**TOP 10 MOTOR VEHICLE CASES OF THE YEAR**

**OTLA 2014 FALL CONFERENCE**

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**INTRODUCTION**

This paper is intended to summarize but a few of the most important tort and accident benefit cases since our last meeting.

There have been a number of interesting accident benefit cases in the last year which addressed important considerations in the context of catastrophic injuries, such as when the GCS scores will apply following a traumatic head injury, and how to manage a catastrophic designation as a result of multiple accidents. The definition of “incurred expenses” in the context of attendant care benefit claims, for accidents which occurred prior to the enactment of Ontario Regulation 347/13 on February 1, 2014, is another relevant consideration. The ability of a claimant to exclude surveillance from the arbitration process is another important victory for the Plaintiff Bar, which has been addressed and reviewed below.

This paper also examines a number of significant tort decisions which have enforced the potential cost consequences that flow from a failure to act in a reasonable manner. The strict onus of proof required when an insurer attempts to seek a collateral deduction from a tort award has also been reviewed below.

In addition, recent decisions concerning the use of treating physicians’ records and testimony in aftermath of the Divisional Court decision in *Westerhof* v. *Gee*, have served to amplify the uncertainty this decision has generated and crucial need for clarification from a higher court.

**ACCIDENT BENEFITS CASES:**

**Catastrophic Designation Clarified: GCS Score of 9 Taken Four days Post-MVA Found to be Within a Reasonable Period of Time, and to Meet Test for CAT:**

*Security National Insurance Company v. Hodges*, 2014 CarswellOnt 9521 (Ont. S.C.J. (Div. Ct.))

Under the SABS, an insured person is deemed to suffer a catastrophic impairment if the insured suffers a brain impairment that results in a score of 9 or less on the Glasgow Coma Scale administered within a “reasonable period of time” after the accident.

In *Hodges and Security National*, the claimant initially had a Glasgow Coma Scale of 11 at the scene and was then intubated, leading to a Glasgow Coma Scale of 3. A day or so after the accident, and after the tube was removed and medication reduced, the Glasgow Coma Scale improved to 10. In the days following, his GCS varied between 7 and 14 until it returned to normal a few days later. The case largely centered on the validity of a GCS score of 9 taken 4 days after the accident.

During the Arbitration and on Appeal, the insurer argued that the Glasgow Coma Scale reading was invalid because of the influence of medication and that it was not taken within a reasonable period of time after the accident. Both the Arbitrator and Director’s Delegate at FSCO found that the reading of 9 or less taken 4 days after the accident was within a “reasonable period of time” following the accident. Furthermore, Director’s Delegate Blackman found that the legislation does not require a brain “injury” but only a brain “impairment” connected to a GCS score of 9 or less.

Security National sought a judicial review of the Director's Delegate decision. The Divisional Court upheld the Director Delegate’s decision and indicated that Security National suggestion that language should be read into the legislation requiring the GCS to be “valid” and “reliable” or “of significance” is incorrect. The Court did say that what is a “reasonable period of time” will be determined on a case by case basis. The Court accepted that if healthcare professionals were continuing to rate and record GCS scores it was because of the patient’s fluctuating consciousness and thus, was done within a “reasonable period of time” following the accident.

The Divisional Court appears to have confirmed that a Glasgow Coma rating of 9 or under will be given a very liberal interpretation and such scores will rarely be excluded even where the insured makes a good recovery.

**Attendant Care Expenses and CAT Designation from Multiple Accidents:**

*Veley v. Motor Vehicle Accident Claims Fund*, 2014 CarswellOnt 6405 (FSCO Arbitration, May 5, 2014)

The claimant was involved in two motor vehicle accidents, the first on December 28, 2010, and a second on June 30, 2011. The subject Arbitration dealt with the first accident. As there was no insurance policy available in respect of the first accident, the Motor Vehicle Accident Claims Fund took responsibility for the accident benefits claim. Axa Insurance Company was the accident benefit insurer for the second motor vehicle collision.

The claimant suffered a significant injury to his left arm in the first accident, and subsequently became paraplegic as a result of the second accident. Unfortunately, as a result of his inability to use his left arm following the first accident, he was unable to complete independent wheelchair transfers following the second accident, resulting in an inability to live an independent life as a paraplegic. As a result, the Applicant was deemed catastrophic from both accidents.

Arbitrator Ahlfeld, relying on the Court of Appeal decision in *Monks v. ING Insurance Company of Canada*, 2008 ONCA, found that as a result of the determination that the Applicant was deemed catastrophic from both accidents, the Motor Vehicle Accident Claims Fund ("Fund") was liable to contribute to the Applicant's monthly attendant care needs following the second motor vehicle accident up to the monthly maximum of $6,000.00. Arbitrator Ahlfed relied on the Court of Appeal’s decision in *Monks, supra* in which it was held that there was nothing in the language of Section 60 (2) of the SABS which would exempt an insurer from having to pay accident benefits that were also being paid as a result of a separate accident. The limitation to same however, was that the amounts received from the second accident were deductible from the overall amount of attendant care on the Form 1.

Arbitrator Ahlfeld found that the monthly attendant care needs following the June 30, 2011 accident to the date of his Order was $9,432.25 per month. Given that Axa was required to pay a maximum of $6,000 per month for attendant care expenses, the Applicant would be entitled to $3,432.25 per month payable by the Fund. Prior to the arbitration however, the Applicant had settled his accident benefit claim with Axa in a lump sum settlement, without any specific information as to what period of time the amounts for attendant care payments reflected. This lump sum settlement was therefore deemed not deductible. Given this finding of non-deductibility, Arbitrator Ahlfeld held that from the date of the accident benefit settlement with Axa of December 20, 2012, the Applicant was entitled to $6,000 per month for attendant care benefits from the Fund.

Arbitrator Ahlfeld also addressed the definition of “incurred”:

The Applicant did receive nursing care, following his release from the rehabilitation program, which was paid by AXA. Following the settlement with Axa, the Applicant stated that given his lack of funds, he had limited nursing care at the time of the subject Arbitration. Arbitrator Ahlfeld held that given the Applicant's need for round-the-clock care had been demonstrated and given that the Applicant had demonstrated that but for his lack of funds, these expenses would have been incurred, the Applicant was entitled to the full $6,000 per month of attendant care payable by the Fund from December 20, 2012, notwithstanding that his actual incurred expenses were less. Arbitrator Ahlfeld found that this view was consistent with the Ontario Court of Appeal decision in *Henry* *v. Gore M**utual Insurance* *Company*, 2013 ONCA 480.

This reliance on *Henry**,* *supra**,* in relation to a December 2010 accident, appears to confirm that the February 2014 SABS amendment to the definition of “incurred expenses”, does not apply retroactively.

**Exclusion of Surveillance in the Arbitration Process:**

*Allstate Insurance Co. of Canada v. Basra*, 2013 CarswellOnt 7096 (FSCO (Appeal Div.))

At the start of the Arbitration Hearing, the Applicant sought and successfully moved to exclude Allstate's surveillance evidence on the basis that Allstate had failed to comply with Rule 40.1 of the Dispute Resolution Practice Code (DRPC), given that it had failed to provide the investigator's handwritten notes at least 30 days before the hearing.

Allstate did not provide the surveillance documentation until 32 days before the hearing and did not include still photographs or a copy of the investigator's notes. The remainder of the surveillance evidence, namely the still photographs and investigator's notes were not delivered to the Applicant until approximately 20 days before the hearing.

Rule 40.1(b) of the DRPC states that, if a party intends to rely on any portion of surveillance evidence, at least 30 days before the hearing, the party **shall** provide copies of all videotapes, photographs, investigative reports, notes and summaries taken or prepared in connection with the issues in dispute.

Arbitrator Fadel excluded the surveillance evidence based on non-compliance with Rule 40. Allstate appealed this interim order.

Pursuant to Rule 50.2, Allstate was required to seek leave of the Director Delegate in order to proceed with the appeal of this interim order.

Director Delegate Evans, relying on the decision in *Allstate Insurance Co. of Canada v. Torok*, 2001 CarswellOnt 6135, held that the overarching principle guiding the discretion under Rule 50.2 is that it should be broadly interpreted to produce the quickest, most just and least expensive resolution of the dispute. The criteria to be considered included the apparent strength of the appeal, the importance or novelty of the issue raised, and whether rejecting the appeal or hearing, would prejudice either party. Based on this criteria, rejected Allstate’s appeal.

Director Delegate Evans, in coming to his decision to reject the appeal distinguished the extraordinary circumstances exception for late service of documents in Rule 39 from that of Rule 40 which specifically addresses surveillance evidence. Rule 40.1(b) set out a 30-day time frame from which no exceptions are provided.

The final Arbitration Decision of Arbitrator Fadel dated June 5, 2014 (2014, CarwellOnt 8386), confirmed the interim decision to exclude the surveillance evidence, noting that Rule 40 was specific on what was to be provided to the other party. If an insurer was going to wait until the last moment to deliver surveillance evidence, it was incumbent upon it to ensure that it provided everything set out in the Rule, if it existed. The Rule specifically states that the failure to do so means that the insurer may not rely on any portion of the surveillance or investigative evidence. Arbitrator Fadel noted that even if the extraordinary circumstances exception in Rule 39 did apply in the subject situation, there was no extraordinary circumstance that would have allowed for the delivery of the surveillance less than 30 days before the hearing.

An important consideration in preparing for arbitrations is to determine the completeness of the surveillance materials provided by the insurer. If the video materials are edited and items such as handwritten notes have not been provided and the 30 day time period has elapsed, a motion should be brought at the commencement of the hearing seeking to exclude the surveillance in its entirety. Other cases which will assist this position include *Sinnapu v. Economical Mutual Insurance Co.*, 2009 CarwellOnt 7002, and *Hotchkiss* v. *Kingsway General Insurance Co*., 2011 CarswellOnt 15120.

**TORT CASES:**

**Strict Onus of Proof in the Context of Collateral Deduction in a Tort Award:**

*Gilbert v. South*, 2014 CarwellOnt 8156 (Ont. S.C.J.)

A jury awarded a Plaintiff injured in a motor vehicle accident $57,250 in "future care cost" damages, for the Plaintiff's future treatment, medication, rehabilitation, intervention and aids from the date of trial onwards.

The Defendant brought a motion for an order that the Plaintiff was obliged to hold "certain future statutory accident benefits and other collateral benefits", in trust for the Defendant, or assign rights to certain statutory accident benefits from the accident benefit insurer to the Defendant, pursuant to Sections 267.8 (9), (10) and (12) of the *Insurance Act*.

Justice Leach found that the order the Defendant sought was effectively a deduction from the Plaintiff’s overall compensation to the credit of the Defendant.

Justice Leach noted that the objective of Section 267.8 was to prevent a double recovery which was to be balanced by the concern that a plaintiff should receive full compensation and not recover less than that to which he or she is entitled. As a result, the statutory provisions were to be strictly interpreted and applied.

Deductions from a plaintiff's damage award to prevent double recovery would only be made if it was “absolutely clear” that the plaintiff's entitlement to such collateral benefits was certain, and that the plaintiff received compensation for the same benefits in the tort judgment. Justice Leach specifically referred to the adage that "apples should be deducted from apples and oranges from oranges". A very strict onus of proof would apply in relation to such matters and it had to be patently clear that the preconditions for an appropriate deduction had been established.

In the case where there was any uncertainty as to a plaintiff's receipt of such benefits, the value of benefits entitlement, and/or the extent, if any, to which the recovered tort damages related to the same type of expense covered by the benefits received, the matters were not beyond dispute in the sense required for deduction, and as a result no deduction should be made.

Justice Leach noted that the subject matter presented various uncertainties which were reflected in the vague and unspecified nature of the Defendant's request for relief, wherein there was no attempt made to "quantify, with any sort of precision, the scope of relief effectively requested".

Justice Leach held that the Plaintiff's entitlement to future statutory accident benefits was not "patently clear". While the Plaintiff had received certain benefits there was no indication as to whether he would receive further benefits, or the nature and extent of such benefits.

The Plaintiff's entitlement to medical and rehabilitation benefits would terminate 10 years post motor vehicle accident. The future care cost award was from the date of judgment forward, without any differentiation as to whether the damages awarded corresponded to the Plaintiff's future care needs before the ten-year period or his needs after that date. The jury was not asked to indicate, and did not indicate, the extent to which any of the $57,250 in future care cost damages was allocated to the time period during which the Plaintiff may be entitled to medical and rehabilitation benefits from the statutory accident benefit insurer.

In addition, the jury had awarded a global sum of damages for "future care costs" which contained absolutely no allocation to any one or more particular category or categories of future care expenditures. There was no way of making an accurate determination of the extent to which the award of damages was intended to cover aspects of future treatment in respect of which the Plaintiff would be entitled to medical and rehabilitation benefits. A deduction from his damages of all such benefits, without any such qualitative distinctions, would run the risk of the Plaintiff receiving less than the full compensation to which he was entitled.

Justice Leach denied the Defendant's motion, taking the position that there was no effective mechanism or ability to achieve the level of certainty required by the authorities to make the effective deductions requested by the Defendant's insurer, in relation to the Plaintiff's future care cost damage award. Any such deduction inherently would entail the impermissible risk of reducing the Plaintiff's recovery to something less than full compensation.

**Cost Consequences where Insurer Fails to Mediate in Accordance with Section 258.6 of the Insurance Act:**

*Ross v. Bacchus*, 2013 CarswellOnt 17632 (Ont. S.C.J.)

Following a six-day trial by jury, the plaintiff was awarded $248,000 in damages. Plaintiff's counsel in his cost’s submissions sought $140,000 for costs and an additional $60,000 in response to the Defendant insurer's failure to comply with its mediation obligations pursuant to Section 258.6 of the *Insurance A**ct*.

Justice Ramsay referred to the fact that defence counsel had advised that the insurer was agreeable to brief mediation at limited cost, yet in writing confirmed that Certas “was not interested in settling the case”. Justice Ramsay found that the Defendant's participation in the mediation was a sham. His Honour inferred that the insurance company conducted itself in the hopes of intimidating the Plaintiff and deterring other Plaintiffs who have meritorious cases. Certas did not attempt to settle the action expeditiously as required by Section 258.5 of the *Insurance A**ct*.

Justice Ramsay ordered $140,000 in partial indemnity costs plus disbursements and HST. In addition, by reason of the refusal to mediate, the award was augmented by $60,000, plus HST.

This case is a reminder that there are significant cost consequences that insurers should consider when failing to mediate with a view to settlement. This decision opens the door to the ability of the Plaintiff bar to raise and seek significant cost consequences in cases where an insurer fails to comply with their obligations pursuant to Sections 258.5 and 258.6 of the *Insurance Act*.

The decision is currently pending appeal.

**Cost Consequence for Unreasonable Statutory Third Party Insurers:**

*Yetman v. Marzec*, 2014 CarswellOnt 10786 (Ont. S.C.J.)

A jury trial in this matter was held granting judgment for the Plaintiff totaling $1,031,000. State Farm had taken an off coverage position and added themselves as a Statutory Third Party.

State Farm sought to argue that their liability was limited to $200,000 and that only half of this limit was available, State Farm having settled with another claimant.

Justice Eberhard, in his decision on costs, noted that while State Farm had denied coverage to the Defendant driver, the issue of coverage was not yet determined. Despite denying coverage, State Farm, at trial, disputed the Defendant driver's liability for the collision and the extent of the Plaintiff's damages.

The Plaintiff, just prior to trial, had offered to accept $101,000 plus interest and costs. State Farm refused to accept this offer thereby forcing the matter to trial.

Justice Eberhard concluded that it would be unjust to allow State Farm as a Statutory Third Party full litigation rights under Section 258 of the *Insurance Act* that generated the need for a trial while also excusing them from cost exposure for that trial. In addition, it was found that State Farm had advanced positions in relation to liability that had no evidentiary support, thereby prolonging the length and complexity of the trial.

Costs were fixed payable to the Plaintiff by State Farm as a Statutory Third Party in the amount of $350,000 inclusive of HST and $100,000 for disbursements and travel costs.

This case serves as a warning to insurers that taking off coverage positions will not necessarily result in an avoidance of a cost exposure.

**Duty to Defend Third Party Claims against Infant Plaintiff's Parents:**

*Bawden v. Wawanesa Mutual Insurance Co.*, 2013 Carswell Ont (Ont. C.A.)

An infant Plaintiff was struck by a motor vehicle while riding her bicycle. The infant's mother, in her capacity as the infant's litigation guardian sued the Defendant driver and owner, seeking damages on behalf of the injured infant Plaintiff.

In turn, the Defendants brought a third-party claim against the infant's parents, alleging negligence in failing to properly instruct and supervise their daughter.

Wawanesa sought to rely on the household exclusion clause contained in their homeowner's insurance policy to deny coverage to the infant's parents. The parents, as Third Parties, brought a fourth party claim against Wawanesa and an application for an order requiring Wawanesa to defend the action against them.

The application Judge found that pursuant to the homeowner's policy of insurance, Wawanesa had a duty to defend the action against the parents. Wawanesa appealed.

The Court of Appeal in upholding the application Judge's decision, focused on the specific wording contained in the subject policy.

The critical coverage provision in the Wawanesa policy read as follows:

“You are insured for claims made or actions brought against you for:

(1) Personal Liability: bodily injury or property damage arising  out of your personal activities anywhere in the world.

The critical exclusion clause in the policy read as follows:

Exclusions: you are not insured for claims made or actions brought against you for:

(3) bodily injury to you or to any person residing in your household other than a residence employee.”

Relying on the principles that coverage provisions are to be construed broadly while exclusions were to be construed narrowly, the Court of Appeal found that the use of "arising out of" in the general insuring clause and the use of "for" in the exclusion clause were not interchangeable. The Court of Appeal found that there was evidence of careful differentiation on the part of Wawanesa in the use of these two terms, given that it had used both of these phrases in other exclusion clauses.

The Court of Appeal held that the critical coverage provision clearly encompassed the third-party claim for contribution and indemnity which arose out of the insured parents personal activities in negligently failing to supervise their daughter, thus resulting in her bodily injury.

The Court of Appeal held that by differentiating the terms "arising out of" and "for", the exclusion clause serves the policy objective of removing from coverage those claims that raised a risk of collusion between the claimant and the insured. The exclusion provision would only catch claims by a family member directly against the insured. Such claims among family members clearly raise a risk of collusion that was simply not present in a third-party claim brought by the Defendants against the parents.

The Court of Appeal held that the wording of the exclusion clause, when compared to the wording of the grant of coverage, and in the context of the Wawanesa policy wording as a whole, was consistent with an intent to exclude only direct claims between or among family members and to leave coverage for indirect claims by third parties against household members intact.

This decision appears to establish the potential folly of defence counsel's attempts to hinder infant personal injury claims through the inclusion of the Third Party Claims against the infant's parents. Such attempts appear to potentially open the pockets of homeowner's insurance policies which would not otherwise be available. One should be cautioned however on the specific nuances between the findings of a duty to defend addressed in this case, versus a duty to indemnify, which was not addressed.

**Jury Charge: Assessment of Damages:**

*Hansen v. Williams*, 2014 CarswellOnt 1553 (Ont. C.A.)

The Plaintiff in this action was injured in a motor vehicle accident in July 2007. She claimed various injuries including thoracic outlet syndrome, injuries to her neck, shoulder and arm and headaches. The Plaintiff testified that these injuries affected her housework, recreational activities, social life, family interactions and employment as a court clerk.

In his charge, the trial judge accepted the Plaintiff counsel's closing submission in which he used the premise of defence counsel's assessment of pain and suffering at $5,000-$10,000 on the assumption that the Plaintiff only had 3 to 6 months worth of symptoms arising from the subject motor vehicle accident, to extrapolate what the value of these damages would be for the rest of the Plaintiff's life, if the Jury disagreed with the defence counsel’s assumption. The trial judge charged the jury as follows:

In closing submissions the Defendant's counsel suggested a range of damages of $5,000 to $10,000. In cases of this kind, the law does permit counsel to suggest possible ranges of damage. You are not bound to accept the range suggested, however, if you accept the submissions of the Defendant's counsel you may well conclude that the range of damages he suggested to be appropriate.

The Plaintiff's counsel did not suggest a possible range of damages but he did suggest one approach would be to extrapolate that if $10,000.00 was appropriate for injuries lasting six months then you should look at that in determining the value over the Plaintiff's lifetime.

This is not a mathematical calculation and that should not be the approach that you take in dealing with general damages. You and you alone determine the amount that is appropriate to reasonably compensate the Plaintiff for her pain and suffering, and loss of amenities of life that have arisen as a result of the motor vehicle accident and in your deliberations you must do so, so as to arrive at an amount that is fair to both parties.

Defence counsel objected arguing that the jury had not been given enough guidance as to the level of general damages that would be appropriate in the circumstances. The trial judge did not recharge the jury.

The jury returned a verdict of $200,000.00 for non-pecuniary general damages. The Defendant appealed the decision on the basis that the jury was not properly charged and on the basis that the award was inordinately high and warranted appellate intervention.

The Court of Appeal in dismissing the Defendant's appeal held that the trial judge had provided the jury with adequate guidance on how to assess damages. There was no requirement that the trial judge provide the jury with a range of damages. The Court of Appeal noted that the trial judge had told counsel that she would not be giving the jury a range for non-pecuniary damages and counsel made their closing submissions with that knowledge.

While the award may have been high, the Ontario Court of Appeal was given very little Ontario jurisprudence involving cases of thoracic outlet syndrome. The significant number of British Columbia cases submitted to the Appeal Court suggested that this was an evolving area rather than one in which a range had been established. The record before the court was thin in respect of the Plaintiff's injuries and the consequences of those injuries to her. As a result, it was particularly difficult for the Court to compare the case at bar with the cases that were relied on. The Court of Appeal found that they were unable to accede to the Appellant’s submissions that the award was so plainly unreasonable and unjust, that they should intervene.

**Admissibility of Treating Doctors' Records and Testimony in the Aftermath of Westerhof:**

As you will note from the three decisions below, the Divisional Court decision in *Westerhof v. Gee* has failed to provide any coherent understanding of the use of treating physician's records or testimony.

Justice Wilson in *Moore v. Getahun*, discussed below, noted that in the aftermath of *Westerhof, supra*, there was uncertainty about the appropriate scope of treating physicians’ testimony, and that this uncertainty required clarification from a higher court.

We will have to await the Court of Appeal decisions in both *Westerhof, supra* and *Moore v. Getahun* to clarify this uncertainty.

*Moore v. Getahun*, 2014 CarswellOnt 298 (Ont. S.C.J.)

The Plaintiff brought a motion during trial seeking to call the emergency room doctor (who had treated the Plaintiff), as a fact witness. The evidence was to include the diagnosis, which the emergency doctor had concluded, upon the examination of the Plaintiff in the emergency room. The emergency doctor had not complied with Rule 53.03. The emergency doctor did not file a medical report. The defence objected to the admissibility of this evidence.

Justice Wilson concluded that the emergency room doctor, as the treating emergency-room physician, was able to give evidence in a comprehensive manner about his recollection of the steps he took on the date he treated the Plaintiff, including his observations, diagnosis at the time, the reasons for his diagnosis, and the steps that he took as a consequence of his observations and diagnosis.

Justice Wilson acknowledged that this fact evidence was inevitably somewhat blurred with opinion evidence relevant to the issue of causation, but was necessary evidence to understand what the emergency room doctor saw and what he did on the date he treated the Plaintiff. Justice Wilson concluded that this approach conformed to the principles in *Westerhof, supra*.

Justice Wilson concluded that the emergency room doctor's observations of a tight cast and the reasons why he cut off the cast were admissible facts for their truth. The emergency room doctor's diagnosis of compartment syndrome was also admissible for its truth and explained the doctor's actions, being his cutting off of the cast, his calling of a specialist, and his conclusion of the need for immediate attention.

The emergency room doctor's opinion evidence on causation and standard of care was not admissible. More specifically, Justice Wilson refused to hear his opinion evidence that the development of compartment syndrome was caused by the tight cast, nor his evidence that the practice for emergency-room physicians dealing with high-impact fractures of the distal radius was to splint the injuries and never use a full circumferential cast.

Justice Wilson sought to create a distinction between the emergency room doctor’s diagnosis when treating the Plaintiff and providing an opinion on the legal issues of standard of care and causation. As a result, the emergency room doctor was permitted to testify about his diagnosis for its truth, notwithstanding that the Plaintiff had not complied with Rule 53.03.

It is important to note that in this decision Justice Wilson also considered the appropriateness for counsel to review expert draft reports. The defence expert had sent a draft report to defence counsel for further comment. Defence counsel reviewed the draft report during a 1 1/2 hour teleconference with the doctor. Counsel for the Plaintiff discovered the existence of the draft reports and notes following the teleconference.

Justice Wilson held that the role of Rule 53.03 was to ensure impartiality and ensure the expert’s duty to the court as opposed to favoring one side over the other. Justice Wilson commented that reviewing draft reports put counsel in conflict and undermined the impartiality of the expert. Discussions or meetings between counsel and an expert to review and shape a draft expert report were no longer acceptable. Counsel's prior practice of reviewing draft reports should stop.

This decision would appear to confirm an additional requirement resulting from the enactment of Rule 53.03 that all expert reports be provided in final draft and that any errors, corrections or points of clarification, should be made in writing and disclosed to the other side.

*Campbell v. Roberts*, 2014 CarswellOnt 9156 (Ont. S.C.J)

The Plaintiff brought a motion at trial seeking to admit the reports of Dr. Faughnan under Sections 35 and 52 of the *Evidence Act*. The Defendants opposed this motion, on the basis of a failure to comply with Rule 53.03, the documents did not qualify as a report under Section 35, and Section 52 of the *Evidence Act* could not be used to circumvent Rule 53.

Justice Gilmore allowed the documents to be filed under Section 52 of the *Evidence A**ct* and allowed the Defendant to cross-examine the doctor. Plaintiff's counsel subsequently advised that they would not be producing Dr. Faughnan due to scheduling difficulties. At issue was what use, if any, could be made of Dr. Faughnan's reports in the circumstances.

Justice Gilmore found that the reports of Dr. Faughnan were admissible into evidence on the basis that:

a) Dr. Faughnan was clearly a practitioner within the meaning of Section 52(1) of the Evidence Act. Justice Gilmore noted that the phrase "obtained by or prepared for a party" within Section 52 (2) of the *Evidence Act* may simply mean that it could be obtained by a party to an action, and in this case, was obtained through the normal course. It did not have to be commissioned by the Plaintiffs.

b) Justice Gilmore noted the purpose of Section 52 was to ensure that trials were heard within a reasonable time and were conducted efficiently. There was a clear logical distinction between hospital records and notes that were admissible under Section 35, reports that could be admitted under Section 52, and reports that expressed a specific expert opinion under Rule 53.03. Taking the position of the Defendants to its most extreme would mean that any report written by a doctor commenting on the treatment of a patient and expressing an opinion in relation to that treatment, would be inadmissible unless the doctor was asked to prepare the report and unless the doctor comes to court. This would be an impractical result.

c) Justice Gilmore agreed with the comments of the Divisional Court in *Westerhof, supra*with respect to the fact that a diagnosis can be treated in different ways, depending on the purpose to which the evidence is put. In this case, it was found that any evidence of diagnosis in Dr. Faughnan's reports was to explain the treatment provided and as such the diagnosis becomes the catalyst for the treatment, and should be admitted on that basis.

d) Given that Plaintiff's counsel refused to have Dr. Faughnan available for cross-examination, his reports were admitted without cross-examination for the factual information only (i.e. that screening tests were completed which were positive for pulmonary AVMs, and the chest CT scan and MRI completed were negative for AVMs). In the event that this doctor was available for cross-examination, Justice Gilmore noted that he did not see that Section 52 had been used by the Plaintiffs to bypass the requirements of Rule 53.03. Proper notice was given and the Defendants would have an opportunity to cross-examine. Justice Gilmore found that there was no opinion given by Dr. Faughnan in relation to the material issue in this case, which was whether the Plaintiff's abscesses were a result of the pulmonary AVMs. Dr. Faughnan merely discussed the possibility of microscopic AVMs and noted that the Plaintiff likely had microscopic AVMs.

*Gaudet v. Grewal*, 2014 CarswellOnt 8193, (Ont. S.C.J.)

A pre-trial motion was brought with respect to the admissibility of the deceased family doctor's clinical notes and records, the clinical notes and records and reports of a neurologist, the reports of a rheumatologist, the reports of the physiatrist, and a report from a Chronic Pain Center. The family doctor, neurologist and physiatrist had executed Acknowledgments of Expert's Duty. The remaining medical practitioners did not.

The Plaintiffs sought to admit the medical documentation of the family doctor and physiatrist under Section 52 of the Evidence Act. The remaining doctor's records were sought to be introduced as business records under Section 35 of the *Evidence Act*.

Justice Ricchetti found that it was difficult to reconcile *Westerhof, supra* with the decisions in *Moore**,* *supra* and *Campbell**,* *supra*. Justice Ricchetti held that cross-examination of the doctor does not, by itself, fully ameliorate the trial efficiency and fairness sought to be achieved by compliance with Section 52 of the *Evidence A**ct* and Rule 53.03. She concluded that, unless there was some other basis upon which a report was admissible, then any medical opinion, whether by a treating doctor or medical legal expert, must comply with Rule 53.03 or the party had to obtain leave from the court for noncompliance with Rule 53.03.

In addition, Justice Ricchetti noted that in *Moore**,* *supra*, Justice Wilson determined that the emergency doctor could provide his diagnosis and this was found necessary to explain his treatment. Of importance was that the emergency room doctor’s diagnosis of compartment syndrome was not disputed by the defense medical legal expert and as a result Justice Ricchetti found that *Moore**,* *supra* was distinguishable.

The clinical notes and records of the deceased family physician including the diagnosis contained therein was admissible on the basis that compliance with Rule 53.03 should be waived in the circumstances. The factual information set out in the notes and records had already been determined to be admissible. The factual information in the notes and records had been reviewed, relied upon and would be commented by the medical legal experts for both sides.

Without an understanding of the diagnosis the family physician based his treatment of the Plaintiff on, both before and after the accident, his treatment and actions regarding the Plaintiff's medical condition throughout the years would not make much sense to the jury. The deceased was a family doctor and not a medical legal expert. The family doctor relied on the assessments of specialists and carried out treatment based on his consultation with these specialists.

Justice Ricchetti did not see that significant weight, if any, would be placed on the working diagnosis of the family doctor. Justice Ricchetti, pointed out that the specialists, who had consulted with the family doctor and provided their assessment of the Plaintiff, could testify and be cross-examined. Justice Ricchetti believed that the evidence of these specialists would have a much greater impact on the issue of the appropriate diagnosis in the circumstances.

Justice Ricchetti noted that Examination for Discovery and defence medicals were available to reduce or eliminate any prejudice to the defence and the defence was aware of the family doctor's death for some time. Justice Ricchetti felt that an instruction to the jury could be provided indicating that the jury could only use any diagnosis set out in the family doctor's notes and records to explain why he treated the Plaintiff in the manner he did.

Justice Ricchetti found that the remaining medical documents with respect to the treating specialists were not admissible under Section 52 or Section 35 of the *Evidence Act*. It was found that despite the completion of an Acknowledgment of Expert's Duty by the treating physiatrist and neurologist, the medical documentation did not comply with the requirements of Rule 53.03 and as such was inadmissible.

**Surveillance Particulars Must be Provided even if the Defendant does not Intend to Rely on it at Trial**

*Arsenault-Armstrong v. Burke*, 2013 CarwellOnt 8681 (Ont. S.C.J.)

During the discovery process, Plaintiff counsel sought an undertaking that the Defendant provide particulars of future surveillance, including date, time, name of investigator, the number of photographs and the number of minutes of video taken. Defence counsel refused to provide such further particulars if she did not intend to rely on the surveillance at trial.

Justice Hambly held that the Defendant was required to provide the surveillance information requested. The surveillance evidence would assist the Plaintiff in evaluating the strength of her case and in arriving at her settlement position prior to trial, thereby avoiding devastating cost consequences.

Even if the Defendant would not be able to use the surveillance evidence for impeachment purposes, as a result of its nondisclosure, the defence would gain knowledge of the Plaintiff from the surveillance evidence which it would be able to use to its benefit.

Justice Hambly held that requiring the defence to produce the surveillance particulars even if it does not presently intend to use it at trial is consistent with the Court of Appeal decision in *Ceci v. Bonk* (1992), 7 O.R. (3d) 381 (Ont. C.A.) in which it was held that discovery rules must be read in a manner to discourage tactics and encourage full and timely disclosure. Disclosure leads sensible people to assess their position in the litigation and to accommodate.

**CONCLUSION:**

Although we are getting clarity in some areas of the law like the definition of catastrophic impairment, other areas remain uncertain. Something must be done by either the Court of Appeal or the Legislature to clarify the law surrounding the introduction of expert evidence at trial. I am sure that Justice Osborne had intended to simplify the trial process and reduce costs with his amendments however, the exact opposite has occurred. It is hoped that over the next year we will obtain some clarity of these legal issues which will in turn improve access to justice.