Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A14-003170

BETWEEN:

FILIZ AYDEMIR

Applicant

and

AVIVA INSURANCE COMPANY OF CANADA

Insurer

DECISION ON EXPENSES

Before:	Arbitrator Alan G. Smith
Heard:	By written submissions due May 22, 2018
Appearances:	Mr. Stanley Razenberg participated for Ms. Aydemir Mr. Jason Frost participated for Aviva Insurance Company of Canada

BACKGROUND:

The Applicant, Ms. Filiz Aydemir, was involved in a motor vehicle accident which occurred on July 9, 2012. She applied for statutory accident benefits from Aviva Insurance Company of Canada (the "Insurer") payable under the *Schedule*[1]. The parties were unable to resolve their dispute through mediation and Ms. Aydemir applied for arbitration at the Financial Services Commission of Ontario ("FSCO") under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

An Arbitration Hearing was held before Arbitrator Arbus on October 17-19, 23-26, November 1, 2, December 13-15, 2017 and January 4, 2018, and by written submissions completed on January 4, 2018. The Arbitrator's decision was released on March 5, 2018 and found the following:

[1] The *Statutory Accident Benefits Schedule – Effective September 1, 2010*, Ontario Regulation 34/10, as amended.

1. Ms. Aydemir did not sustain a Catastrophic Impairment within the meaning of the *Schedule* as a result of the accident.
2. Ms. Aydemir is not entitled to receive Non-Earner Benefits for the period from January 9, 2013 to date and ongoing.
3. Ms. Aydemir is not entitled to Attendant Care Benefits for the period from July 9, 2012 to date and ongoing.
4. Ms. Aydemir is not entitled to payments for the treatment plans as set out in the Application.
5. Ms. Aydemir is not entitled to a Special Award in this Arbitration.
6. Ms. Aydemir is not entitled to interest for any overdue payments of benefits as prescribed in the *Schedule*.
7. If the parties are unable to agree on the amount of expenses, an Expense Hearing may be arranged in accordance with Rules 75 - 79 of the *Dispute Resolution Practice Code*.

The Insurer now requests an Expense Hearing.

ISSUES:

The issue in this Expense Hearing is:

1. Is the Insurer entitled to expenses arising from this proceeding and, if so, in what amount?

Result:

1. The Applicant shall pay to the Insurer $101,205.11 inclusive of disbursements and all applicable taxes.

THE LAW

Rule 79.1 of the FSCO *Dispute Resolution Practice Code* (the "*Code*") provides that where an Arbitrator has determined all issues in dispute except expenses, and the parties cannot agree on entitlement or amount of expenses, either party may request, in writing, an Expense Hearing within 30 days from the date of the decision on all other issues in dispute. My jurisdiction to conduct an Expense Hearing is set out in section 282(11) of the *Insurance Act*.

Pursuant to Rule 75.2 of the *Code*, an arbitrator is to consider only the following six criteria for the purposes of awarding all or part of the expenses incurred in respect of an Arbitration proceeding:

a) Each party's degree of success in the outcome of the proceeding;

b) Any written offers to settle made in accordance with Rule 76;

c) Whether novel issues are raised in the proceeding;

d) The conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders;

e) Whether any aspect of the proceeding was improper, vexatious or unnecessary;

f) Whether the insured person refused or failed to submit to an examination as required under section 42 of Ontario Regulation 403196 (*Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*), made under the *Act*, or refused or failed to provide any material required to be provided by subsection 42 (10) of that regulation; and

g) Whether the insured person refused or failed to submit to an examination as required under section 44 of Ontario Regulation 24110 (*Statutory Accident Benefits Schedule — Effective September 1, 2010)*, made under the *Act*, or refused or failed to provide any material required to be provided under subsection 44 (9) of that regulation.

Rule 76 of the *Code* provides:

> 76.1 An adjudicator will consider an Offer to Settle in connection with an award of expenses provided that:

(a) it was made in writing, was served on the other parties and contains:

(i) the full terms of the Offer to Settle;

(ii) the date when the Offer was served and the time period during which it remained open for acceptance

AND

(b) the Offer was made after the conclusion of mediation and before the conclusion of the hearing, with particular consideration given to any Offer served after the conclusion of the pre-hearing discussion or preliminary conference as the case may be, up to 5 days before the commencement of the hearing.

With the exception of criteria f) in this present Expense Hearing, all of the Rule 75.2 criteria are arguably relevant.

ARGUMENT AND ANALYSIS

The Insurer's Claims

The Insurer is claiming expenses in the total amount of $133,908.41 (at the *Code* and FSCO Expense Regulation Rate), including legal fees, disbursements and H.S.T. The fee element of the Insurer's claim is based on a preparation days to hearing days ratio ranging from 6:1 to 2:1 for various members of the defence law firm.

The Applicant submits that the Insurer should bear its own expenses in defending the Application or, in the alternative, a preparation to hearing days ratio of 2:1, or at most 3:1, should be applied.

Degree of Success

In its written submissions the Insurer argues, "The Insurer seeks its costs as the completely successful party in this complex 13-day arbitration over four months involving seven potential motions, appointment of a substitute decision maker and extensive closing written submissions".

The Applicant responds in his written submissions:

> The Applicant acknowledges that the Insurer was successful at the hearing. The Applicant, however, submits that a lack of success at arbitration does not automatically make her responsible for the Insurer's expense. As noted by Arbitrator Killoran in *Shreet v. RBC General Insurance Co.*[2], "*While changes to the Expense Regulation have moved toward a* ***more*** *results based approach to expenses, the approach cannot be entirely results based* or the legislative purpose of the Insurance Act could be undermined."
>
> In *Halim* v. *Security National Insurance Co*.[3], Director's Delegate, Lawrence Blackman acknowledged the expense criteria must be viewed and applied to promote consumer protection and "fair and reasonable" access to justice. Further, as held by Arbitrator Killoran in *Reid and ING insurance Company of Canada*[4], the contractual relationship between the insured and insurer entitles the insured person to the dispute resolution process at FSCO.

The Insurer's success is a factor which I will take into account in favour of the Insurer. However, I agree with the Applicant that the results of the Arbitration is only one factor to be taken into account.

Offer to Settle

In its written submissions the Insurer notes:

> On October 10, 2017, a week prior to the hearing, the Insurer made a Rule 76 Offer in writing to the Applicant's counsel in the amount of $6,000. The offer remained open for acceptance until 5:00pm on October 16, 2017, the day before the hearing. The Insurer

[2] (FSCO A05-002602, February 28, 2008.)
[3] (FSCO Appeal P07-00035, November 23, 2008)
[4] (FSCO A05-002870, May 22, 2008)

> beat its offer to settle. On October 12, 2017, the Applicant made an informal offer for costs of $1.8 million. She was awarded $0.

The Applicant takes the position that, "As no reasonable Offer to Settle was made by the Insurer, the Applicant was forced to proceed with the arbitration or forego benefits and catastrophic designation".

In my view, the "reasonableness" of the offer is of no relevance, i.e. the fact remains that the Insurer offered an amount which was better than what the Applicant was awarded by the Arbitrator. The rejected offer to settle is a factor which I will take into account with regard to the Insurer's expense request.

Whether Novel Issues were Raised in the Proceeding

In its written submissions, the Applicant states that:

> …there were two novel issues within this arbitration proceeding: whether surveillance obtained during a private mediation should be excluded at the hearing and the application of s. 3(8) of the SABS that the Insurer unreasonably withheld or delayed payment of a benefit. The hearing Arbitrator held that the issue raised in relation to the surveillance was outside of his jurisdiction and permitted the use of surveillance at the hearing; this is now one of the matters under appeal. At the time of the hearing, there was no case on point until *Cariati* v *Wawanesa Insurance Company*[5] was released.

The Insurer made no submissions with regard to the "novel issue" criteria.

As a result, Rule 75.2 (c) of the *Code* shall be a factor which I will take into account in favour of the Applicant.

[5] (FSCO A15-005769, October 30, 2017.)

Whether the conduct of a party or a party's representative tended to prolong, obstruct or hinder the proceeding

The Insurer argues that:

> The arbitration was initially scheduled to proceed in May 2017 for 8 days. The Applicant rescheduled it to October 17, 2017 to obtain a capacity assessment. The issue of the Applicant's capacity was raised by the Insurer on November 16, 2015. The Applicant failed to properly address this until nearly a year later, after being prompted by the Insurer. The capacity assessment was completed in March and July 2017. However, the report was not provided until September 20, 2017, less than 30 days before the arbitration hearing. This avoidable process unnecessarily prolonged the arbitration and resulted in additional costs….
>
> On September 15, 2017, the Applicant provided the Insurer with its proposed list of witnesses, including the names of attendant care service providers. These names were requested by the Insurer 22 times prior to the arbitration. Remarkably, the Applicant indicated they would be calling 24 witnesses, forcing the Insurer to prepare extensively for the hearing. Only nine were actually called. The Insurer was required to summons and pay witness fees to 21 witnesses to be prepared to respond to the Applicant. Failure to summons these witnesses could have seriously prejudiced the Insurer.
>
> Within the 30 days of the scheduled hearing, the Applicant notified the Insurer of their intention to bring motions to exclude surveillance evidence, include Dr. Turall's late served capacity report, exclude Dr. Gnam's s. 44 addendum report, remove Insurer's counsel from record, appoint a substitute decision maker, add the issue of Special Award and compel the attendance of 4 adjusters. All these motions required additional preparation by the Insurer. Many were unnecessary as the Applicant could have addressed them prior to the 30-day deadline. As it was, the Applicant only moved forward with the substitute decision maker, surveillance and special award motions….

> The Applicant prolonged the arbitration by calling nine witnesses, one of which was a community leader that did not speak to any of the issues in dispute.

The Applicant responds that:

> This arbitration, initially scheduled to proceed on November 7, 2016, was adjourned to May 8, 2017, at the Insurer's request as it was still completing CAT assessments….The Applicant received the Insurer's CAT reports on April 10, 2017, less than 30 days before the arbitration…. The Applicant rightfully needed to obtain rebuttal reports…
>
> The Insurer called 6 witnesses after having advised of its intentions to call 18 witnesses; 6 of whom were identified as experts, by letter, dated September 15, 2017.
>
> The Applicant only brought one evidentiary motion; a motion to exclude all 8 of the Insurer's surveillance reports, on the basis, *inter alia*, that 2 of these surveillance investigations showed the Insurer's investigators making, or attempting to make, direct contact with the Applicant, who was represented by counsel, and that investigations were carried out during a private mediation, at which time the investigators listened and recorded conversations that were subject to solicitor-client privilege. Given these issues, the Applicant believed it was both reasonable and necessary to bring this motion pursuant to *Rule 40* of the *DRPC.* Although the Applicant was not successful, had the Insurer's surveillance investigations been excluded, the findings on this arbitration may have yielded a different result. On this basis, it was incumbent on the Applicant to bring this motion and the Applicant respectfully submits that this motion did not unnecessarily prolong the hearing. Arbitrator Mervin made a similar finding in *Nguyen v TD Home and Auto Insurance Co.*[6]
>
> This arbitration was heard over the course of 13 days. One of the main reasons that contributed to the length of the hearing was due to scheduling limitations of the Arbitrator and availability of witnesses. As a result, the parties and their witnesses were required to

[6] (FSCO A04-002390, April 9, 2018.)

> make multiple scheduling revisions to accommodate changes in the hearing schedule. In addition, although this hearing was 13 days, each hearing day was not a full 8 hour day.
>
> The Applicant submits that another contributing factor to the lengthy hearing was the Insurer's extensive surveillance evidence, *208.5 hours* of video footage over the course of 49 days, which the Insurer obtained and relied on. This evidence was shown to multiple witnesses and the resultant cross-examinations and submissions were significantly time consuming.

In my view, the parties are equally guilty of contributing to the unnecessary prolongation of the proceeding. I will, therefore, not consider *Code* Rule 75.2 (d) in this decision.

Whether any aspect of the proceeding was improper, vexatious or unnecessary

The Insurer further argues that:

> The Arbitrator questioned "the validity of Ms. Aydemir's assertions" and accepted that it was "implausible that the impairment claimed to have been suffered by Ms. Aydemir could have been caused by the auto accident in question"….
>
> The arbitration itself was unreasonable. The Applicant presented differently throughout her claim and her evidence was entirely contradictory with the accepted scientific and medical evidence. The Applicant was a malingerer. The costs award should reflect the Applicant's conduct and the Legislature's stated goals of reducing fraud, discouraging unmeritorious claims, and lowering insurance premiums in Ontario.

The Applicant disagrees, stating:

> The Applicant respectfully submits that no aspect of this proceeding was improper, vexatious or unnecessary. The Applicant vigorously objects to the Insurer's submissions that her claims were "fraudulent" and that she "misrepresented" her claims; no such findings were made by the Arbitrator….

> Although the Tribunal did not accept the Applicant met the various disability tests, it cannot be said that proceeding to a hearing was vexatious or improper, particularly given the various medical and other evidence, including Dr. Turrall's finding that the Applicant lacked capacity.

From my perspective, the Applicant had a right to have her claim adjudicated. I agree with the Applicant that various medical and other evidence was proffered at the hearing, apparently in good faith, in support of the Applicant's case. The fact that the arbitrator ultimately dismissed the claim does not necessarily mean it was brought improperly or was vexatious or unnecessary. As a result, I decline to consider *Code* Rule 75.2 (e) as a factor to be considered in this hearing.

Whether the insured person refused or failed to submit to an examination as required under section 44 of the Schedule

The Insurer states:

> The Applicant failed to participate meaningfully in a number of s. 44 Insurer's Examinations, despite completing assessments with her own experts. Most notably, she refused to complete testing with Dr. Zakzanis. This s. 44 non-compliance engages s. 7 of the Section F – Expense Regulation. This is a rare case where the Insurer is entitled to an award of the FSCO insurer assessment fee of $3,000.

The Applicant responds that:

> …in his Catastrophic Assessment, Dr. Zakzanis noted the Applicant was "unfit to undertake a neuropsychological examination to produce any resemblance of reliable psychometric test findings", which was similar to the comments of Dr. Braganza in 2015. Furthermore, the opinion of Dr. Turrall that the Applicant lacked capacity, an assessment requested by the Insurer and eventually paid by the Insurer, also added further evidence of why the Applicant may not have been able to fully participate.

Given Dr. Zakzanis' finding of incapacity, in my view it cannot be said that the Applicant's failure to complete the neuropsychological testing is evidence of the Applicant's failure or refusal to submit to a s. 44 examination. I will not, therefore, consider *Code* Rule 75.2 (g) as a factor to be considered.

THE INSURER'S BILL OF COSTS

The Jurisprudence

In *Henri and Allstate Insurance Company of Canada*,[7] Arbitrator Makepeace provided guidance to the general principles arbitrators should consider when deciding these cases, including, but not limited to:

> • the overriding consideration in fixing arbitration expenses is reasonableness.
> • a line-by-line assessment of the expenses claimed is not appropriate. Rather, the Arbitrator should make a global assessment of reasonable expenses.

It has long been accepted that the *Schedule* is consumer-oriented legislation, designed so that access to justice is available to the public without fear of exorbitant costs or other consequences[8].

The Supreme Court of Canada's decision in *Smith* v. *Co-operators General Insurance Co*[9] established that consumer protection is one of the main objectives of automobile insurance law. In that decision, Justice Gonthier reasoned:

> There is no dispute that one of the main objectives of insurance law is consumer protection, particularly in the field of automobile and home insurance. The Court of Appeal was unanimous on this point and the respondent does not contest it. In *Insurance Law in Canada* (loose-leaf ed.), Professor Craig Brown observed, that, "In one way or another, much of insurance law has as an objective the protection of customers".

[7] (FSCO A-007954, August 8, 1997).
[8] *Nguyen* and *TD Home*, *Supra*, Footnote 6.
[9] [2002] 2 S.C.R., 129, 2002 SCC 30.

Bearing these principles in mind, a line-by-line analysis of the bill of costs is virtually impossible. The breakdown in the Insurer's bill of costs submitted does not provide sufficiently detailed information to do so for the several staff members who worked on the file. Moreover, Parts of the Insurer's bill of costs submitted provides no details. In the circumstances, a more "global" approach to assessing expenses makes sense.

Fees

The Rule 75.2 criteria favouring the Insurer's reimbursement are its 100% success at Arbitration and the fact of the Rule 76 offer being rejected by the Applicant. On the other hand, I found that the hearing included novel issues the fact of which serves to somewhat ameliorate the Applicant's liability. In the result, I will allow the usual preparation days to hearing days ratio of 4:1 for counsel and a 2:1 ratio for the articling student. In my view, these ratios respect both the principle of proportionality and reasonableness. I have included 9 hours for the articling student to prepare the Insurer's bill of costs.

Accordingly, the following number of hours will be reimbursed at the applicable Legal Aid Ontario tariff rates:

Counsel Frost :	365 hours @ $122.78	= $44,814.70
Counsel Duggan :	35 hours @ $122.78	= $4,297.30
Student-at-Law Tasevska:	164 hours @ $64.73	= $10,615.72
Total Fees Reimbursable:		= $59,727.72

Disbursements

The Applicant argues that:

> In its Bill of Costs, the Insurer indicated that it has incurred $39,026.03 in disbursements. [Including] charges for "Witness Attendant Fees" in the amount of $1,240.40 and also…

> $4,859.00 in "Total Fees for Witnesses". The Applicant submits that this charge is unreasonable.

I agree with the Applicant and will accept $4,859.00 as reimbursement for preparation and attendance of witnesses pursuant to the *Code's Expense Regulation*.

The Applicant also submits that:

> The Insurer also billed a total of $1,907 for Photocopying and Printing. The Applicant respectfully submits that the Insurer does not provide any details as to the cost per page, number of pages or the dates/purpose. In *Nguyen*[10] Arbitrator Melvin, on this same basis reduced the Insurer's photocopying expense.

Again, I agree with the Applicant and hence will reduce the Insurer's photocopying and printing claim by 50% to $953.50.

As noted above, I disagree with the Insurer's submission that the Applicant refused or failed to submit to an examination as required under section 44 of the *Schedule*. I therefore disallow the Insurer's claim for reimbursement of the FSCO Insurer assessment fee of $3,000.

All other disbursement claims appear to be allowable under the FSCO Expense Regulation. They also all seem reasonable. In the result, calculated at the Expense Regulation rate, I will allow reimbursement of disbursements in the amount of $29,834.33.

CONCLUSION

Total Legal Fees:	$59,727.72
Disbursements:	$29,834.33
HST @ 13%:	$11,643.06

[10] *Supra*, Footnote 6.

TOTAL AWARD FOR ALL FEES, DISBURSEMENTS AND HST:	$101,205.11

For the reasons set out above, the Applicant shall be ordered to pay the Insurer's expenses in respect of defending the Application, fixed in the amount of $101,205.11 (inclusive of fees, disbursements and taxes).

Alan G. Smith Arbitrator	June 5, 2018 Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A14-003170

BETWEEN:

FILIZ AYDEMIR

Applicant

and

AVIVA INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1. The Applicant shall pay to the Insurer $101,205.11 inclusive of disbursements and all applicable taxes.

June 5, 2018

Alan G. Smith
Arbitrator

Date