respondent's counsel be restricted to hourly rates of $96.95. I am not persuaded that extraordinary circumstances are required to award up to the $150 maximum under Rule 78 of the *Code*. Rather, that provision only requires that the higher amount be justified.

   The complexity of the *Schedule* in this case, with numerous substantive and procedural issues, required more experienced counsel. I am further persuaded that the hourly rates claimed by the Respondent for articling students and law clerks, from $30.82 to $61.64 per hour, are reasonable and justified. I am not persuaded by the Appellant that these modest hourly rates should be reduced to $23 and $46 an hour.

   Nor am I persuaded by the Appellant's argument that it should not have to pay for three different articling or summer students. I accept the Respondent's argument that articling and summer students do change and/or rotate.

I am persuaded that the Respondent's claim of $66,666.16 for legal fees is reasonable. I am not persuaded by the Appellant that this amount should be reduced to no more than $28,474. However, at paragraph 17 of its May 17, 2016 expense submissions, the Appellant submits that the Respondent's reasonable global arbitration legal expenses should be fixed in the amount of not more than $20,000, even when it sets out $31,647.32 as its reasonable arbitration expenses, and $64,706.69 as its full indemnity arbitration account.

Regarding the Respondent's claimed disbursements:

1. I find the Respondent's claimed $4,415.20 for copying, courier, postage, long distance phone calls, research and binding compensable as either specifically listed items under section 4 of the *Expense Regulation* or encompassed in the "catch-all" subsection 4(4) "out of-pocket expenses incurred in the furtherance of the arbitration hearing." I further find these amounts claimed to be reasonable. The Respondent, which did not have the onus of proof, claimed $1,902.69 in similar expenses.

2. Subsection 5(4) of the *Expense Regulation* sets out a maximum of $1,500 for the preparation of a report. The Respondent concedes there is no ambiguity in this provision. I deduct $4,315.02 from the claimed medical report disbursements, as follows:

   (a) $710 from Dr. Sequeira's July 20, 2010 invoice of $2,210.
   (b) $855 from Gowan Health Consultants' June 5, 2011 invoice of $2,355.
   (c) $340 from Dr. Sequeira's July 20, 2012 invoice of $1,840.
   (d) $1,267.52 from Yvonne Pollard & Associates' April 22, 2014 invoice of $2,767.52 (Future Care Costs Report).
   (e) $1,142.50 from Gowan Health Consultants' April 25, 2014 invoice of $2,642.50.

   I allow the balance of $8,784.31 claimed for medical reports and records. The Appellant's May 27, 2016 responding arbitration submissions requested a breakdown of the $13,099.33 sought for medical records and reports. That, however, had already been provided by the Respondent in 40 pages of supporting documentation in his prior May 5, 2016 written

expense submissions, including what was paid and what was not. I leave it to the parties, now that the Appellant is aware of this breakdown, to resolve any questions in this regard.

3. Subsection 5(3) of the *Expense Regulation* sets out a maximum of $200 per hour of attendance, up to a maximum of $1,600 a day. Subsection 5(4) of the *Expense Regulation* allows up to a maximum of $500 to an expert witness for preparation for a hearing at which the witness testifies.

I find that it was reasonable for the Respondent to call his witnesses. As set out above, the Appellant refused to settle any individual issues and required the Respondent to prove every issue in dispute, including causation. I am not persuaded by the Appellant's argument that the Respondent called "6 medical witnesses to simply restate the opinions expressed in their written reports." The Appellant's May 15, 2014 letter, less than a month before the start of the arbitration hearing, stated that it might require the attendance of five of those witnesses, namely Dr. Bailey, Dr. McKillop, Dr. Sequeira, Ms. Gowan and Ms. Fox.

The Appellant submitted that Dr. McKillop, Ms. Buffone, massage therapist, Ms. Gowan, OT, and Ms. Fox, physiotherapist, were only entitled to a lesser hourly rate under the Professional Services Guidelines of between $58.19 and $150 an hour because they were not expert witnesses.

One queries that if there is no objection to reports being entered as being expert, as required for compensation under subsection 5(5) of the *Expense Regulation*, how can the testimony of the author of the report be denied payment under the subsections 5(3) and (4) of the same Regulation?

In any event, Ms. Fox was qualified as an expert as a physiotherapist at pages 3 to 6 of the June 12, 2004 transcript. At page 16 of the June 11, 2015 transcript, the Appellant's counsel specifically stated she had no issue with Ms. Gowan being "qualified as an expert in the field of Occupational Therapy and Disability Management, including attendant care assessments, ergonomic assessments and qualified to give evidence in that regard." At page 6

of the June 13, 2015 transcript, Dr. McKillop was tendered as having particular expertise in rehabilitation psychology.

At page 155 of the June 11, 2015 transcript the Arbitrator accepts Ms. Buffone's expertise in massage therapy but states to counsel "I'm not sure you want to put her in as an expert." I am not sure what that means, especially as Ms. Buffone was asked and gave her opinion on the reasonableness of treatment. That was not objected to by either the Appellant or the Arbitrator. In any event, I am persuaded that Ms. Buffone's hourly rate of $102 is reasonable. I am not persuaded to reduce that hourly amount by $41.81 as argued by the Appellant.

The Appellant submits that Dr. Bailey and Dr. Sequeira attended the hearing for not more than three hours each, Dr. McKillop for not more than 1.5 hours, Ms. Buffone for not more than one hour, Ms. Gowan, three hours, Ms. Fox 2.5 hours. I agree with the Respondent that a witness' account is not limited to the time the witness actually gives testimony, but also includes reasonable waiting and travel time. I am reducing the claimed $11,161 for witness fees to $4,766, plus HST, (not the Respondent's requested $3,641) on the following basis:

(a) I allow Dr. McKillop his itemized, most reasonable June 16, 2014 account of $480.
(b) Dr. Bailey's June 16, 2014 account is $4,500 for a total of 2.5 hours: 1.5 hours for preparation and one hour for attendance. That is $1,800 an hour. I award $200 for Dr. Bailey's attendance and $350 for preparation, for a total of $550.
(c) Ms. Gowan's June 17, 2014 account is in the amount of $3,045, including HST. A breakdown of hours is not provided. I allow $500 for hearing preparation and $800 for hearing attendance, for a total of $1,300.
(d) Dr. Sequeira's July 17, 2014 account is in the amount of $4,520, including HST. A breakdown of hours is not provided. I again allow $500 for hearing preparation and $800 for attendance, for a total of $1,300.
(e) I allow Ms. Buffone her very reasonable account of $306, $204 for preparation and $102 for attendance at arbitration.
(f) I allow Ms. Fox her very reasonable and extremely well-supported account of $830 consisting of $500 for preparation and $330 for attendance.

This totals $4,766. Added to $66,666.16 for legal fees, $8,784.31 for medical reports and records and $4,415.20 for other out-of-pocket legal expenses, the total allowed for arbitration legal fees and disbursements is $84,630.67. Adding 13% HST, the total is $95,633.79.

IV. APPEAL LEGAL EXPENSES

The Appellant submits an Appeal Bill of Costs at the legal aid rate of $11,865.72. This includes 146.3 legal hours at varying hourly rates of up to $94.27 an hour. In a separate Bill of Costs, at hourly rates of up to $400 an hour, the Appellant set out its legal expenses as $33,164.13. The Appellant submits that if successful on appeal, each party should bear their own appeal legal expenses. It argues that if it is only partially successful, then the Respondent's expense award should be reduced to reflect the degree to which he was not successful.

The Respondent seeks $30,160.31 in appeal legal expenses. This includes $1,397.94 for disbursements. In addition, 263.3 hours are sought at up to $150 an hour.

I concur with the Respondent that both sides acted reasonably in agreeing, at the end of the November 11, 2015 oral appeal hearing, that rather than returning any issues to arbitration that this Appellate Officer determine those issues on the basis of the arbitration transcript, the exhibits and the parties' argument. However, I am persuaded that the Appellant should pay the Respondent his reasonable appeal legal expenses for the following reasons:

1. The Respondent was largely successful on appeal.

2. The Respondent was successful in resisting most of the Appellant's requested stays, which resulted in the Appellant's immediate payment of $79,815.32.

3. The Notice of Appeal contained less than half a page of submissions on the Appellant's requested stay. The January 21, 2015 Response to Appeal states, in part, that the Appellant's reasons for appeal were not fully particularized and that some reasons lacked sufficient detail for a proper response. The Appellant's reply submissions set out 23

pages of argument. In fairness, oral submissions were required for the preliminary issue of the Appellant's requested stay of the Arbitrator's orders, at extra cost to both parties.

4. I agree with the Respondent that grounds of appeal included questions of fact, not law, contrary to subsection 283(1) of the *Insurance Act*.

Regarding the quantum of the appeal legal expenses sought:

1. Legal appeal expenses are also an access to justice issue. The larger reasonable expense claims of insured persons for legitimate benefits claims are reduced, the greater portion of legal expenses that the insured person must personally carry.

2. I agree with the Respondent that this appeal required counsel "to have mastery of the issues, law, facts, and evidence" in this appeal involving numerous issues and considerable, if not massive, documentation.

3. I agree with the Respondent that the appeal was important as it pertained to his access to assistance in his continued recovery and rehabilitation.

4. I agree with the Respondent that he conducted the appeal in a manner that promoted its least expensive and most efficient resolution. Senior counsel, seeking $150 an hour, spent 24 hours on this appeal compared with more junior counsel, seeking $130 an hour, who spent 109.4 hours. As well, articling students and law clerks spent 129.9 hours, at their much lower hourly rates of between $30.82 and $64.73 an hour. The Respondent, however, conceded that the 70 hours allotted for articling students, while at a considerably lower rate, may be "overkill" due, in part, to their inexperience.

5. Because most of the preparation work for this appeal was done by more junior counsel, I find in the specific circumstances of this case that it was entirely reasonable for the two counsel to both attend in-person oral appeal submissions. Accordingly, I allow the 8.5 hours claimed by more junior counsel for her attendance at oral submissions to assist senior counsel who would be far less familiar with the extensive appeal material.

6. I allow the hours claimed by the two counsel (133.4). That is less than the 134.4 hours claimed by counsel acting on behalf of the Appellant (plus 12.9 hours articling students and law clerks, for a total of 146.3 hours). I am reducing the hours claimed by the Respondent in respect of the articling students and law clerks, as set out below.

7. The senior counsel retained by the Respondent was called to the bar in 1977. The junior counsel was called in 2008. I am not persuaded that the Respondent's counsel should be restricted to the legal aid rates, argued by the Appellant to be no more than $96.95.

   As stated, I am not persuaded that extraordinary circumstances are required to award up to the $150 maximum under Rule 78 of the *Code*. Rather, that provision only requires that the higher amount be justified. I am persuaded that the higher amounts are justified based on the Respondent's overall success, the expertise and efficiency of his counsel, the legitimate importance of the issues to the Respondent, and the complexity of the appeal in terms of the number of issues and the rehearing of certain arbitration issues, as agreed by both parties. Further, the $150 maximum allowed is far below the hourly rates of counsel of both the Appellant and the Respondent.

In *Lunn and State Farm Mutual Automobile Insurance Company*, (OIC A-013960, March 15, 1996), Arbitrator Kirsch found that that rather than a line-by-line assessment of legal expenses a global assessment of reasonable expenses was appropriate. In *Henri and Allstate Insurance Company of Canada*, (OIC A-007954, August 8, 1997), Arbitrator Makepeace confirmed that the main consideration in determining legal expenses is reasonableness. She held that a ratio of preparation time to hearing time served as a rough approximation of the reasonableness of the submitted account.

However, Delegate Evans, in *Rooz and Certas Direct Insurance Company and Zapisnoy*, (FSCO P07-00017, November 18, 2009), held "that ratios in appeals are of limited assistance, given that the bulk of work done in appeals goes to preparing written submissions for relatively short oral submissions and that brevity may in fact reflect a considerable amount of work."

In *Bains and RBC General Insurance Company*, (FSCO P09-00005, September 8, 2010), I reviewed twenty appeal expense awards. The average award was $4,733.58 where expenses were awarded to insured persons (reflecting a higher allowed hourly rate) and $2,812.91 where expenses were awarded to insurers.

I find the present case to be distinctly different from the average appeal case considering (1) the number of issues in this appeal, (2) the parties' agreement that I decide any issues that would normally be returned to arbitration and the parties addressing those issues, and (3) the 146.2 hours expended by the Appellant.

I allow the Respondent's senior counsel 24 hours at $150 an hour and his more junior counsel 109.4 hours at $130 an hour, as claimed. This amounts to $17,822. Given my finding that the hours claimed by articling students and law clerks are excessive, I reduce the Respondent's total claimed fees from $25,292.60 to $20,000. I find the Respondent's claim for $1,397.94 for disbursements, largely for copying and couriers, to be reasonable. The Appellant claimed $557.63 for similar expenses.

13% HST on $21,397.94 is $2,781.73. Accordingly, I award the Respondent its legal appeal expenses fixed in the amount of $24,179.67.

___________________________	July 29, 2016
Lawrence Blackman Director's Delegate	Date