**TOP 10 ACCIDENT BENEFIT CASES**

**INTRODUCTION**

The past year has produced some interesting accident benefits cases which will be of use to practitioners in this field. Of interest are a few Appeals and Judicial Reviews which are of particular benefit to counsel representing injured parties.

Attendant Care Benefits

**1. BELAIR INSURANCE CO. v. McMICHAEL, [2007] 86. O. R. (3d) 68 (Ont. Div. Ct.)**

The Applicant David McMichael was injured in a motor vehicle accident in June of 1998. Mr. McMichael, suffered significant injuries including: a skull fracture; compound femur fracture; broken ribs; fractured scapula; pneumothorax; cuts and abrasions requiring plastic surgery; post-traumatic confusion; amnesia; mild traumatic brain injury; TMJ; and a crushed T9 vertebra with 25% loss of vertebral height. Unfortunately, while recuperating from his injuries Mr. McMichael became a crack cocaine addict. It appears clear from the initial arbitration decision that the crack addiction was the most disabling problem by the time of the arbitration hearing. The initial arbitration decision contains an excellent discussion on defining catastrophic impairment pursuant to Section 2 (1.1) (g) [Mental Impairment]. However, the sole issue that proceeded to Judicial Review was the entitlement to past attendant care benefits from the date they were denied onward. During much of the time since Mr. McMichael had become a crack cocaine addict he had secluded himself from his family and did not have the money to hire an attendant. Because neither his family nor a professional had actually provided the past attendant care, the insurer argued that it was not “incurred” and therefore was not a payable expense. Mr. McMichael’s counsel argued on the other hand that the word “incurred” ought to be given a broad liberal interpretation. He also argued that fundamental policy consideration ought to ensure that an insured person who has the money to purchase services should not be treated better than those without similar financial resources.

Justice Lane writing on behalf of the Divisional Court determined that the word “incurred” should be given a broad and liberal interpretation upholding the Arbitrator and Director’s Delegate’s decisions on this issue. Despite the fact that the Applicant had not actually received the attendant care, he was entitled to a payment of the benefits in any event. It is important to realize that Applicant’s counsel had laid the proper foundation for claiming attendant care benefits. This included submission of an application and Form 1 identifying the applicant’s need. This decision essentially means that insurer’s deny attendant care benefits at their own risk. Insurer’s will not benefit simply because the applicant is unable to obtain the services following the insurer’s initial denial.

1. **HAIMOV v. ING. INSURANCE CO. OF CANADA, [2007], F.S.C.O. A05-002734 and BELAVIA v. ALLIANCE/ING. INSURANCE CO. OF CANADA [2006], F.S.C.O. A05-000807**

In both of these cases, the Applicant was seriously injured in a motor vehicle accident and remained in medical facilities (i.e. hospital or long-term care facility). Both Applicants required ongoing daily care in their medical facilities. However, in both cases, family members were also required to provide ongoing assistance which included grooming, washing the insured, taking him or her out for air, clipping toenails, monitoring tracheal device, taking him or her on outside excursions such as a concert, providing emotional support, providing general supervision when the nurses were not around, etc.. The Arbitrator in both cases found that the tasks performed by the family were supplementary to the care provided by the hospital staff and were linked to the insured’s safety, ongoing comfort, quality of life and physical and emotional well-being. These tasks were therefore, “reasonable and necessary attendant care services” under the SABS.

These decisions address the issue of co-payments under the Attendant Care provisions. Essentially, the Arbitrators in both cases decided that the insured could receive attendant care payments concurrently from an aide/attendant under Section 16(2) (a) and from a long-term care facility under Section 16(2) (b).

Thus, in both the *Haimov* and *Belavia* cases, the insurance companies were required to pay family members accident benefits for their daily supervision even though the insured’s were receiving 24 hour care in hospital/long term care facilities.

Furthermore, in the *Haimov* decision the Arbitrator, sighting the *McMichael* decision confirmed that retroactive payment for attendant care benefits is possible even if the insured did not receive the attendant care during the period in question.

Catastrophic Impairment

**3.** **MS. G. v. PILOT, P06-00004, September 4, 2007**

This is a follow-up decision on a case which has previously been reported through the Financial Services Commission of Ontario. Ms. G. was injured in a motor vehicle accident on August 20, 1998. She sustained serious orthopedic and psychological injuries. This particular decision focuses on the issue of catastrophic impairment and nanny expenses. Because both issues are so important, I will deal first in this part of my paper with the catastrophic impairment decision and later, I will deal with the nanny expenses.

The application for catastrophic determination was made pursuant to Section 2(1.1)(f) [55% whole person impairment]. This case presented significant challenges for Arbitrator Blackman. Several assessments of Ms. G.’s condition had been undertaken to analyze the percentage of whole person impairment. The Applicant, the insurer and a DAC all opined on whole person impairment. In addition, there had been a MED REHAB DAC which had contributed significantly to the assessment of Ms. G’s dental/dietary impairments. After reviewing all of the evidence, Arbitrator Blackman commented that it was not his job to simply accept one of the conflicting medical opinions about catastrophic impairment above all others. Instead the Arbitrator conducted a detailed analysis that involved accepting some parts of various medical reports and rejecting other portions of the same reports to arrive at a final conclusion. This also involved the very difficult process of calculating whole person impairment in accordance with the AMA Guidelines. In addition, Arbitrator Blackman’s decision made it clear that he was at liberty to arrive at different impairment ratings for areas of physical, mental and psychological impairments then the catastrophic assessors.

On appeal, Director Delegate Makepeace agreed with this approach which was “consistent with Justice Spiegel’s treatment of the issue in *Desbiens vs. Mordini*”. This stands out as a example of just how far Arbitrators at the Financial Services Commission are prepared to go in order to broadly interpret catastrophic impairment provisions.

1. **AUGELLO v. ECONOMICAL MUTUAL INSURANCE CO., FSCO**

The Applicant asked for a determination as to whether he had been catastrophically impaired as a result of the injuries suffered in a motor vehicle accident on September 7, 2002. Economical had raised a preliminary issue which had been appealed on consent of the parties to the Director of Arbitrations. Economical wanted the case directly stated to the Divisional Court in order to have a determination of whether or not a Judge and/or Arbitrator were allowed to assign percentages under Section 2 (1.1.) (f) for physical, mental and psychological impairment. The Director of Arbitrations noted that this “combining approach” was accepted by Justice Speigal in *Desbiens* and had also been accepted by FSCO in *Battiste v. Pilot*, *Ms. G. v. Pilot*, *P. (B.) v. Premium Insurance.* The Director further stated that if a request was made to state this case to the Divisional Court, then the Applicant would have lost his right to choose the forum for decision on a Statutory Accident Benefits claim. Recent decisions including *Fernandez* and *Baron* make it clear that the choice of forum is up to the insured person, not the insurer.

Nanny Expenses

**5.** **MS. G. v. PILOT, 2008 CAN L II, 2602 (ON S.C.D.C.)**

This was a judicial review from the decision of Director’s Delegate Makepeace which set aside the Order of Arbitrator Blackman allowing nanny expenses as rehabilitation benefits pursuant to Section 15 of the Statutory Accident Benefits Schedule. In the opinion of the Divisional Court, this was an issue of law, thus, on review the correctness standard was applied.

As noted above, Ms. G. suffered serious injuries in a motor vehicle accident of August 28, 1998. At the time of the accident, she was single. Following the accident, she married and had a daughter on April 20, 2004. The Future Cost of Care report commissioned by Pilot recognized that “in the future she might need services of a nanny to help care for a child as she was unable to perform some of the physical activities necessary for care of her young child”. It was estimated that the nanny would be needed for a future 5 year period for the care of two children until the age of 3 for up to 50 hours a week, 48 weeks of the year for a total annual cost of $25,800.00. The plan was prepared by Ms. Saunoris, R.N. Pilot rejected this proposal and argued that the expense was not reasonable and necessary as a result of injuries sustained in the accident and further that the applicant was not deemed catastrophic (note: obviously she has been deemed catastrophic in accordance with the decision noted above). A MED REHAB DAC was conducted in January and February of 2005 and found that “50 hours of nanny services weekly for 6 to 12 months to be then reviewed was reasonable and necessary for the applicant to ensure the safe care of the children”.

Upon, Judicial Review, the Divisional Court decided that “the Director’s Delegate view that because the class of expense can be obtained under Section 13 (caregiver) they could not be available under Section 15 was not logical”. It was noted that Section 15 “deals with the rehabilitation of the injured person herself”. Section 13 “deals with an allowance to replace caregiver services which the injured person provided to others at the time of the accident”. The Court found that the plan of Ms. Saunoris, R. N. was rehabilitative for the applicant.

The initial decision of Arbitrator Blackman was based on findings of fact that ought to have attracted deference from the Director’s Delegate and the Court. The Director Delegate’s decision on appeal seemed to have been based partly on the fact that allowing this claim could open the “floodgate”. The Divisional Court rejected this argument. Thus, the decision of Arbitrator Blackman was restored and nanny expenses were allowed.

Failure to Properly Terminate IRB’s

**6. STRANGES v. ALLSTATE [2007], 47 C.C.L.I. (4TH) 244 (S.C.J.)**

Ms. Stranges was injured in a motor vehicle accident on May 16, 1996. Income replacement benefits were terminated on September of 1997. An action tried before the Honorable Mr. Justice Borkovich, claimed ongoing income replacement benefits because: a) Allstate did not follow proper procedures to terminate and b) she remained disabled.

Following review of all of the evidence, Justice Borkovich found as a fact that Ms. Stranges had recovered sufficiently from her injuries by the Fall of 1998 that she no longer met the disability test.

However, Justice Borkovich, following the reasons in Smith v. Co-operators, held that the notice of termination was improper and therefore invalid. Justice Borkovich also found that the disability DAC did not assess all of the impairments and thus, was contrary to the Statutory Accident Benefits Schedule. Justice Borkovich found that because of both the improper notice and the improper DAC, the insurer ought to pay income replacement benefits from the date of termination to the date of judgment and ongoing until such time as proper termination and DAC assessment were conducted for Ms. Stranges. This is despite the fact that Ms. Stranges, (according to Justice Borkovich) had not been disabled since 1998. Even though Ms. Stranges was not found to be disabled by Justice Borkovich, she is entitled to a Judgment in excess of $750,000.00. This case is under appeal.

Collateral Benefits

**7. CROMWELL v. LIBERTY MUTUAL (2008) Can L II, 3409 (ON. S.C.)**

This is a decision of Mr. Justice Lofchik on a Summary Judgment Motion. The Plaintiff was involved in a motor vehicle accident on August 13, 1998 where she alleges to have sustained catastrophic injuries. Income replacement benefits were paid following the accident. There was a termination, although eventually income replacement benefits were paid up to May 30, 2003. Trial regarding the plaintiff’s entitlement to income replacement benefits is pending.

However, after the accident, the Plaintiff had also claimed benefits from Sun Life through her long term disability policy. Following presentation of an action and Examinations for Discoveries, the plaintiff settled her claim with Sun Life on December 12, 2003 for $15,000.00 (for benefits which were for past long term disability and deemed taxable) and $160,000.00 of which was designated as “non-taxable”. As a result of the settlement, Sun Life received a Full and Final Release of all claims including costs. Shortly after the settlement, Liberty Mutual Insurance Company took the position that the Sun Life payments were collateral benefits and thus, they were entitled to reduce income replacement benefits accordingly.

Adopting the Supreme Court of Canada Case, *Tsiaprailis*, Justice Lofchik determined that payment of future long term disability benefits under the settlement ($160,000.00) were not a collateral benefit to which Liberty was entitled to take credit. In so finding, Justice Lofchik stated as follows:

Applying that reasoning to the present case, Sun Life was not obligated, under the terms of its policy to pay a lump sum with respect to future payments. There is no evidence before me that the lump sum paid was in any way calculated taking into account the future value of those payments but was rather arrived at on the basis of the amount of money available under the authority of the person authorizing the settlement. I also consider that the Release delivered also released claims against Sun Life with respect to mental stress, aggravated and punitive damages for which Sun Life denied liability in the Release. On that basis, the payment does not qualify as “net weekly payments for loss of income… under any income continuation benefit plan.

This is a significant case and is presently under Appeal.

Productions

**8. HUNTLEY v. STATE FARM MUTUAL AUTOMOBILE INSURANCE CO. (FSCO A-05-002293)**

The Applicant was injured in a motor vehicle accident on October 12, 2001. Income replacement benefits were terminated November 26, 2004. Ms. Huntley underwent a DAC assessment on November 2004 to June of 2005. On behalf of State Farm, Mrs. Huntley had been assessed by Dr. MacDonald, Neurologist on April 23, 2003 and February 3, 2004. Dr. MacDonald had addressed the question of complete inability. In addition, Dr. MacDonald provided an updated report based on new medicals which became available on October of 2004. In the FSCO proceedings, State Farm brought an application for production of a defence medical conducted in the tort action dated June 13, 2005. Following thorough analysis, Arbitrator Nastasi found that Ms. Huntley was not required to produce the defence medial in the tort action as it would cause “doubling up by the insurer”.

Surveillance

**9. SEKYIWAA v. KINGSWAY GENERAL INSURANCE (FSCO A07-001502)**

Arbitrator Blackman ordered Kingsway to produce to the applicants any surveillance or investigation pertaining to the applicant which came into existence prior to the Application for Mediation. In addition, Kingsway was ordered within 60 days of the Pre-Hearing to confirm with the applicant whether it intended to rely upon any portion of its surveillance investigation evidence. Kingsway was also ordered to produce complete disclosure of surveillance investigation videos, photographs, investigative material, notes, summaries taken or prepared in connection with the issues in dispute within 60 days of the pre-hearing if they intended to rely upon that surveillance evidence. Kingsway had argued that the Arbitrator exceeded its jurisdiction and relied upon *Morgan and Security National* in support of its position. Relying upon this decision, Kingsway’s counsel indicated that *Morgan* enshrined Rule 40 of the Dispute Resolution Practice Code as “not merely as separate production Rule, but a distinct area of privilege; that privilege may be claimed under Rule 40 for surveillance or investigation evidence, even in the absence of any claim for litigation or solicitor/client privilege”. The Arbitrator rejected this submission and ordered that the surveillance be produced earlier within the proceedings then is required by Rule 40 of the Dispute Resolution Practice Code.

Videotaping of IE Examinations

**10. VASINA v. ING, A05-001207, May 31, 2007 (FSCO A05-B-001207)**

Ms. Vasina claimed to have suffered catastrophic injuries in an accident in 2004. The insurer wanted a multi-disciplinary Section 42 assessment. Ms. Vasina wanted the assessment videotaped. The assessors objected and thus, the insurer refused. As Ms. Vasina, insisted upon the videotaping, the insurer took the position that she had not made herself “reasonably available” for an examination and brought a Motion to stay the Arbitration. Arbitrator Muir who reviewed the relevant case law, found:

An applicant must establish that there is some basis for the concern giving rise to the request. The Court of Appeal articulated the standard as “a potential for a bone fide concern”. It seems to me that this includes a significant subjective component. There may be circumstances where an entirely subjective belief on the part of the applicant in, for example the unreliability of an expert would support the recording of an assessment.

...

Such requests are apparently not routine and indeed should not be, as they inevitably will add to the complexity and expense of these matters.

…

It also must be shown that the method of recording will not adversely affect the ability of the assessor to do their job and provide the insurer the information it needs to make a determination of entitlement. For the Court of Appeal in *Bellamy*, this was the primary consideration, although in reading between the lines of reasons of Justice Doherty, it may be that this onus is easily met by an applicant and may in deed shift some point to the assessors and questions show what the problem with a recording would be.

…

Finally, there must be consideration of the impact the recording of such assessments on the dispute resolution process and on the conduct of the ultimate arbitration hearing if there is one. I don’t think that, as did the arbitrators in *Peters* and *Cameron*, that there are important distinctions between a Section 42 (or a DAC) assessment and a defence medical that would suggest a higher level of openness and transparency than might be required in a traditional tort case.

In ordering videotaping, Arbitrator Muir commented that it might enhance settlement possibilities because Mrs. Vasina could have more confidence in the conclusions of the assessors and the ability of her counsel to weigh the strength and weaknesses of such medical reports.

**CONCLUSION**

This past year has been a particularly good one for insured persons making claims against their accident benefit carrier. A number of decision noted above ought to be helpful in pursing the benefits available to injured persons who suffer at the hands of their insurance company.