Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A06-000399

BETWEEN:

T.N.

Applicant

and

PERSONAL INSURANCE COMPANY OF CANADA

Insurer

REASONS FOR DECISION

Before: Eban Bayefsky

Heard: November 2, 2012 and September 24-26, 2013, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: Kevin Doan for T.N.
Philippa Samworth for Personal Insurance Company of Canada

Issues:

The Applicant was catastrophically injured in a motor vehicle accident on October 29, 2000. She applied for and received certain statutory accident benefits from Personal Insurance Company of Canada ("Personal"), payable under the *Schedule*.[1] Personal denied the Applicant's claim for various other benefits. The parties were unable to resolve their disputes through mediation, and the Applicant applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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

I issued a decision on the Applicant's substantive claims for benefits on July 26, 2012, making the following orders:

1. T.N. is not precluded from receiving income replacement benefits.

2. T.N. was employed at the time of the accident.

3. T.N. did not fail to submit an application for attendant care benefits as required, and is entitled to arbitrate her entitlement to those benefits.

4. T.N. did not fail to submit an application for housekeeping benefits as required, and is entitled to arbitrate her entitlement to those benefits.

5. Personal Insurance Company of Canada shall pay T.N. attendant care benefits from October 29, 2000 and ongoing, at the rate of $5,056.80 per month, less any amounts already paid.

6. Personal Insurance Company of Canada shall pay T.N. two hours of housekeeping benefits per week, from May 1, 2008 and ongoing.

7. Personal Insurance Company of Canada shall pay T.N. $720 for nutritional counselling services.

8. Personal Insurance Company of Canada shall pay T.N. medical benefits for the purchase of medical marijuana, from March 27, 2007 and ongoing, at the rate of $567.60 per month.

The hearing reconvened to address the issues of interest and special award.

The issues in this hearing are:

1. Is the Applicant entitled to interest on the income replacement benefits, the attendant care benefits and the benefits for nutritional counselling services ordered to be paid, and if so, for what periods?

2. Is the Insurer liable to pay a special award, and if so, for what amount?

Result:

1. The Applicant is entitled to interest, as follows:

   (i) on income replacement benefits from May 2, 2003 to July 26, 2012, in an amount to be determined, if required, upon the filing of revised calculations;

   (ii) on attendant care benefits from January 19, 2001 to July 26, 2012, in the amount of $3,027,960;

   (iii) on benefits for nutritional counselling services from February 23, 2001 to July 26, 2012, in an amount to be determined, if required, upon the filing of revised calculations.

2. The Insurer is liable to pay a special award, in the amount of $750,000.

EVIDENCE AND ANALYSIS:

1) The Applicant's Claim for Interest

Pursuant to section 46(1) of the *Schedule*, "an amount in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part." Pursuant to sections 35(1) and (2) of the *Schedule*, "on receiving an application for an income replacement benefit,…an insurer shall promptly determine whether a benefit is payable" and "if the insurer

determines that a benefit is payable, the insurer shall pay the benefit to the person within 14 days after receiving the application."

The Applicant submitted a report, dated September 12, 2013, from the accounting firm of JK Economics Inc., regarding the amounts to be used in calculating interest. The parties agreed to use this report as the basis of the relevant calculations. The report sets out the amounts for the principal and interest on IRBs, attendant care benefits and nutritional counselling benefits as of the date of the first decision in this matter, July 26, 2012, as follows:

IRBs: principal - $131,331; interest - $521,493
Attendant Care: principal - $565,348; interest - $3,027,960
Nutritional Counselling: principal - $720; interest - $9,920

(i) Interest on Income Replacement Benefits

At the outset of this arbitration, the Applicant claimed entitlement to income replacement benefits ("IRBs") on an ongoing basis from a week post-accident, namely, November 6, 2000. Prior to the commencement of the hearing, the parties resolved the issue of the Applicant's entitlement to IRBs from November 6, 2000 to May 2, 2003, the date of the Insurer's last denial of IRBs. This denial was on the basis of a post-104 week Disability DAC which found that the Applicant did not suffer a complete inability to engage in any employment for which she was reasonably suited by education, training or experience. At the commencement of the hearing, the parties advised that the only issue for determination respecting IRBs was the Applicant's entitlement to those benefits from May 2, 2003 onward. The Insurer had also raised a procedural issue regarding the Applicant's entitlement to IRBs, namely, whether she was precluded from receiving IRBs on the basis that she had failed to apply for mediation and arbitration within two years of the Insurer's refusal to pay those benefits, pursuant to section 51(1) of the *Schedule*. As noted in the initial decision in this matter, in the course of the hearing, the Insurer conceded the Applicant's substantive entitlement to IRBs from May 2, 2003, but continued to maintain its procedural objection to the Applicant receiving those benefits. I ultimately found that the Applicant was not precluded from receiving income replacement benefits.

In her submissions at this stage of the proceeding, the Applicant maintained that the issue of interest should be considered from the earliest possible date, namely, a week post-accident, November 6, 2000, not the date from which IRBs were to be considered at the initial hearing in this matter. The Applicant submitted that this flowed from an agreement reached by the parties, as summarized in a letter from her lawyer to counsel for the Insurer, dated April 5, 2010, which letter was introduced at the commencement of the hearing to assist in framing the issues for arbitration. The relevant portions of that letter are as follows:

> Further to our numerous exchanges of email, letters and discussions, this letter is to consolidate the writer's understanding regarding issues…
>
> **I. ISSUES FOR ARBITRATION:**
>
> **1. Income Replacement Benefit**
>
> …
>
> 1.3 *What is the amount of weekly IRBs since November 6, 2000 to date and ongoing?*
>
> This issue is resolved as follows: in respect of only quantum, the parties agree that the weekly IRB rate is $312.00 if employed, and $304.15 if self-employed, on a going forward basis as from February 28, 2010. The parties further agree that as at February 28, 2010, the past outstanding IRBs, exclusive of interest and past IRBs paid by the Insurer, is (a) $108,000 if employed; (b) $132,000 if self-employed without facility expenses added; and (c) $214,000 if self-employed with facility expense[s] added.
>
> 1.4 *Is the applicant entitled to income replacement benefit[s] from November 6, 2000 to date and on-going under section 4 of the Schedule?*
>
> …
>
> **8. *Interest* on overdue benefits. The applicant proposes that the calculation of interest, if any, be done after a determination of any benefits owing.**

(emphasis in original)

The specific parameters of the issue of interest were not established in the course of the initial hearing, other than to say that the parties would discuss the matter between themselves once the decision on the substantive issues was released, and, if required, address it at a resumption of the hearing.

At the resumption, the Insurer maintained that the only issue at the initial hearing was the Applicant's entitlement to IRBs and interest in what was broadly referred to as the "post-104" period (though commencing May 2, 2003) and that no interest on IRBs before that point should be paid given that I had made no order in respect of the Applicant's entitlement to IRBs in the earlier period.

I am not at all satisfied that there was an agreement between the parties to address the issue of interest on IRBs prior to May 2, 2003, notwithstanding that the issue of the Applicant's entitlement to those benefits was resolved prior to the hearing. I do not see this as arising from the letter of April 5, 2010, given that the issue of interest was only stated to be in respect of the general matter of "overdue benefits", given that interest was only intended to be calculated after a determination of "any benefits owing", and given that the letter only spoke to the issues of entitlement and quantum of IRBs prior to the resolution of pre-104 IRBs. I accept that the issue of interest was still to be addressed at a resumption of the hearing if the parties could not resolve it between themselves, but I did not understand that to mean that interest on pre-104 benefits was still at issue in the arbitration, particularly in light of the fact that entitlement to pre-104 IRBs was specifically removed as an issue for the hearing.

I accept, as submitted by the Applicant, that the mere fact that the issue of substantive entitlement to benefits is resolved prior to a hearing does not automatically preclude a consideration of the matter of interest (as well as that of a special award).[2] However, in my view, the subject of interest on benefits not being addressed from a substantive perspective at a hearing must be specifically identified as an issue at the hearing in order to be considered. I do not find that the issue was so identified.

[2]See, for example, *Shaikh and Aviva Canada Inc.* (FSCO A09-000013, December 30, 2009)

I note that, although the issue of the Applicant's substantive entitlement to "post-104" IRBs was conceded by the Insurer during the hearing, it continued to object to the Applicant's receipt of those benefits on procedural grounds, and as such, I still considered the issue of interest on those benefits to be very much at play.

I, therefore, conclude that the issue of interest on IRBs is only in respect of the post-104 period.

Regarding the Applicant's claim for interest on IRBs, I find that she is entitled to interest commencing May 2, 2003. The Insurer maintained that no interest on IRBs was payable given that it had conceded entitlement to those benefits in the course of the hearing, and no order was made in respect of the Applicant's substantive entitlement to IRBs. The Insurer also suggested that its success on the issue of whether the Applicant was self-employed at the time of the accident militated against its having to pay any interest on post-104 IRBs. I reject both of these arguments.

As indicated, the fact that the Insurer conceded the Applicant's substantive entitlement to IRBs did not end the matter. The Insurer continued to maintain that the Applicant was disentitled to post-104 IRBs due to a delay in filing for mediation and arbitration. While I did not specifically order post-104 IRBs to be paid, my finding that the Applicant was not procedurally precluded from receiving IRBs, coupled with the Insurer's concession of her substantive entitlement to those benefits implied that she was, in fact, entitled to the benefits, and that the Insurer was still liable to pay interest on those benefits. Further, in light of the fact that interest had clearly been identified as an issue in respect of benefits found to be owing, and the Applicant did not abandon her claim for interest on post-104 IRBs after the Insurer conceded her substantive entitlement, I find that the Insurer continued to be open to an order to pay interest on post-104 IRBs.

Regarding the Insurer's success on the issue of self-employment, I do not find that this affects the Insurer's liability to pay interest on post-104 IRBs. I accept that it is relevant to the calculation of the quantum of IRBs owing to the Applicant (the available options having already been resolved by the parties prior to the hearing). But it is not relevant to the question of whether the Applicant was either substantively or procedurally entitled to IRBs in the disputed period

(the issues identified for adjudication at the hearing). In the present case, this is what is relevant to determining whether IRBs were overdue for the purpose of an award of interest.

As a result, I find that the Applicant is entitled to interest on IRBs as of May 2, 2003.
As indicated in the initial decision, the Insurer denied the Applicant IRBs on three separate occasions, and the Applicant ultimately proceeded to arbitration on the issue of her entitlement to IRBs from the date of the last denial (which denial, as indicated, was on the basis that she did not meet the test of disability for post-104 week IRBs). The Insurer abandoned its substantive challenge to the Applicant's entitlement to IRBs, leaving only its objection to the Applicant receiving IRBs from May 2, 3003 on the basis of a delay in filing for mediation and arbitration. As noted, I did not accept that as a valid basis for denying the Applicant IRBs. I, therefore, conclude that the payment of IRBs to the Applicant became overdue as of May 2, 2003, and that she is entitled to interest on IRBs from that date to the date of the first decision in this matter, July 26, 2012.

The September 12, 2013 report of JK Economics Inc., calculated interest on IRBs as of a week post-accident. Given my findings on this issue, new calculations of the interest owing on IRBs must be conducted. I, therefore, find that the Applicant is entitled to interest on income replacement benefits from May 2, 2003 to July 26, 2012, in an amount to be determined, if required, upon the filing of revised calculations.

(ii) Interest on Attendant Care Benefits

In the initial decision in this matter, I found that the Applicant was entitled to attendant care benefits from the date of the accident, October 29, 2000, onward, at a rate of $5,056.80 per month, less amounts already paid by the Insurer. At the first hearing, the Insurer objected to the Applicant's receipt of attendant care benefits from the date of the accident on the basis that the Applicant did not apply for attendant care benefits within 30 days of receiving the application forms, as required by section 32(3) of the *Schedule*, and that the Insurer should not be required to pay attendant care benefits prior to December 18, 2006, when the Applicant submitted an application for attendant care benefits, in the prescribed Form 1.

I found that, although there was some delay in the Applicant forwarding a formal Application for Benefits, the Insurer had more than sufficient information to begin the process of adjusting the claim for attendant care benefits, and had, in fact, indicated that it would commence the assessment of the Applicant's attendant care needs. I, therefore, found that the Applicant's failure to comply with section 32(3) of the *Schedule* did not, in itself, relieve the Insurer of paying the Applicant any attendant care benefits to which she may have been entitled.

I further found that the fact that the Applicant did not submit a Form 1 to the Insurer until December 2006 did not relieve the Insurer of its obligation to pay the Applicant any attendant care benefits to which she might have been entitled. As with my determination under section 32(3), I also found that the Insurer had ample information in the early stages of the claim to begin to address the issue of attendant care benefits, especially in light of the fact that the Applicant had likely been catastrophically impaired in the accident. I, therefore, concluded that, while the Applicant did not formally and specifically apply for attendant care benefits until December 2006, the Insurer was well aware of the issue of attendant care benefits from early on in the process, and in fact anticipated the possibility that the Applicant might seek to claim such benefits retroactively.

At the resumption of the hearing, the Insurer maintained that, while I ordered attendant care benefits to be paid from the commencement of the claim, those benefits did not become overdue for the purposes of the payment of interest until December 2006, when the Applicant submitted a Form 1 for attendant care benefits, and not until February 18, 2010 when the Applicant submitted a claim for retroactive attendant care benefits from October 2000 to December 2006. The Insurer also maintained that there were certain factors beyond its control that relieved it of the need to pay interest. For example, while (even in the absence of a Form 1 from the Applicant in the early stages of the claim) it prepared its own Form 1 on September 17, 2001 (indicating that the Applicant did not require any attendant care assistance), this report was forwarded to the Applicant and the Applicant did not respond with her own Form 1 until December 2006. Further, between late 2001 and mid-2005, when the Applicant changed lawyers and began to take a more active approach to her claims, the evidence suggested that the Applicant was, in fact, recovering

well from her injuries, and the focus of the parties shifted primarily to the Applicant's ability to return to productive employment.

I find that the attendant care benefits ordered to be paid from the date of the accident became overdue as of January 18, 2001. Pursuant to section 39(3) of the *Schedule* (as it read at the time of the accident), an insurer is required to pay attendant care benefits within 30 days of receiving an application for attendant care benefits, or within 14 days of receiving a certificate from a health professional that the requested expenses are reasonable and necessary. In this case, the Insurer did not require the provision of a certificate. As set out in the first decision in this matter, by December 19, 2000, the Insurer had ample information to commence the process of adjusting the claim on the matter of attendant care benefits, and, in my view, should be deemed to have received an application for those benefits at that time.

I have rejected the Insurer's position that attendant care benefits are only payable for the period after the submission of a Form 1. I do not accept that the Applicant's lack of response to the Insurer's own Form 1 in September 2001 shields it from the need to pay interest. In my view, the Insurer had the information to assess the Applicant's need for attendant care, actually proceeded to assess that need, and informed the Applicant of the results of the assessment (to the effect that the Applicant did not require any attendant care assistance). In my view, it does not lay with the Insurer to say that, because the Applicant did not take any formal steps to claim attendant care until much later, its own information, assessment and advice to the Applicant were of no consequence. And, while the evidence might have suggested that the Applicant was recovering well from her injuries, and the parties' focus shifted to the Applicant's return to productive employment, this did not, in my view, alter the fact that the Insurer had already concluded and advised the Applicant that she did not require any attendant care assistance. On the contrary, from the Insurer's perspective, the Applicant's medical improvement was, no doubt, further support for its view that she was not entitled to attendant care benefits, a position which, of course, the Insurer maintained even after it received the Applicant's Form 1 in December 2006. I, therefore, find that the attendant care benefits became overdue on January 19, 2001 (being 30 days from the time of the deemed receipt of the application for attendant care benefits on December 19, 2000), and that interest is payable from that date to July 26, 2012.

Based on the September 12, 2013 report of JK Economics Inc., the amount owing to the Applicant for interest on attendant care benefits is $3,027,960.

(iii) Interest on Nutritional Counselling Benefits

The Applicant claimed the cost of an eight-session nutritional counselling programme, in the amount of $720, recommended in a treatment plan dated February 1, 2001, from Nancy Polsinelli, a registered dietician at Springdale Physiotherapy. The Insurer initially denied this claim on February 19, 2001, on the basis that the Applicant had not yet provided a completed Application for Benefits. Following receipt of the Application for Benefits on April 4, 2001, the Insurer denied the nutritional counselling treatment plan on April 10, 2001, on the basis that it needed clarification whether the programme was covered under OHIP, indicating that it would seek the required clarification from Springdale Physiotherapy. As set out in the first decision, I found the recommended nutritional counselling programme was reasonably required and that the Insurer had failed to provide any evidence that it sought the clarification it wanted as to whether the programme was covered under OHIP (or evidence that the programme was, in fact, covered under OHIP). I ordered the cost of this programme to be paid by the Insurer.

At this hearing, the Applicant sought interest on the cost of the programme from March 1, 2001, pursuant to section 38(11) of the *Schedule*, which requires payment of medical and rehabilitation benefits within 30 days of receiving an invoice for them. The Insurer acknowledged that interest should be paid on the cost of the programme, but only from April 24, 2001, pursuant to section 38(8) of the *Schedule*, which, in part, requires payment of medical and rehabilitation benefits within 14 days of receiving an application. The Insurer also submitted that interest should only be payable until November 18, 2008, when the Insurer allegedly accepted the nutritional counselling treatment plan.

I find that interest should be paid on the cost of the nutritional counselling programme from February 23, 2001, which is 14 days from the Insurer's receipt of the February 1, 2001 treatment plan. As noted in the first decision, the Insurer had ample information to commence the adjustment of the Applicant's claim from December 2000. I find that the provision of the

treatment plan for nutritional counselling was more than adequate to complete the application process for that benefit, within the meaning of section 38 of the *Schedule*. The Insurer has conceded that interest should be paid on this item, and I agree that, in addition to the Applicant's substantive entitlement to the programme, the Insurer did not properly respond to the claim.

However, I do not accept the Insurer's submission that interest should cease as of November 18, 2008. The Applicant's entitlement to the programme was an issue at the hearing, and the Insurer contested it throughout. The Insurer only pointed out that the treatment plan was approved in an Explanation of Benefits dated November 18, 2008, at the hearing on interest and special award. There is no evidence that the Applicant was, in fact, paid for the programme. I, therefore, find that the Applicant is entitled to interest on the cost of the nutritional counselling programme from February 23, 2001 to July 26, 2012.

Given the slight difference in the dates for calculating interest on these benefits, I find that the Applicant is entitled to interest on the nutritional counselling services in an amount to be determined, if required, upon the filing of revised calculations.

2) The Applicant's Claim for a Special Award

Pursuant to section 282(10) of the *Insurance Act*, where an insurer has unreasonably withheld or delayed payments, an Arbitrator can, in addition to awarding benefits and interest to which an insured person is entitled under the *Schedule*, 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 person (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*.

The Applicant sought the maximum special award in this case on various grounds, the most salient of which are that the Insurer breached its procedural obligations under the *Schedule*, improperly delayed the payment of benefits, improperly sought to deflect responsibility for the claim to another insurer, and failed to properly assess medical evidence relevant to the

Applicant's entitlement to benefits. The Applicant submitted that her entitlement to a special award should be considered in light of the criteria set out in the civil case of *Whiten v. Pilot Insurance Company*, [2002] 1 S.C.R. 595 (and related cases), where rationality and proportionality were seen as the basis of an appropriate award of punitive damages. The principles set out in *Whiten* were summarized and applied in the arbitration appeal decision of *Liberty Mutual Insurance Company and Persofsky*, (FSCO P00-00041, January 31, 2003), as follows:

> Rationality 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 refers to the need to ensure that the consequences imposed on the insurer are rationally related to the misconduct at issue. The Supreme Court of Canada identified various dimensions of proportionality for punitive damages, which I find relevant to special awards. To paraphrase, the award should be proportionate to: (i) the blameworthiness of the insurer's conduct; (ii) the vulnerability of the insured person; (iii) the harm or potential harm directed at the insured person; (iv) the need for deterrence; (iv) the advantage wrongfully gained by the insurer from the misconduct; and (vi) should take into account any other penalties or sanctions that have been or likely will be imposed on the insurer due to its misconduct.

The September 12, 2013 report from JK Economics Inc. sets out the amounts to be used in calculating the special award as of the date of the first decision in this matter, July 26, 2012. The parties agreed to use this report as the basis of any calculations of a special award, and agreed that July 26, 2012 was the appropriate date to be used in those calculations. The report indicates the following, in respect of the amounts to be used in the calculation of a special award as of July 26, 2012:

IRBs: principal - $652,824; interest - $1,248,883; total - $1,901,706

Attendant Care: principal - $3,593,308; interest - $7,250,828; total - $10,844,136

Nutritional Counselling: principal - $10,640; interest - $28,374; total - $39,015

Based on this report, and her request for the maximum special award, the Applicant sought a special award in the amount of $6,250,000.

The Insurer accepted the principles set out in *Whiten* and *Persofsky* as relevant to the analysis, but maintained that its conduct in the present case was not sufficiently egregious to warrant any special award at all. In particular, the Insurer submitted that it complied with its procedural obligations in adjusting the claim, did not improperly delay or deflect the payment of benefits, and fully assessed the relevant medical evidence on file. The Insurer noted that the Applicant, herself, did not pursue her claim in a timely manner and that this prejudiced the Insurer's adjustment of the claim. The Insurer also claimed that no special award could be made on benefits that had not been ordered after the first hearing in this matter.

For the following reasons, I find that the Insurer is liable to a special award in this case.

I do not accept the Insurer's position that a special award can only be made on benefits specifically ordered after a substantive hearing. I agree with the case of *Shaikh and Aviva Canada Inc.* (cited earlier), which found that an arbitrator has the jurisdiction to consider a special award despite substantive benefits having been resolved and paid prior to the hearing. In my view, while the substantive issue of pre-104 IRBs was resolved before the hearing, and while the issue of post-104 IRBs was conceded part way through the hearing, the general conduct of the Insurer in adjusting the claim on these matters (as well as on attendant care and nutritional counselling) is still relevant to the determination and calculation of a special award.

I find certain important problems in the Insurer's handling of this case. As set out in the initial decision, the Insurer attempted to maintain a limitation period defence with respect to the Applicant's entitlement to IRBs. I noted that the limitation period begins to run from the date an applicant receives a clear and unequivocal refusal of benefits, and that, pursuant to section 49 of the *Schedule,* an insurer who refuses to pay benefits must advise the applicant in writing of the dispute resolution process. I found that the Insurer failed to provide a clear and unequivocal refusal of benefits so as to trigger the relevant limitation period and that the alterations and deficiencies in the third and final denial of IRBs (regarding, in part, the dispute resolution

process) were fatal in themselves and rendered the overall denial process confused and ineffective.

The Insurer refused to pay attendant care benefits, in part, on the basis that it had not received a formal application for those benefits, in the prescribed Form 1. However, I found that the provision of a Form 1 was not fatal to the Applicant's claim, that the Insurer had ample information in the early stages of the claim to begin to address the issue of attendant care, (especially in light of the fact that the Applicant had likely been catastrophically impaired in the accident), and that the Insurer actually proceeded to assess the Applicant's attendant care needs (finding that she required no attendant care). I saw no evidence that the Insurer was incapable of properly responding to the claim once it was made and that it had, therefore, been prejudiced by the late submission of a Form 1. I am particularly troubled by the internal conduct of the Insurer which belies any serious consideration of the Applicant's attendant care needs or a real need for the Applicant to provide a Form 1. The Insurer's log notes of August 3, 2001 indicated that a Form 1 was to be completed "to ensure that clients attnd [attendant] care needs are $0" and that this was "to be documented, should the client attempt to submit a backdated attndt care claim." Not surprisingly, at the Insurer's request, Aneez Virani, an occupational therapist, prepared a Form 1 on September 17, 2001, concluding that no attendant care was required, and, on December 19, 2001, the Insurer, itself, concluded that, based on the Form 1, there were "no attendant care issues." I find this to be a blatantly self-serving exercise regarding the vitally important rehabilitation needs of the Applicant. I find it particularly ironic that the Insurer concluded that no attendant care needs existed when, to respond to a claim that the Applicant *might* make, it "commissioned" a report to reflect that the Applicant had no attendant care needs.

As noted, I find this relevant to the Insurer's insistence that a Form 1 was required before it could begin the process of assessing the Applicant's attendant care needs. However, it raises further problems in light of the fact that the Insurer provided Mr. Virani's report to the Applicant without formally denying her attendant care benefits. Pursuant to section 39(1) of the *Schedule*, within 14 days of receiving an application for attendant care benefits, an insurer is required to either approve the application or notify the insured of the need to provide the prescribed attendant care certificate. Pursuant to section 39(3), if an insurer is required to pay attendant care

benefits, they must do so within 30 days of receiving the application or within 14 days of receiving the certificate. Pursuant to section 39(4), if the insurer determines that an insured person is not entitled to the benefits, it must require the person to be assessed by an attendant care DAC, and provide them with reasons for its determination and the assessment, within 14 days of receiving the application or certificate. Pursuant to section 39(6), an insurer is required to pay the insured person attendant care benefits pending receipt of the DAC report.

The problem in the present case is that the Insurer had sufficient information to constitute an application for the purpose of adjusting the Applicant's need for attendant care, pre-emptively determined (or more accurately, *pre-determined*) that the Applicant was not entitled to attendant care benefits, and then informed the Applicant of this without providing a formal denial of benefits. In my view, this was a breach of the Insurer's duty to either promptly approve the benefits, or require the prescribed certificate and then pay the benefits or require the insured to attend a DAC. And, by not formally denying the benefits and sending the Applicant to a DAC, the Insurer avoided its obligation to pay attendant care benefits pending receipt of the DAC report.

It is true, as pointed out by the Insurer, that the Applicant was recovering well at this stage of the claim, that she did not respond to Mr. Virani's report, and the focus of the parties (including the lawyer who represented the Applicant for the first number of years after the accident) shifted to the Applicant's ability to return to productive employment. I find this tempers the Insurer's conduct somewhat. Nevertheless, I find that the Insurer clearly breached its statutory obligations, particularly in light of its desire to forestall a claim by the Applicant for attendant care benefits, and that this potentially deprived the Applicant of such benefits, at least until the time of an attendant care DAC. I also, of course, found that, despite the Applicant's improvement following the accident, she required round-the-clock attendant care from the outset of the claim.

The Applicant submitted that the Insurer improperly sought to deflect responsibility for the claim to another insurer. However, as the Applicant acknowledges, the Insurer had a right to raise and pursue the priority issue in this case, since there was a question of whether consent had been given for the car driven in the accident. What I do accept, however, is that the priority issue was

of considerable concern to the Insurer at the same time it was failing to provide the Applicant much-needed attendant care. In addition to the process-related problems discussed above regarding Mr. Virani's assessment, as noted in the first decision, Mr. Virani's analysis was extremely limited, revolving essentially around the Applicant's self-report of substantial *physical* recovery and having resumed her self-care and homemaking tasks, as well as some of her vocational duties. This assessment failed to account for the significant psycho-emotional upheaval in the Applicant's life, and the counselling and support she needed and was receiving from the people around her. Had less emphasis been placed on the need for a formal application and the priority issue, a fuller assessment of the Applicant's attendant care needs may very well have been conducted (as was later done in 2007 and 2010 by one of the Insurer's assessors, Ms. Vrckovnik, who found that six hours a day of attendant care would have been required in the early stages of the claim). Again, I found that the Applicant required 24-hour attendant care from the time of the accident.

The Applicant maintained that the Insurer did not properly consider the available medical evidence concerning her need for IRBs. While there are reports before me on whether the Applicant's disability precluded her from performing her pre-accident work or a suitable alternative, I am hampered in determining whether the Insurer unreasonably withheld IRBs because these were not fully addressed at the hearing. As set out in the first decision, the Insurer formally denied the Applicant IRBs on three separate occasions, the first and third of those containing important defects. The Insurer also only issued its first denial upon receiving a completed application in April 2001 (raising some of the issues more fully canvassed in relation to attendant care benefits). In general, however, the Insurer followed the required procedures in ultimately terminating the Applicant's entitlement to IRBs (based on a post-104 disability DAC in May 2003). Therefore, while there were certainly some breaches in respect of the Applicant's receipt of IRBs, I am unable to conclude that that they were of the same degree and significance as those pertaining to attendant care benefits.

The Insurer acknowledged that the issue of nutritional counselling was not handled well. I agree. For the reasons set out in respect of interest on nutritional counselling, I also find that a special award is warranted here. The Insurer had sufficient information to assess the matter, denied the

benefits on a questionable basis and, in any event, did not properly pursue the issue they, themselves, had raised.

I return, then, to the criteria set out in *Whiten* and *Persofsky*, namely, (i) the blameworthiness of the insurer's conduct; (ii) the vulnerability of the insured person; (iii) the harm or potential harm directed at the insured person; (iv) the need for deterrence; (iv) the advantage wrongfully gained by the insurer from the misconduct; and (vi) should take into account any other penalties or sanctions that have been or likely will be imposed on the insurer due to its misconduct.

I find the Insurer's conduct in respect of attendant care benefits and nutritional counselling to be blameworthy to a significant degree, but to a lesser degree on the issue of IRBs. Given the catastrophic injuries suffered by the Applicant and her need for significant care and assistance following the accident, she was clearly a vulnerable individual. I am cognizant, however, of the fact that the Applicant was represented by counsel throughout, and particularly in the early stages of the claim. I am unable to find that the Insurer intentionally set out to harm the Applicant. However, by failing to promptly and adequately address her personal and nutritional needs, I find that the Applicant was deprived of important rehabilitative care and assistance.
In respect of the issue of deterrence, I do not have any evidence before me of previous special awards or punitive damages being issued against the Insurer, but it is, of course, important that the Insurer understand the significance of the breaches that occurred in this case, so that they are not repeated. By taking the approach it did, the Insurer gained the advantage of not having to pay the significant statutory accident benefits ultimately ordered. There are no other penalties or sanctions that I am aware of that have been, or likely will be, imposed on the Insurer due to its misconduct.

As noted earlier, the Applicant sought a very significant special award, one which would certainly make it the highest ever ordered by the Commission. While revised calculations remain to be made respecting interest for IRBs and nutritional counselling, given that I am not prepared to order a special award to the extent sought by the Applicant, I find that I am still able to determine an appropriate figure for a special award, based on the figures that are currently before me.

I am cognizant of the factors set out in *Persofsky* with respect to fixing an amount for a special award:

- the amount of the benefits unreasonably withheld or delayed
- the time the benefit is withheld or delayed
- failing to respect important obligations under the *SABS*
- other factors that increase the gravity of the insurer's conduct
- mitigating factors
- other penalties

A very significant quantum of benefits was withheld in this case, and for a significant period of time. The Insurer breached important procedural obligations under the *Schedule*, and failed to fully respect the Applicant's needs and vulnerability. However, as discussed, the Insurer's conduct was tempered somewhat by the manner in which the Applicant, herself, pursued her case. Finally, while not necessarily determinative, I am cognizant of the significant interest payable in this case.

In all of the circumstances, I find that a significant special award is warranted in this case, but not to the degree urged by the Applicant. I find that a reasonable special award in this case is $750,000.

EXPENSES:

The parties have not yet addressed the issue of expenses. This will be done at a further resumption of the hearing, if required.

Eban Bayefsky Arbitrator	November 20, 2014 Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A06-000399

BETWEEN:

T.N.

Applicant

and

PERSONAL INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Personal Insurance Company of Canada shall pay to T.N. interest, as follows:

   (i) on income replacement benefits from May 2, 2003 to July 26, 2012, in an amount to be determined, if required, upon the filing of revised calculations;

   (ii) on attendant care benefits from January 19, 2001 to July 26, 2012, in the amount of $3,027,960;

   (iii) on benefits for nutritional counselling services from February 23, 2001 to July 26, 2012, in an amount to be determined, if required, upon the filing of revised calculations.

2. Personal Insurance Company of Canada shall pay to T.N. a special award in the amount of $750,000.

November 20, 2014

Eban Bayefsky
Arbitrator

Date