Owusu v. TD Home & Auto Insurance Co., [2010] O.J. No. 5522

Ontario Judgments

Ontario Superior Court of Justice

Divisional Court

A.D.K. MacKenzie, A.M. Molloy and A.L. Harvison Young JJ.

Heard: November 29, 2010.

Judgment: December 1, 2010.

Court File No. 86/09

[2010] O.J. No. 5522 | 2010 ONSC 6627 | 92 C.C.L.I. (4th) 197 | 2010 CarswellOnt 9223

RE: Victoria Owusu and Patience Sarpong, Applicants, and TD Home & Auto Insurance Company and the Financial Services Commission of Ontario, Respondents

(19 paras.)

Case Summary

Pensions and benefits law — Public pension plans — Veterans' pensions and allowances — Disability and survivors' pension — Appeals and judicial review — Standard of review — Reasonableness — Application for judicial review of a delegate of the Director of Arbitration for the Financial Services Commission of Ontario's decision to dismiss the appeals from an arbitrator's decision denying the applicants statutory accident benefits dismissed with $7,500 in costs — There was no breach of natural justice or procedural fairness — The delegate's decision was reasonable in every respect — The arbitrator carefully addressed the parties' submissions and there was no reason for interfering with his decision — The burden was on the applicant to establish the elements required to show entitlement to benefits.

Application for judicial review of a delegate of the Director of Arbitration for the Financial Services Commission of Ontario's decision to dismiss the appeals from an arbitrator's decision denying the applicants statutory accident benefits. By statue, the appeal to the delegate was solely on a question of law. The applicants argued they were not given fair notice of the case they had to meet before the arbitrator. The arbitrator found the applicants were not credible and that they had not established they were entitled to the income replacement benefits they were seeking. The applicants argued the arbitrator incorrectly placed the burden of proof on them to prove they were disabled and unable to work because of that disability.

HELD: Application dismissed with $7,500 in costs.

There was no breach of natural justice or procedural fairness. The delegate's decision was reasonable in every respect. The delegate reviewed the arbitrator's decisions and considered the issues on appeal before him. He carefully addressed the parties' submissions and there was no reason for interfering with his decision. There was nothing in the record to indicate that the argument concerning the burden of proof was raised before the delegate or the arbitrator and it was not mentioned in either of the decisions. It was not referenced in the applicant's factum and was raised for the first time in oral argument. Accordingly, the issue was not properly before the court. Alternatively, the arbitrator applied the correct burden of proof. There was no authority supporting the submission that the persuasive burden of proof shifts to the insurer once an application had been filed and the insurer had failed to provide reasons for refusing it within 14 days. The burden was on the applicant to establish

the elements required to show entitlement to benefits. Even if the arbitrator's taking judicial notice of the distance from Jane and Dundas Streets to 3801 Dundas St. West could be said to be a legal error, it was a minor aspect of the decision and could not be said to have affected the result. The delegate correctly noted that it was open to the arbitrator to determine how much weight to place on the medical reports submitted by the applicants as they were based on self-reporting and the credibility of the applicants was an important factor.

Statutes, Regulations and Rules Cited:

Insurance Act, *R.S.O. 1990, c. I.8, s. 283*(1)

Statutory Accident Benefit Schedule -- Accidents on or after November 1, 1996, *O. Reg. 403/96, s. 35*(1), s. 42

Counsel

Murray Tkatch, for the Applicants.

Andrew Grayson, for the respondent TD Home & Auto Insurance Company.

Joe Nemet, for the respondent Financial Services Commission of Ontario.

ENDORSEMENT

The following judgment was delivered by

THE COURT

Introduction

1 This is an application for judicial review of the decision of a delegate of the Director of Arbitration for the Financial Services Commission of Ontario ("FSCO"). The Director's Delegate was sitting on appeal from the decision of Arbitrator Muir denying statutory accident benefits to the applicants. By statute, the appeal to the Director's Delegate from an arbitration decision is solely on a question of law.[1] What is before this Court is not an appeal from the decision of the original arbitrator Muir, but rather a judicial review of the decision made by the Director's Delegate. There is clear authority that the standard of review from such decisions is reasonableness,[2] including on questions of statutory interpretation of the Director's home statute, the *Insurance Act*,[3] and the *Statutory Accident Benefit Schedule* ("*S* ABS").[4] Some of the grounds for judicial review raised by the applicants were cast as issues of procedural fairness or natural justice. The Arbitrator was obliged to ensure that the rules of procedural fairness and natural justice were followed, and the Director's Delegate was likewise obliged to ensure that this had been done. Where there has been a breach of natural justice or procedural fairness at the hearings stage, the decision cannot stand.

2 We are of the view that there was no breach of natural justice or procedural fairness. Further, in our opinion, the decision of the Director's Delegate was reasonable in every respect. Indeed, even if a correctness standard were

applied, we would find no basis upon which to interfere with the Delegate's decsion. For the reasons that follow, the application is dismissed with costs to the respondent TD Home & Auto Insurance fixed in the amount of $7,500.00.

Procedural Fairness

3 The applicants argue, as they did before the Director's Delegate, that they were not given fair notice of the case they had to meet before Arbitrator Muir. The insurer had argued that the claims were fraudulent and that the applicants had conspired to submit false claims. While the arbitrator did not find that the insurer had established fraud, he did not find the applicants to be credible and found that they had not established that they were entitled to the income replacement benefits they were seeking. The Director's Delegate considered this argument and applied the correct test, determining on the record that the applicants did have notice of the case that they had to meet, including issues relating to their employment and their disability claims. We find no basis for interfering with his conclusions.

Burden of Proof

4 The applicants argue that the arbitrator incorrectly placed the burden of proof on the applicants to prove they were disabled and unable to work because of that disability. They submit, based on *Monks v. ING Insurance Co. of Canada*,[5] that this burden had shifted to the respondent once the applicants had filed the documentation required to establish their claims, as prescribed by SABS. This argument also fails.

5 We note that the burden of proof issue appears to have been framed differently before this court than it had been before the Director's Delegate. There, the argument had been that the insurer's failure to arrange an assessment pursuant to s. 42 of SABS effectively obligated the insurer to pay the benefits claimed. Before us, the applicants did not rely on s. 42, but instead argued that the insurer had failed to comply with section 35(1) of SABS, by failing to "promptly determine" whether the benefits were payable. They argued that, having failed to provide the insured with reasons for a refusal to pay, these provisions support the argument that the burden of proof has shifted to the respondent.

6 There is nothing in the record before us to indicate that this argument was raised before the Arbitrator or the Director's Delegate and it is not mentioned in either of the decisions. Further, it is not referenced in the Applicants' factum and was raised for the first time in oral argument. Accordingly, this issue was not properly before us on this judicial review application.

7 That said, we have considered whether the Arbitrator applied the correct burden of proof and are satisfied that he did. Counsel for the applicants was unable to provide the court with any authority to support his submission that the persuasive burden of proof shifts to the insurer once an application has been filed and the insurer has failed to provide reasons for refusing it within 14 days. The *Monks v. ING* decision does not deal with this issue, but rather is a case in which the insurer had terminated benefits after having paid them for some time. In that situation, the Court of Appeal imposed a burden upon the insurer to show a basis for terminating benefits. In the case before us, there was no termination of benefits. The insurer refused to pay the benefits from the outset, initially for lack of information, and ultimately alleging that the claims were fraudulent.

8 The Director's Delegate considered the applicants' argument that the burden of proof should have been on the insurer (although it had been presented on a somewhat different legal footing). The Director's Delegate applied the case of *Shakur v. Pilot Insurance Co.*[6] in support of his conclusion that the burden of proof rests on the insured to establish a right to recover under the terms of the policy and does not shift. In our view, he is correct. The burden is on the applicant to establish the elements required to show entitlement to benefits. There is no presumption of entitlement cretated in the legilsation, nor should one be implied. It was clear in this case that the insurer disputed the claim for income replacement benefits from the outset. It was incumbent upon the applicants to prove their claims in this regard.

Credibility

9 The decision of the Arbitrator turned largely on adverse findings of credibility against each of the applicants. The Director's Delegate carefully considered those findings and the arguments advanced by the applicants, and found no basis to interfere with the decision of the Arbitrator. We agree.

Judicial Notice of Distance

10 According to the Reasons of the Arbitrator, Ms. Owusu had testified that in order to get to work she took a bus from her school at the intersection of Keele Street and Wilson Avenue to Jane Street and Dundas Road (which involved one transfer) and that she then walked to 3801 Dundas Street West, which was just past Scarlett Road. She also testified that this trip took 45 minutes. The Arbitrator referred to this as a lengthy bus trip ending with a walk of more than one kilometer from Jane Street to Scarlett Road and stated that while it was not impossible to do this in 45 minutes, it "seems unlikely."

11 One of the issues raised before the Director's Delegate was that the Arbitrator improperly took judicial notice of the distance from Jane and Dundas to 3801 Dundas Street West. First of all, the applicants did not obtain a transcript of the proceedings before the Arbitrator and it is therefore not clear whether he heard evidence with respect to the distance or took judicial notice of it. However, the Director's Delegate appears to have accepted that the Arbitrator took judicial notice of this fact and we are prepared to accept it on that basis.

12 Mr. Tkatch submitted before us, and before the Delegate, that the Arbitrator's attention to this detail evidenced a determination to seek evidence in support of the conclusion he wished to reach. In our view, the Director's Designate addressed this point appropriately. There is nothing about this point that indicates any bias on the part of the Arbitrator, nor any reasonable apprehension of bias. The Delegate found no legal error in respect of the Arbitrator's reasoning on this issue, and we find the Delegate's decision to be reasonable on this point.

13 Further, even if taking judicial notice of this distance could be said to be a legal error, it was clearly only one minor aspect of the arbitrator's decision and could not be said to have affected the result in this case.

Medical Evidence

14 The applicants argue that the Arbitrator was bound to accept the uncontradicted medical evidence submitted by them because the insurer failed to obtain its own medical assessments to rebut their reports. The Director's Delegate reviewed the law on this issue and concluded that it was open to the Arbitrator to determine how much weight to place on a medical opinion placed in evidence. The Delegate correctly noted that the nature of the injuries alleged made credibility an important issue. He further ruled that the Arbitrator had given adequate reasons for placing little weight on the medical reports provided by the applicants and had acted within his jurisidction in doing so. We agree.

15 Mr. Tkatch argues that the decision of the British Columbia Court of Appeal in *Chouinard v. Insurance Corp. of British Columbia*[7] is dispositive of this issue. We disagree. In *Chouinard*, an insurer had denied benefits. The insured sued successfully and the trial judge concluded that "special costs" were warranted in light of the insurer's conduct in denying the claim. The Court of Appeal upheld the trial judge's decision based on the fact that the insurer had denied coverage "in the face of uncontradicted medical reports that described objective symptoms of injury."[8] This case is clearly distinguishable from the case before us. The medical reports submitted by the applicants in this case were entirely dependent upon the applicants' subjective descriptions of their own conditions. There was no evidence of an objective nature to support the symptoms as reported by the applicants. Therefore, the credibility of the applicants became an important factor in determining the weight to be placed on the medical reports. For the reasons stated by the Delegate, this was appropriately dealt with by the Arbitrator and there is no basis to interfere.

Other Issues

16 Although not pressed in oral argument, the applicants raised an issue in their factum about the failure of the insurer to pay for transcripts of the hearing before the Arbitrator, suggesting that this was a matter of procedural fairness and natural justice. This was also mentioned briefly in the course of oral argument by Mr. Tkatch. This was the subject of a motion before the Director's Delegate, which was dismissed. There is clearly no legal obligation on the successful party in an arbitration to pay for a transcript for the assistance of the unsuccessful party's appeal. Likewise, there is no breach of procedural fairness in requiring appellants to pay for their own transcripts if they are required for an appeal. There is no merit to this ground of judicial review.

17 A number of other issues referred to in the factum were not addressed in oral argument. To the extent they require references to evidence, the absence of a transcript makes it impossible to address those issues.

Conclusion

18 In conclusion, the Director's Delegate reviewed the Arbitrator's decisions and considered the issues on appeal before him. He carefully addressed the submissions of the parties, and we find no reason for interfering with his decision to dismiss the appeals.

19 This application is dismissed. Costs are fixed at $7,500.00 inclusive of tax and disbursements, payable by the applicants to the respondent insurer forthwith. FSCO seeks no costs.

A.D.K. MacKENZIE J.
A.M. MOLLOY J.
A.L. HARVISON YOUNG J.

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1 *Insurance Act*, R.S.O. 1990, c. I-8, s. 283(1).

2 *Wawanesa v. Uribe*, 2010 ONSC 5904 (Div. Ct.); *TTC Insurance Company Limited v. Watson*, [2008] O.J. No. 3820 (Div. Ct.); *Aviva Canada Inc. v. Murugappa* (2009), 251 O.A.C. 193 (Div. Ct.).

3 *Supra*, note 1.

4 In the present case, the *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996*, O. Reg. 403/96, as amended.

5 2008 ONCA 269.

6 74 O.R. (2d) 673 (C.A.).

7 2001 BCCA 333.

8 *Ibid.* at para. 9.