Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A09-003237

BETWEEN:

EVERLISTON COWANS

Applicant

and

MOTORS INSURANCE CORPORATION

Insurer

REASONS FOR DECISION

Before: Arbitrator John Wilson

Heard: August 11, 12 and 17, 2010, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: David S. Wilson for Mr. Cowans
Catherine Korte for Motors Insurance Corporation

Issues:

The Applicant, Everliston Cowans, was injured in a motor vehicle accident on April 2, 2007. He applied for and received statutory accident benefits from Motors Insurance Corporation ("Motors"), payable under the *Schedule*.[1] Motors terminated income replacement benefits on the basis of a determination that Mr. Cowans did not meet the post-104 week test for entitlement to benefits. The parties were unable to resolve their disputes through mediation, and Mr. Cowans applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended

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

Prior to the arbitration, Mr. Cowans and Motors were able to come to an agreement on all issues in dispute, with the notable exception of Mr. Cowans' claim for a special award.

The issues in this hearing are:

1. Is Mr. Cowans entitled to a special award?

Result:

1. Mr. Cowans is entitled to a special award in the amount of 40%.

EVIDENCE AND ANALYSIS:

As noted above, this case is a "stand-alone" special award claim, since all other elements of Mr. Cowans' claims have been dealt with prior to this hearing. It arises because Mr. Cowans believes that in cutting off his income replacement benefits after the 104 week mark, Motors acted unreasonably.

To a degree, as well, Mr. Cowans' claims bring into question the way Motors and perhaps other insurers deal with the determination of entitlement to benefits in a post-DAC world and how the system of insurer's assessments that replace the DAC system fits into such determinations.

Prior to his motor vehicle accident on April 2, 2007, Mr. Cowans worked as a shipper with Muir's Cartage Limited in Brampton Ontario, a job that entailed working as a fork lift operator, as well as loading, and unloading boxes by hand, and shrink-wrapping loaded skids.

Mr. Cowans was born and raised in Jamaica where he is said to have completed the equivalent of Grade 10. Following emigration to Canada, he worked in a variety of jobs including a body shop before settling in at Muir's, a trucking company with warehouse services in Brampton.

Mr. Cowans had been with Muir's since 1998, and worked significant overtime, with hours of work said to reach at times as high as 90 hours per week. Mr. Cowans' remuneration from Muir's reflected this high level of work. Indeed, the Employer's Confirmation Form (OCF-2)

issued on April 12, 2007 shows a gross income of $49,739.44 in the 52 weeks prior to the accident, and an income of $1,376.75 in the week prior to the accident.

The foundation for Mr. Cowans' claim for a special award is his allegation that Motors failed to properly consider his education, training and experience, especially his demonstrated ability to maintain a significant income stream, in making its determination as to entitlement to income replacement benefits after the 104 week mark.

Mr. Cowans asserts that, had there been a reasoned assessment of the alternative jobs proposed by Motors in making its determination as to entitlement, including the level of remuneration generally received by Mr. Cowans, the proposed jobs could not have been considered in good faith to be "employment for which he or she is reasonably suited by education, training or experience."

Section 5(2) of the *Schedule* provides that:

> The insurer is not required to pay an income replacement benefit,
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> (a) for the first week of the disability;
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> (b) for any period longer than 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience; …

Arbitral decisions have held that this test is not to be construed literally but rather in the context of the whole of the insured person's education, training and experience', such that an individual is able to meet reasonable standards of productivity in a competitive market place.

> In determining the meaning of 'any gainful occupation' for which an insured is 'reasonably fitted by his education, training and experience the test is not whether a job is within the insured's capability, rather, the test is whether there is a full time job for which the insured is reasonably fitted by what he has done before.[2]

[2] *Nantsios v. The Canada Life Assurance Company* [1997] I.L.R. I-3411

Arbitrator Seife as well has summarized comments in the arbitration forum about the question of "suitable employment" as follows:[3]

> 1. The question of suitable employment in every case is a question of fact: the work must be suitable for that applicant, viewed fairly and realistically in the context of his or her educational and employment background.
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> 2. Suitable work is not limited to what the applicant was doing at the time of the accident, provided that it is not unrelated to his or her previous experience. However, work is not necessarily suitable because an applicant has done a stint of it in the past. If the job is substantially different in nature, status, or remuneration it may not be an appropriate alternative.
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> 3. In deciding suitable employment, one must consider such factors as the nature and status of work compared with what the applicant did before, the hours of work and level of remuneration, the applicant's employment experience and length of time spent in different jobs, his or her age, and his or her qualifications and technical training and know-how.
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> 4. The primary focus is on an applicant's functional limitations; however, job-market considerations are relevant in determining suitable employment.

Motors as noted earlier ceased to pay Mr. Cowans income replacement benefits on the basis that he was able to perform suitable alternative employment. In its letter to Mr. Cowans dated May 8, 2009, Motors stated:

> A Comprehensive Vocational Evaluation including a Labour Market Survey was also completed as part of the assessment and identified alternative occupations that are within you (sic) current physical tolerance and ability, your level of education, training and experience, are readily available in the vicinity of your home, and are commensurate to your pre-accident employment in terms of status and remuneration….

Mr. Cowans' income replacement benefits were terminated on this basis.

Prior to the hearing of this matter, Motors agreed to an order reinstating Mr. Cowans' income replacement benefits "as of May 17, 2009", the date of termination. By consenting to this order Motors implicitly agreed that Mr. Cowans continued to meet the requirements for

[3] *Wigle and Royal Insurance Company of Canada*, (OIC A-012312), January 12, 1996)

ongoing income replacement benefits after the 104 week mark, and that it was wrong in its initial determination.

Earlier arbitral decisions however have established the principle that merely being wrong did not oblige an insurer to pay a special award. As Arbitrator McMahon noted in *Cripps and AXA*:

> With the clarity of hindsight it is easy to say that the Insurer ought to have made inquiries to ascertain how someone as severely injured as Mr. Cripps had managed to make such a remarkable recovery, and to satisfy itself that the surveillance material was not being misinterpreted. However, the standard is not one of perfection….[4]

While a standard of perfection is not necessarily demanded of insurers, reasonableness in making determinations of entitlement is. More recent jurisprudence looks at hindsight with a more nuanced analysis:

> The Appellant relies on Delegate Draper's statement in *Zurich Insurance Company and C.L.* that he was "not persuaded that benefits can be unreasonably withheld or delayed where the insurer *had* an acceptable basis for not paying them, even if its second reason was wrong" [emphasis added]. By using the past tense, I find that this decision confirms that it is not sufficient for an insurer to say that it was ultimately vindicated at the arbitration hearing that the evidence was equivocal. It is not a question of hindsight or perfection, as stated in *Cripps and AXA Insurance (Canada)*, (OIC A-013360, February 7, 1997), but whether the initial and ongoing withholding or delay in payment of accident benefits was reasonable at the time in question.[5]

In *Plowright and Wellington*[6], Arbitrator Palmer enunciated the classic statement of an insurer's standard of conduct in dealing with accident benefits:

> The standard expected of an insurer's examiner and her supervisors is one of sound and moderate judgment.

In *Kingscourt Auto Enterprises Inc. v. General Accident Assurance Co. of Canad*a, Mr. Justice Herold identified the general standard of care imposed upon an insurance adjuster:

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[4] *Cripps and AXA Insurance (Canada)*, (OIC A-013360, February 7, 1997)
[5] *Melchiorre and Wawanesa Mutual Insurance Company*, (FSCO P07-00014, April 25, 2008)
[6] *Plowright and Wellington Insurance Company* (OIC A-003985, October 29, 1993)

> The standard of care imposed upon the adjusters in this case is not to be error-free but simply to take reasonable steps similar to those that a reasonably prudent and careful claims adjuster would take. [7]

As I noted in much jurisprudence, "reasonableness" is not decided in a vacuum. "Unreasonable" conduct suggests a breach of a commonly understood obligation or standard. In an insurance context, while the standard of conduct of an insurance adjuster making decisions on benefit entitlement may not generally be as high as that demanded of a trustee, it is however significant.

O'Connor J.A. in *702535 Ontario Inc. v. Non-Marine Underwriters, Lloyd's of London*, stated that:

> The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy.[8]

It is important to note that intent is not a fundamental part of a finding of unreasonable delay or withholding of benefits. An insurer with the best of intentions can fall below the standard of reasonable conduct. Nor is there a requirement of an independent actionable wrong to provide the foundation for a special award.

That is not to say that intention is irrelevant. The presence of malice or malicious intent would serve to underline the unreasonableness of a particular decision and speak eloquently to the arbitrator's discretion in fixing the amount of the special award.

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

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[7] (1992), 8 C.C.L.I. (2d) 21, [1992] I.L.R. 1-2824 (Ont. Gen. Div.)
[8] 184 D.L.R. 4th 687 (C.A.)

Motors' position in this matter is quite clear. It maintains that it, in good faith, made a determination that Mr. Cowans was no longer entitled to income replacement based on the opinions of qualified experts that it retained to examine and evaluate Mr. Cowans. Given that its determination was backed by these opinions, its termination and consequent withholding of the benefits could not be "unreasonable."

It further asserts that as information became available, it reconsidered its prior determination and, indeed, ultimately, made the decision to reinstate benefits without waiting for an arbitration to be completed.

In support of its position, Motors called one of the I.E. assessors, Dr. Richard Finkel, and Mr. Albert Cesario, a claims supervisor with Motors.

Mr. Cesario, referencing the insurance company records, outlined the procedures that Motors undertook in making a determination as to benefit entitlement in this matter.

Mr. Cesario indicated that he was aware of the criteria for the payment of income replacement benefits after the 104 week mark. He was also aware of the need to properly assess an insured in order to obtain the necessary information to make a determination.

It was clear from the evidence, however, that neither Mr. Cesario, nor the actual adjuster, Ms. Jacqueline Naccarato, were actively involved in obtaining relevant assessment reports. Rather, it would appear that the process was delegated to Health Impact Multidisciplinary Assessment Centres which arranged for separate assessments by a psychiatrist, a physiatrist, a labour market analyst and vocational assessor, and a kineticist who performed functional abilities evaluations.

These individual assessors were assigned the work by Health Impact, presumably from a list of persons contracted to perform assessments on behalf of Health Impact.

Mr. Cesario testified that on receipt of the reports from Health Impact, Motors simply acted on the recommendations of the assessors. This is reflected in the internal notes of the Motors adjuster Ms. Naccarato:

> I reviewed the section 42 multidisciplinary post 104 week IE report. The report finalizes that the claimant continues to suffer from chronic pain despite the recent completion of a pain program, and ongoing psychological counselling and support. No significant findings were reported by the physiatrist, who suggested that there was no reason why the claimant should not be able to operate a forklift.
> In functional testing, the claimant revealed better results as far as ability and tolerance from an assessment completed 1 year prior. The psychiatrist evaluated that the claimant sffered (sic) from Adjustment Disorder with Mixed Anxiety and Depressed Mood, but did not otherwise suffer a complete inability to carry on a normal life. The psychiatrist did recommend a review of the anti-depressent (sic) medication taken by the claimant, with a shift to a more effective medication. The vocational evaluation identified 6 alternative occupations that were with the claimant's functional ability and tolerance, and for which he was suited by education, training and experience, are readily available in the community where the claimant lives, and are similar in status and remuneration to his pre-mva occupation. In light of the post-104 IE, OK to stop IRB benefit. Rebuttal available. Recommendation regarding psychiatric medication outlined. OK to send letter/ OCF 9.

I have quoted this entry in its entirety since it seems to completely summarize the extent of the determination process. This is reflected in the termination letter sent to Mr. Cowans by Ms. Naccarato on May 8, 2009. In fact the letter is even more precise. Motors relied solely on the opinion of Mr. Jean, the vocational assessor, in terminating benefits.

On cross-examination by counsel for Mr. Cowans, Mr. Cesario conceded that he and his adjusters took the expert reports at face value, and assumed that, being professionals, the experts would do their jobs properly. Mr. Cesario, although he professed to have read the reports in reviewing the termination, was not aware whether or not Mr. Jean, the vocational assessor, had a realistic appreciation of Mr. Cowans' actual income at the time the vocational assessment was performed.[9] He merely assumed that all relevant information was taken into consideration.

[9] Mr. Cesario conceded that the OCF-2 listing Mr. Cowans' income was not among the documents noted by Mr. Jean, the vocational assessor, as having been obtained for use in the preparation of his opinion. When asked how a vocational assessor could provide a vocational report without any real knowledge of Mr. Cowans' pre-accident income, Mr. Cesario stated that he could only assume that as a professional he would have extracted that information in the course of his assessment.

Mr. Cesario also confirmed that he and his staff were aware that knowledge of pre-accident income was a critical element in any analysis of whether an alternative occupation was appropriate to any particular insured.

It was clear from Mr. Cesario's testimony that although he professed to have read the I.E. reports leading to the determination, he could not have given them any close scrutiny, or analyzed their conclusions in a critical manner. Rather, I suspect that he engaged in the same process as outlined in Ms. Naccarato's report: a short review of conclusions followed by a decision to adopt the recommendation of the most favourable report.

I note specifically that although the I.E. reports are called a multidisciplinary assessment, there is no attempt to bring forward a consensus report as to collective recommendations made by an assessment team. Rather, the report is prefaced by a "Synopsis" prepared by a David Goldstein, MD, who is not listed among the examining assessors. Dr. Goldstein provides a simple summary of the opinions of the assessors, without attempting to interrelate the findings or observations of the different assessors.

By contrast, the co-ordinator of a true multidisciplinary assessment was required to do the following:

> **Primary Evaluator**
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> The primary evaluator is the clinical coordinator for that case and is in charge of the assessment process. His/her role is to ensure smooth, efficient and appropriate handling of the assessment, from intake to the end of the reporting phase. The primary evaluator must be a health professional. Specific functions include:
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> - Review file, note and respond as appropriate to any particular concerns which might put the claimant at risk in proceeding with the assessment.
> - Ensure the referral is complete and determine if any additional information is required (see DAC General Guideline 4).
> - Prepare the assessment plan.
> - Review all draft reports and determine there are no inconsistencies and that consensus has been reached. Where necessary, coordinate a conference between all pertinent assessors.
> - Create the Executive Summary
> - Complete the OCF-11B.[10]

[10] Section 2.4.2 of the *Disability Designated Assessment Centre Assessment Guide* "*A guide to conducting Disability DAC assessments" Minister's Committee on the Designated Assessment Centre System* April 2000

While the previous Designated Assessment system for which the above directions were developed has been dispensed with, there were sound policy reasons for much of their mandate. Specifically, the mandate of the primary assessor; to "determine that there are no inconsistencies and that consensus has been reached" is lacking in the present free-for all. There was a cogent reason for co-ordination, as stated in section 2.3 of the guide:

> Although each member of the team contributes assessment outcomes from his/her unique clinical perspective, disability determination requires the integration of assessment outcomes so that the combined impact of the claimant's disability can be considered.

Under the sort of "multidisciplinary assessment" carried out by Motors in this matter, there is no attempt to draw together the different viewpoints of the assessors. A prime reason for this absence is the nature of the determination being made. Rather than the DAC assessment team making a preliminary and binding determination, it is the Insurer, through its designated staff, which makes any determination. As H.E. Sachs J. observed in a case involving the records of similar section 42 examiners:

> The experts in question are not parties being sued because of the opinions that they gave or the assessments that they performed. The party who is being sued is the insurer. The appellant insurer may have relied on these expert opinions, but it was the insurer's responsibility to make the decision after assessing and critically examining these opinions.[11]

My impression from both the Insurer's notes and Mr. Cesario's testimony is that Motors did not live up to its obligation to make its decision only after assessing and critically examining these opinions. Rather, Mr. Cesario made it clear that although he was aware that pre-accident income was a necessary part of the alternative employment analysis, he did not feel inclined to call the assessor, or to question the assessor as to the absence of such information in the documents reviewed. Indeed, he was clear that he relied upon the assessor to have made the correct decision and accepted the recommendation of the most favourable assessor without any critical analysis.

While in the absence of contrary information one might be entitled to rely on an expert's professionalism in making a determination, what is troubling about Mr. Cowans' case is that, at the time of Motors' determination, there was credible information in the hands of the Insurer

[11] *Babakar v. Brown* [2010] O.J. No. 414 Div. Ct.

casting the recommendations of Mr. Jean into doubt. In fact, even a critical reading of the "multidisciplinary assessment" ought to have raised question marks about the conclusions that Motors ultimately relied upon in its termination of benefits.

Mr. Jean made certain assumptions about Mr. Cowans' abilities that were reflected in his suggestions of alternative employment. Foremost amongst these was that Mr. Cowans was most suited to employment where one could learn on the job.

Mr. Jean apparently extrapolated an ability to learn on the job from the absence of evidence of academic achievement and Mr. Cowans' employment history. Mr. Jean also notes that "Mr. Cowans indicated that he participated in 'on the job training' when working." There was no evidence of just what such training involved, but in the context of the relatively basic nature of Mr. Cowans' employment, it is unlikely we are talking about a significant apprenticeship or even the acquisition of complex skill sets in the context of employment.

It should be remembered that Mr. Jean, as part of his assessment, administered a battery of tests aimed at measuring Mr. Cowans' academic and other abilities. The WRAT3 test showed a reading level of Grade 3, and Spelling and Arithmetic at a Grade 4 level. The Compass assessment showed a low aptitude in reasoning, math, language, general learning, verbal aptitude, numerical aptitude, a medium score in form perception and a high score in colour discrimination.

Indeed, Mr. Jean concludes that "Mr. Cowans would be limited in his ability to work in settings where reading and writing are involved or required as an essential demand of the job." Mr. Jean also reported that :

> The combination of these two factors (average reasoning abilities and low average general learning abilities) would suggest that this individual may require additional opportunities for practice and repetition when learning new skills. He may struggle when learning new information; this would be less of a struggle when information is presented orally and more difficult when information is presented in a more forma (sic) manner (i.e. requiring reading and writing).

Yet, according to Mr. Jean:

> Mr. Cowans' current training and education would allow him to consider jobs with the following employment requirements:
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> - No formal education or training requirements
> - On the job training or experience
> - Some high school education.

There would appear to be a substantial disconnect between someone with a reading level of Grade 3, and a spelling and arithmetic level of Grade 4 meeting a job requirement of "some high school education." The same might also be said for "on the job learning" for someone who "may struggle when learning new information."

Notwithstanding Mr. Jean's comment that "Mr. Cowans' current skills and aptitudes would allow him to pursue this type of employment", the conclusion that Mr. Cowans could meet reasonable standards of productivity in a competitive market place as a final inspector/packager of small products, a plastic products inspector, an inspector/tester of electrical appliances/apparatus, a process control operator, a rubber products inspector, or a repairer/servicer of small/light products strains credulity. Each occupation would seem to require some product or process knowledge that would be substantially different from loading and unloading pallets.

The first occupation outlined, that of final inspector/packager, talks of persons who "assemble and inspect a variety of products, such as jewellery, silverware, clocks and watches, musical instruments, sporting goods, toys, and other miscellaneous products" would seem far from driving a fork lift or doing prep work in a body shop, and would imply both dexterity and some familiarity with the product being assembled.[12]

There was also the important question of economic compatibility of the proposed jobs. Mr. Jean's employment survey listed ranges from $12 to $14 per hour for an electrical tester position, $9.50 to $12.35 per hour for a process control operator, and $13 to $18 per hour for a repairer/servicer. As Motors was well aware from the OCF-2 prepared by Mr. Cowans' employer, his gross weekly income in the week prior to the accident was $1,376.75.

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[12] **Inspect** *v.tr.* **1** look closely at or into, esp. to assess quality or check for shortcomings. **2** Examine (a document etc.) officially. *The Canadian Oxford Dictionary*.

At $12 per hour, a 40-hour week would bring in a gross revenue of $480. Even $18 per hour would have brought in about $720 per week.

Mr. Cesario explained away the significant discrepancies in income by pointing out that Mr. Cowans generally worked overtime, and stated that the real comparative income for Mr. Cowans was somewhere between $30,000 to $35,000 rather than the $49,000 that he actually earned. By that calculation, the repairer/servicer position whose upper range of wages was $18 per hour would have been a roughly equivalent position. The $12 per hour starting rate would not have been, however.

Mr. Cesario acknowledged that it would be highly unlikely that an employer would offer an untrained person such as Mr. Cowans a starting salary in the high range. Still, neither he nor the adjuster called Mr. Jean in an attempt to understand how the alternative occupations were economically comparable.

Mr. Cesario also soon had in his hands an August 24, 2009 report by David Antflick and by January 2010 a further vocational report by Atila Balaban.

Mr. Antflick opined as to Mr. Cowans' training and skill sets:

> He had never been trained or educated to do more complex forms of work and he had no finely tuned skills that would allow him to compete for more complex jobs in the workforce. He was just barely literate in English and had negligible computer skills.

Mr. Antflick further commented as to the physical aspects of the proposed work:

> However, I think Mr. Jean has minimized the physical demands of those jobs for which Mr. Cowans was allegedly suited, especially with regard to the required standing/walking demands and the demands that require a combination of body movements needed to accomplish the essential tasks of the employment.

Mr. Antflick then examined the wage potential of the proposed occupations noting:

> Even if one accepts that these jobs are suited to him based on his education, training and experience (which I do not) one notes that it will not be before year 10 in any of those occupations that he would be able to approximate his pre accident income.

Mr. Antflick concluded that:

> ...the significant wage difference when compared to his pre accident wage is evident. This would make any of those jobs unsuitable for that reason alone.

Mr. Cesario testified that he discounted the Antflick report because of what he considered an obvious discrepancy in the attribution of pre-accident income.[13] Nor did he act on the report, or even re-examine the assumptions of the Jean report when those assumptions were critiqued by Mr. Antflick.

By the time that the reports were received an application for arbitration had been filed and out of "respect for the dispute resolution process", Mr. Cesario felt it was somehow inappropriate for Motors to act on the Antflick report. Once the arbitration was begun Mr. Cesario believed that there was no reason to send out any reports received from Mr. Cowans for consideration.

Another less charitable conclusion would be that Mr. Cesario, having made a determination, was not inclined to revisit it on behalf of Motors, notwithstanding that there was credible evidence in Motors' hands that challenged both the assumptions and the conclusions of the assessor Motors relied upon in terminating and refusing to pay ongoing income replacement benefits.

In *R. v. Sansregret*[14], the doctrine of wilful blindness was outlined.[15]

> ...wilful blindness arises where a person who has become aware of the need for some inquiry declines to make the inquiry because he does not wish to know the truth. He would prefer to remain ignorant. The culpability in recklessness is justified by consciousness of the risk and by proceeding in the face of it, while in wilful blindness it is justified by the accused fault in deliberately failing to inquire when he knows there is reason for inquiry.

Of course, wilful blindness is not only a criminal concept. It also applies in civil situations, especially when the good faith actions of a party are at issue.[16] A person claiming under section

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[13] Mr. Antflict used the numbers shown in the employer's confirmation of income as a comparator.

[14] *R. v. Sansregret* [1985] 1 S.C.R. 570

[15] Sopinka J. in *R. v. Hawkins* [1995] 4 S.C.R. 55 also noted: "It is well established in criminal law that wilful blindness will also fulfill a *mens rea* requirement...Deliberately choosing not to know something when given reason to believe further inquiry is necessary can satisfy the mental element of the offence."

2(1) of the *Factors Act* for example, that title has passed in goods, and that they were unaware of any defect in title, cannot be wilfully blind to circumstances that might have called out for further enquiry.

Likewise, an insurer in making a determination cannot ignore credible evidence that is available to it. An insurer has an obligation to assess and critically examine these opinions, and not simply pretend that they do not exist. To repeat, as O'Connor J. noted in *702535 Ontario Inc. v. Non-Marine Underwriters, Lloyd's of London*: "In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner." I do not accept that it is reasonable to ignore or discount credible information that merely disagrees with preconceptions or conclusions already made.

While an insurer's decision as to benefit entitlement may not be elevated to the level of a statutory power of decision[17], the use of the word "determination" (determiner) to describe the decision-making process suggests that the legislators have high expectations of the insurer's decision-making process.

It was also clear from the approach that Mr. Cesario took to this process that much of the need for a critical assessment of relevant information was more or less delegated to the assessors, whose "professionalism" Motors relied upon.

While the assessment protocols relied upon by Motors may well be common in the industry they are not a substitute for a balanced and considered determination by an insurer.[18]

Dr. Finkel's testimony provided some insight into the details of the assessment process in this matter. Dr. Finkel, of course, was part of the multidisciplinary assessment arranged by

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[16] See *Webster v. Webster Estate* [2006] O.J. No. 2749 C. Robertson J.; *Assaad v. The Economical Mutual Insurance Group et al.* [2002] I.L.R. I-4116; *Bartin Pipe & Piling Supply Ltd. v. Epscan Industries Ltd.* [2005] 1 W.W.R. 290 Alberta Court of Appeal

[17] See the discussion at p. 14 of *Sinnapu and Economical Mutual Insurance Company* (FSCO A09-000900, July 30, 2010)

[18] See Professor Fleming's treatise, *The Law of Torts*, 7th ed. (Sydney: Law Book Co., 1987), at p. 109 who notes that while conformity with general practice, may dispel a charge of negligence "all the same, even a common practice may itself be condemned as negligent if fraught with obvious risk."

Health Impact. Dr. Finkel's prime occupation is doing psychiatric assessments, principally for a variety of insurers mostly in the automotive sector.

He is not, however, usually directly retained by an insurer but rather by an assessment company such as Health Impact whose raison d'être is the provision of assessments services. Dr. Finkel also confirmed that Mr. Cowans' assessment was a brief, one-time interview, one of up to 45 to 50 he might do in a month.[19]

He would receive the paperwork, including the documents indicated on his report, proceed to the assessment location, interview the insured, and then write a report. Given the volume of examinations, it could not be supposed that there was significant time for detailed reflection on each assessment.

Although Dr. Finkel was apparently provided with a copy of the Insurer's FAE assessment for comment, his evidence was that, following the initial assessment, there was no contact from Motors nor any other further relevant documents sent to him for consideration. In fact, Dr. Finkel stated that there was never any direct communication between him as an assessor and Motors.

More importantly, with the exception of the provision of the FAE report, there is no evidence of a co-ordinated attempt to reach a consensus between assessors or to deal with disability other than in the narrow view of each discipline. Given that Mr. Cowans claimed that he was disabled due to a mixture of psychological problems, pain issues, and physical constraints, such an omission, is highly problematic.

Although much was made of Dr. Finkel's preconceptions as to accident victims, and his obvious dependence on the insurer's goodwill for his lucrative assessment business, I do not believe that this is a central problem in Mr. Cowans' case. Rather, the problem would appear to be more systemic.

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[19] Although it was possible to infer even higher numbers of examinations from Dr. Finkel's cross-examination, for the purpose of this analysis I accept that the number was intended to be on a monthly basis, a presumption that would be consistent with Dr. Finkel's projected income from assessments being in the range of some $600,000 per year.

Assuming for example that the 40–50 assessments figure related to a month, that would mean that Dr. Finkel on some weeks may have performed at least 10 assessments per work week. The time permitted to review, assess and report on any individual would have been at most 4 hours from start to finish, including the reading of voluminous documentation.[20]

Whether Dr. Finkel was biased or prejudiced or not, I find that it tests credulity to believe that an assessment mill[21] such as described by Dr. Finkel could ever generate meaningful results.

In this matter, as the 104 week "any occupation" test loomed, Motors, quite rightly, anticipated that it would need to make a determination as to ongoing income replacement benefits. It, also, quite rightly, realized that specialized assessments could be of assistance in making that determination, and apparently retained Health Impact to set these in motion.

Where Motors began to go astray in the determination process is in the absolute trust it appeared to give to Health Impact to get the assessments right. Motors had no input into the choice of assessors or the assessment protocols − that was apparently done by Health Impact. In fact, other than reading the conclusions of the various assessors, it remained a totally hands-free assessment process as far as Motors was concerned.

It should be remembered that disability in accident benefit matters is a legal test, albeit one which usually requires medical input. Making a determination requires the application of the medical evidence – all the available medical evidence to the legal test. Since it is the Insurer who makes the determination, it is incumbent upon an insurer to critically review the available evidence and to apply it to the test for entitlement contained in section 5(2) of the *Schedule*.

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[20] Assuming a 40-hour work week. Even doubling this figure to 80 hours per week would still leave little room for a considered, professional assessment, given that Dr. Finkel also still saw some OHIP patients in the same work week.

[21] Even at the lower *monthly* rate of assessments, I do not accept that given time off for holidays, travel time to and from assessments and unforeseeable intake volume, that sufficient time would be available for considered, professional assessments on important issues. In fact, this analysis is supported by the relatively low amount per assessment indicated by Dr. Finkel as being charged for his time.

Cumming J. noted:

> the insurer may not treat the insured as an adversary whose interests may be disregarded. This encompasses a duty to settle claims without litigation in appropriate cases: Plaza at 672. This implies a reasonable and competent investigation to determine whether a claim will be honoured.[22]

Now that the burden of making a legal "determination" has devolved on the insurer with the abolition of DACs, Cumming J.'s comments are even more critical.

In Motors' case, delegating the investigation, unsupervised, to what seems to have been an assessment mill, and merely reciting the summary of the assessment before terminating benefits was not "a reasonable and competent investigation."

Although Mr. Cesario testified that he had read the reports that were commissioned by Motors, I do not accept that he could have done so closely or analytically. Otherwise he would have noticed internal inconsistencies and key missing evidence[23] that would have been necessary for a sustainable finding that Mr. Cowans was indeed capable of doing remunerative work at an appropriate occupation.

Read together, the reports of Mr. Cowans continuing to suffer from chronic pain despite the recent completion of a pain program, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Mr. Jean's comments that Mr. Cowans would be limited in his ability to work in settings where reading and writing are involved or required as an essential demand of the job, should have set the alarm bells ringing, or at the very least triggered further enquiry on behalf of Motors.

Likewise, the problem of whether Mr. Jean's suggested alternative occupations actually responded appropriately to the criterion of equivalent remuneration should have been apparent upon any critical analysis.

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[22] *Bullock v. Trafalgar Insurance Co. of Canada* [1996] O.J. No. 2566 Ont. Sup. C.J.

[23] The absence of any consensus report also ought to have raised concerns on behalf of Motors, especially given that each assessor, quite properly, refused to answer questions that each deemed to be outside of his or her expertise, with the result that there were serious gaps in the conclusions made.

I note in passing that Mr. Cesario seemed to have some highly individualized impressions of just what the test in section 5(2) meant in actual practice. As I mentioned earlier, the test is essentially a legal test, but there was no suggestion that either Mr. Cesario or Ms. Naccarato sought legal advice either to clarify their understanding of the test to be met or to deal with the inconsistencies in their own expert reports.

I also note again that Motors had in its possession credible information provided by Mr. Cowans[24] that supported his contention that he remained disabled.

Although Motors raised the point that not all relevant evidence was provided on a timely basis, I cannot accept that the time of delivery of any reports would have likely affected Motors' decision-making process. After all, even the receipt of reports rebutting Mr. Jean's conclusions generated no action, no enquiries and no change of mind when actually received by Motors. Motors' change of heart indeed only came with the approach of the arbitration hearing, and presumably with the receipt of considered legal advice in preparation for that hearing.

Under the circumstances, I find that Motors' decision to terminate benefits owed to Mr. Cowans was not only wrong but unreasonable. The finding of such an unreasonable withholding of benefits automatically attracts a special award, and consequently I so order.

Quantum of special Award:

An arbitrator's discretion with regard to a special award relates mainly as to the quantum. Once a finding of unreasonableness is made, the only element of discretion is as to the amount of the award that an arbitrator decides is appropriate to the conduct in question.

A key concept in accident benefits is the prompt payment of an income benefit. This is reflected in the wording of subsection 282(10) of the *Insurance Act* dealing with special awards. The lack of prompt payment is not only undesirable under the scheme of the *Act*, but also frequently has serious ramifications for an insured as well.

[24] These included progress reports by North Peel, the records of Dr. Sobers, various disability certificates, an FAE from Austin Rehab, treatment plans and reports from Dr. Tory Hoff, and various insurer's examination reports, all of which testified to the seriousness and chronicity of Mr. Cowans' complaints.

There is a strong representation of recent immigrants, such as Mr. Cowans, and persons with low income or limited attachment to the workforce amongst accident benefits claimants.

This is likely because of the deductibility of collateral benefits, whether through employment or private insurance schemes, which makes accident benefit claims irrelevant to much of the comfortably employed population.

In Mr. Cowans' case, although an immigrant with few formal qualifications, he had demonstrated an ability to earn an above average income over a period of years. This was not necessarily because he had specific skills that were attractive to employers, but rather because he was willing to work long hours of extensive overtime on a regular basis.

Prior to the accident in question, Mr. Cowans was able to work long hours at a physically challenging work. After the accident, despite attempts to return to work, he could not even carry out the basic elements of his job on a sustained basis.

It was bad enough after the accident that his gross income was reduced by almost a half to the level of the maximum income replacement benefits. After Motors' decision to terminate benefits, his income further plunged to nil. The various assessments refer to Mr. Cowans' concern over his financial status, his rising debt and his disappearing income.

The record in this matter shows that Mr. Cowans' financial distress was communicated to the Insurer. Mr. Cesario in his testimony conceded that he was aware of Mr. Cowans' plight when Motors terminated income replacement benefits on the basis of a patently flawed assessment process.

In *Liberty Mutual and Persofsky*, the Director recognized both conduct and effect as elements in setting a special award.

> 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; (v) 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.[25]

As Arbitrator Blackman stated in *Murray and Wawanesa*, "The effect of the Insurer's unreasonable withholding or delaying of payments on the Applicant is also a factor to be taken into consideration in making a special award."[26]

That the effect of a failure to perform obligations under an insurance contract should have repercussions on an award in the favour of an insured should not come as a surprise.

In a matter which arose from the failure of a disability insurer to live up to the terms of its contract with an insured, the Supreme Court noted in *Fidler*:

> The bargain was that in return for the payment of premiums, the insurer would pay the plaintiff benefits in the case of disability. This is not a mere commercial contract. It is rather a contract for benefits that are both tangible, such as payments, and intangible, such as knowledge of income security in the event of disability. If disability occurs and the insurer does not pay when it ought to have done so in accordance with the terms of the policy, the insurer has breached this reasonable expectation of security.[27]

In addition to whatever financial embarrassment that Mr. Cowans may have suffered, it is also appropriate to consider that a person suffering, as the Insurer itself noted, "Adjustment Disorder with Mixed Anxiety and Depressed Mood" would be negatively impacted by Motors' failure to uphold "this reasonable expectation of security."

Consequently, counsel for Mr. Cowans has requested that I order a special award in the amount of 50 per cent of all withheld benefits.

Motors, while denying that a special award is appropriate, suggests that an award, if made, must recognize the fact that it took its responsibilities seriously. If there were faults in the assessment process, it should be considered that Motors retained qualified professionals in whom it was entitled to trust.

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[25] *Liberty Mutual Insurance Company and Persofsky et al.*, (FSCO P00-00041, January 31, 2003)
[26] *Murray and Wawanesa Mutual Insurance Company*, (OIC A-003224, August 23, 1996)
[27] *Fidler v. Sun Life Assurance Co. of Canada* [2006] S.C.J. No. 30

Mr. Cowans as well did not make the determination process easy, by retaining expert reports his counsel had in his possession for months before ultimately providing them to Motors. Furthermore, Motors, once it had all the information in hand, recognized that there was entitlement and reinstated benefits.

While I accept that there is logic in Motors' latter submission, the primary responsibility for making a fair determination devolved upon Motors itself. As noted earlier, I found that it did not live up to its obligations in this regard, with serious consequences for Mr. Cowans.

As for the delay in providing documentation, while regrettable, I am not convinced that even prompt delivery of every report would have changed matters. Mr. Cesario's testimony made it clear that Motors would not act on any reports once an application for arbitration had been submitted.

Motors should not be penalized for taking a second look at the evidence and reinstating benefits prior to the arbitration hearing. On the other hand, it also must not be forgotten that Motors withheld and continued to withhold benefits until the last minute without cause.

Motors already saves considerable statutory interest by settling without insisting on a full hearing. It also saves legal costs, both its own and those of Mr. Cowans, that it would have likely been required to pay for a full hearing on entitlement.

Some consideration must also be given to providing Motors with an incentive for re-considering its assessment and determination process. Too low a special award might well make it more acceptable for Motors to continue with its current, flawed process, and to just consider a small special award as the cost of doing business efficiently.

But for the settlement, in light of Mr. Cowans' vulnerability, Motors intransigence, and its failure to understand its obligations to make a fair and dispassionate determination, I would have made a special award towards the maximum 50% mark. Given the settlement, albeit late and, at least in the case of Mr. Cesario, grudgingly, I would reduce that amount by some 6%.

I would also recognize that some of the key reports in the hands of counsel for Mr. Cowans may not have been delivered on a timely basis. While I have held that the timing may not have made any difference, it still does not sit well to demand respect of the principle of timeliness from only one side. I would reduce the percentage award by a further 4% in recognition of this fact.

Notwithstanding the above comments, I still find the withholding of benefits to be egregious and meriting a 40% special award.

I leave the parties to calculate the exact amounts outstanding, and I remain seised of this issue in the event of a failure to come to terms on the quantum of the order.

EXPENSES:

If the parties cannot agree as to the issue of expenses, I may be spoken to on that issue provided that notice is given within 30 days of the issuance of this decision.

	October 15, 2010
John Wilson Arbitrator	Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A09-003237

BETWEEN:

EVERLISTON COWANS

Applicant

and

MOTORS INSURANCE CORPORATION

Insurer

ARBITRATION ORDER

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

1. Mr. Cowans is entitled to a special award in the amount of 40%.

2. I leave the parties to calculate the exact amounts outstanding, and I remain seised of this issue in the event of a failure to come to terms on the quantum of the order.

3. If the parties cannot agree as to the issue of expenses, I may be spoken to on that issue provided that notice is given within 30 days of the issuance of this decision.

October 15, 2010
Date

John Wilson
Arbitrator