
# LAT - 2 Years Later:

## *Where We Were, Where We Are, and Where We Are Headed*

**Stephen Ross and Alon Barda**

**Rogers Partners LLP**

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## I. INTRODUCTION

The passage of Bill 15, *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, on November 20, 2014 marked a significant alteration of the dispute resolution system (DRS) for statutory accident benefit disputes in Ontario. One of the cornerstones of the legislation was the proposal to transform the DRS, so that Ontario drivers could settle their disputes faster by making the process more effective and efficient while remaining accessible for accidents victims.

The Bill was subject to much debate and controversy. Indeed there were noted concerns regarding:

- Removal of the court option;
- Moving the DRS from the Financial Services Commission of Ontario (FSCO) exclusively to the Licence Appeal Tribunal (LAT);
- The limited circumstances where **costs** may be awarded;
- The proposed short **timelines** to adjudicate disputes at the LAT;
- The **expertise** of the adjudicators; and
- The **appeal process**, among others.

Despite these concerns, the amendments to the *Insurance Act*[1] came into effect on April 1, 2016. We are now almost two years later and it appears the LAT is here to stay.

This paper will consider whether the LAT has addressed the various concerns the legislation was designed to fix in the first place. The paper will also provide a review of some of the notable decisions to date and identify the trends in terms of timelines and outcomes. Overall, it will be seen that the transfer of statutory accident benefit disputes from FSCO to the LAT has resulted in a DRS that is largely efficient and well-balanced.

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[1] R.S.O. 1990, c. I.8.

Nevertheless, issues remain, particularly in the area of costs. It is the opinion of the writers that the successful party at the LAT should be entitled to a reasonable measure of cost indemnity. This will likely require an amendment to the *Insurance Act,* which should be enacted in an effort to remedy a clear access to justice issue for applicants under the current system. The resulting efficiencies are laudable but if the price for quicker more measured justice is to deny access to those for whom the system was redesigned, then the price is simply too steep.

We move now to a look at where the process began and provide an overview of notable developments at the LAT – 2 years later.

## II. FROM FSCO TO THE LAT: THE BACKGROUND BEHIND THE CHANGE

FSCO was established on June 30, 1998 with the enactment of the *Financial Services Commission of Ontario Act*, 1997. The mandate of FSCO's Dispute Resolution Services Branch was to ensure a fair, accessible and timely process for determining an applicant's entitlement to statutory accident benefits (SABs).[2]

However, issues with efficiency and timelines at FSCO arose in 2007 with the dramatic increase in Applications for Mediation. In 2006-2007 FSCO received 13,053 new applications and in 2011-12 it received 35,727.[3] The impact of this 174% increase in applications was detailed in the Annual Report by the Office of the Auditor General of Ontario in 2011.

The report found that the increasing demand and strains on resources at that time had resulted in significant backlogs in FSCO's mediation services for disputes between applicant's and insurers. In particular, the report highlighted that mediations in 2010/2011

[2] Ontario Automobile Insurance Dispute Resolution System Review Interim Report, October 2013, page 7 (Interim Cunningham Report).
[3] Interim Cunningham Report, p.8.

were mostly being completed in 10-12 months rather than the required 60 days after the filing of an application.[4] As a result, by the end of 2011 there was a backlog of approximately 30,700 files and FSCO was receiving an average of approximately 3,000 applications for mediations every month.[5]

While the backlog was subsequently alleviated to a certain degree through a combination of productivity improvements and additional resources,[6] the Liberal Government looked to conduct a review of the DRS for SABs claims. The Honourable J. Douglas Cunningham was appointed to complete the review, which had the goal of making the DRS more efficient and effective.[7]

In his interim report in October 2013 Justice Cunningham stated that the high number of disputes suggested systemic problems that needed to be addressed with timeliness being a central concern.[8] In this regard, Justice Cunningham outlined that the DRS was created to provide quick access to dispute resolution without the need to go to court and the system worked when the volumes were more manageable.[9] However, as result of its early success, the demands at FSCO had increased and FSCO struggled to keep up with the resulting demand.

According to Justice Cunningham, the result was that FSCO was taking too long to resolve disputes, including all facets of the process from appointing a mediator to releasing decisions. As such, he found that FSCO came to mirror the court system and had become saddled by the very issues it was initially created to remedy.[10]

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[4] 2011 Annual Report – Office of the Auditor General of Ontario, pages 47 and 60. Also see Section 10 of Ontario Regulation 664 (R.R.O. 1990) in effect at that time, which outlined that a mediator was required to attempt to effect a settlement of a dispute within sixty days after the date the application was filed.
[5] Interim Cunningham Report, p.8.
[6] Namely, through the allocation of claims to the private dispute resolution service provider ADR chambers.
[7] 2014 Ontario Automobile Dispute Resolution System Review (Cunningham Report).
[8] Cunningham Report, page 1.
[9] Ibid at p.23.
[10] Ibid at p.27.

Justice Cunningham's final report was released in February 2014 and included 28 recommendations. One of the recommendations was to implement statutory timelines (as opposed to the *Dispute Resolution Practice Code* timelines that he felt were not being applied in all cases) regarding the various steps in the DRS.[11] Furthermore, he stated that if either party is not ready to proceed within the statutory timeframes, they should not be eligible to claim their costs at the conclusion of the arbitration.

In terms of the court option, he noted a concern that lawyers may find shorter timelines and cost sanctions less appealing and would take a case to court, where he noted the same expertise in interpreting the *Statutory Accident Benefits Schedule* (*SABS)* as compared to FSCO arbitrators may not be present. As such, Justice Cunningham recommended the removal of the court option to resolve SABs disputes.[12]

His final recommendations surrounded the hearing of disputes and how they would be divided into different streams, including factors such as the complexity of the case and the quantum of the benefits in dispute.[13] He also recommended that appeals be heard by a single judge of the Ontario Superior Court of Justice on a question of law.

Many of Justice Cunningham's recommendations were ultimately adopted as part of Bill 15 and form an essential part of the current DRS. Most notably, the court option was removed and all statutory accident benefit disputes must now be heard at the LAT.

## III. THE LAT – COMPOSITION, RECONSIDERATION, APPEAL AND JUDICIAL REVIEW

### A. Composition

[11] Cunningham Report, p.10.
[12] Ibid at p.13.
[13] Ibid at p.27.

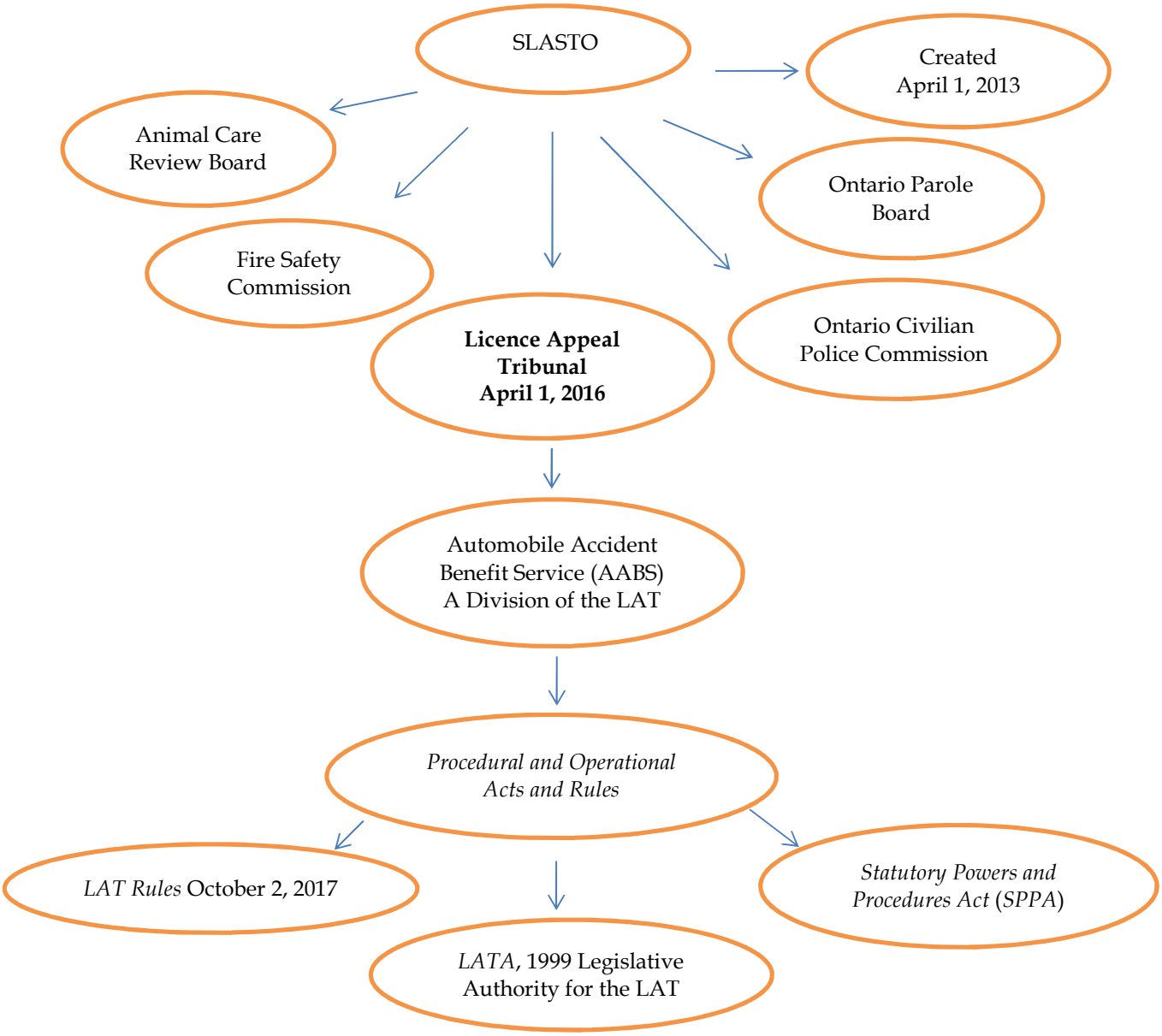
The Safety, Licencing Appeals and Standards Tribunals Ontario (SLASTO) is a cluster of adjudicative tribunals that was created on April 1, 2013. SLASTO is designated as a cluster pursuant to s. 15 of the *Adjudicative Tribunals Accountability, Governance and Appointments Act*, 2009[14] and section 4 of Ontario Regulation 126/10. SLASTO is comprised of five tribunals, including the LAT, which resolve and decide matters arising from over 30 statutes relating to public protection and safety. The Executive Chair of SLASTO is Linda P. Lamoureux.

Effective April 1, 2016, the LAT began accepting applications to the Automobile Accident Benefits Service (AABS), which is a division of the LAT and aims to quickly resolve disagreements about accident benefits between individuals and insurance companies.

The legislative authority for the LAT is found in the *Licence Appeal Tribunal Act, 1999* (*LATA*).[15] The Tribunal is also subject to the *Statutory Powers and Procedures Act* (*SPPA*)[16] and the *SLASTO Common Rules of Practice & Procedure,* effective October 2, 2017 (LAT Rules),[17] which are made pursuant to s.25.1 of the *SPPA* and s.6 of the *LATA*. Rule 12 of the LAT Rules provides that the Tribunal may hold a hearing in any format it considers appropriate, including a written hearing. In addition, FSCO decisions are not binding on the LAT.[18]

The chart on the next page outlines the applicable framework:

[14] S.O. 2009, c. 33, Sched. 5.
[15] S.O. 1999, c. 12, Sch. G.
[16] R.S.O. 1990, c. S.22.
[17] From April 1, 2016 to October 1, 2017 these rules were known as the Licence Appeal Tribunal Rules of Practice and Procedure, Version 1 (April 1, 2016).
[18] See, for example, *16-001976 v. Co-operators General Insurance Company*, 2017 CanLII 39602.




Through this legislative framework, the LAT operates as an administrative tribunal with an operational system of procedural rules, including an internal appeal process.

### B. Reconsideration

At the LAT, the internal appeal process is known as reconsideration. Section 18.1 of the LAT Rules outlines that the Executive Chair of SLASTO may on his or her own initiative, or upon the request of a party within 21 days of the decision, reconsider any decision of the Tribunal. Pursuant to section 18.2, the Executive Chair or his or her delegate shall not make an order under section 18.4 (b) of the LAT Rules unless he or she is satisfied that one or more of the following criteria are met:

(a) The Tribunal acted **outside its jurisdiction** or violated the Rules of natural justice or procedural fairness;
(b) The Tribunal made **a significant error of law or fact** such that the Tribunal would likely have reached a different decision had the error not been made;
(c) The Tribunal heard **false or misleading evidence** from a party or witness, which was **discovered** only **after** the hearing and likely affected the result; or
(d) There is **new evidence** that could not have reasonably been obtained earlier and would have affected the result.

Pursuant to section 18.4(b) or the LAT Rules, upon reconsidering a decision of the Tribunal, the Executive Chair may dismiss the request; or, after providing all parties an opportunity to make submissions, may confirm, vary, or cancel the decision or order; or, may order a rehearing on all or part of the matter. In short, the Executive Chair has broad powers to intervene and remedy any significant error made by the LAT.

### C. Judicial Review and Appeal

Pursuant to section 11(6) of the *LATA*, a party may **appeal** from a decision of the Tribunal relating to a matter under the *Insurance Act* on a **question of law only**. This appeal must be made to the Divisional Court.[19] A party may also bring an application for judicial review.[20]

[19] Pursuant to 11(1) of *LATA*.
[20] Pursuant to the *Judicial Review Procedures Act*, R.S.O. 1990, c. J.1.

### *i. Judicial Review and Prematurity*

The only reported judicial review application to date was a motion for an immediate stay of a LAT proceeding pending judicial review of two decisions. In *Aviva Canada Inc. v. Taylor*[21] the insurer requested a stay of the LAT proceeding pending judicial review of two decisions in which the insurer's requests to adjourn a hearing on the determination of a legal issue were denied.

The Court held that a motion for a stay of the Tribunal proceedings pending the outcome of the judicial review is premature as it "offends the general rule against judicial non-interference with ongoing administrative processes."[22] In this regard, the Court noted that the legislature signalled an intention to have disputes of this nature dealt with at the Tribunal, where "the rules and procedures are intended to provide a dispute resolution mechanism that is efficient, fair and proportional." Furthermore, the Court highlighted that it is "important to afford the Tribunal an opportunity to do what the legislature directed it to do."[23]

On the issue of prematurity, the Court went on to state that "absent exceptional circumstances, parties to an administrative proceeding cannot engage the court system until the administrative process has run its course." The Court also stated that "typically, concerns about procedural fairness and natural justice do not qualify as the exceptional circumstances necessary to warrant judicial intervention."[24] In addition, the Court noted that the insurer had not availed itself of alternate procedures and this "was an appropriate circumstance in which to ask the Executive Chair to weigh in on the denial of two requests for adjournment."[25]

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[21] 2017 ONSC 2661.
[22] Ibid at para 22. See also *Volochay v. College of Massage Therapists of Ontario,* 2012 ONCA 541.
[23] Ibid.
[24] Ibid at para 23.
[25] Ibid at para 26.

The motion for a stay was ultimately dismissed on the basis that it was premature and failed to meet the appropriate criteria. Considering the analysis in this case and the caselaw in general on the issue of **prematurity**, it would seem that a party should look to exhaust all internal procedural remedies, including seeking a reconsideration, before the Executive Chair, prior to seeking the intervention of the Court through judicial review.

We note that, the standard of review on an application for judicial review of a decision of the Director's Delegate at FSCO was reasonableness. We believe the same standard of review will apply to judicial review of LAT decisions considering the jurisprudence in this area post-*Dunsmuir*.[26]

### *ii. Appeal on a Question of Law*

As noted above, pursuant to section 11(6) of the *LATA*, an applicant may also appeal a decision of the Tribunal to the Divisional Court on a question of law only. The wording specifies that the appeal may be made from the Tribunal. The *LATA* defines "Tribunal" as the Licence and Appeal Tribunal and, while the Executive Chair is a member,[27] the wording in the *Act* appears to indicate that the right of appeal is directly from the LAT and not necessarily the reconsideration decision.

As such, it appears on a question of law, an applicant may seek reconsideration or potentially an appeal directly from the Tribunal to the Divisional Court.

There has been only one appeal to date. In *Melo v. Northbridge Personal Insurance Corporation*[28] the applicant appealed to a three-judge panel of the Divisional Court directly from the LAT, which had found the applicant was not entitled to income replacement benefits (IRBs).

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[26] [2008] 1 S.C.R. 190. In particular, see: *Pastore v. Aviva Canada Inc*., 2012 ONCA 642 at paras 17-26 and very recently *Security National Insurance Co. v. Allen*, 2017 ONSC 6779 at para 36.
[27] See section 16 of the *Adjudicative Tribunals Accountability, Governance and Appointments Act*, 2009.
[28] 2017 ONSC 5885.

In the decision, the Court confirmed that an appeal from the Tribunal may be made on a question of law only and the standard of review is one of reasonableness. The three judge panel held that the applicant had ultimately failed to establish an error of law and that the Tribunal's decision was reasonable as it was "within the range of possible outcomes."[29]

The court did not address the fact that there was no reconsideration prior to the appeal. As noted above, the *LATA* appears on the plain wording to permit an appeal on a question of law from the Tribunal directly to the Divisional Court.

However, we note that in *Sazant v R.M. and C.I.C.B.*,[30] the Divisional Court stated that the same principles apply to a judicial review and the appeal on a question of law, which is that the "court is always reluctant to intervene in proceedings that are still ongoing before an administrative tribunal" and will decline to hear the appeal or judicial review on the basis of prematurity.[31] Furthermore, citing an earlier decision, the Court noted that it is inconsistent to "permit participants before an administrative tribunal to come running to Divisional Court on judicial review **prior to having exhausted all of their remedies and appeal routes** within the administrative regime (**emphasis added)**."[32]

As such, although each situation will need to be addressed on its own merits it appears, generally speaking, the preferred approach would be to pursue reconsideration first so as to remove the risk that the appellate court will take the position the appeal is premature. Further, the court may prefer, and it may be better for the development of the law to permit, the Executive Chair to weigh in on the legal issue particularly when the issue involves an interpretation of the Tribunal's home statute (*SABS*).

The following chart represents the appeal process:

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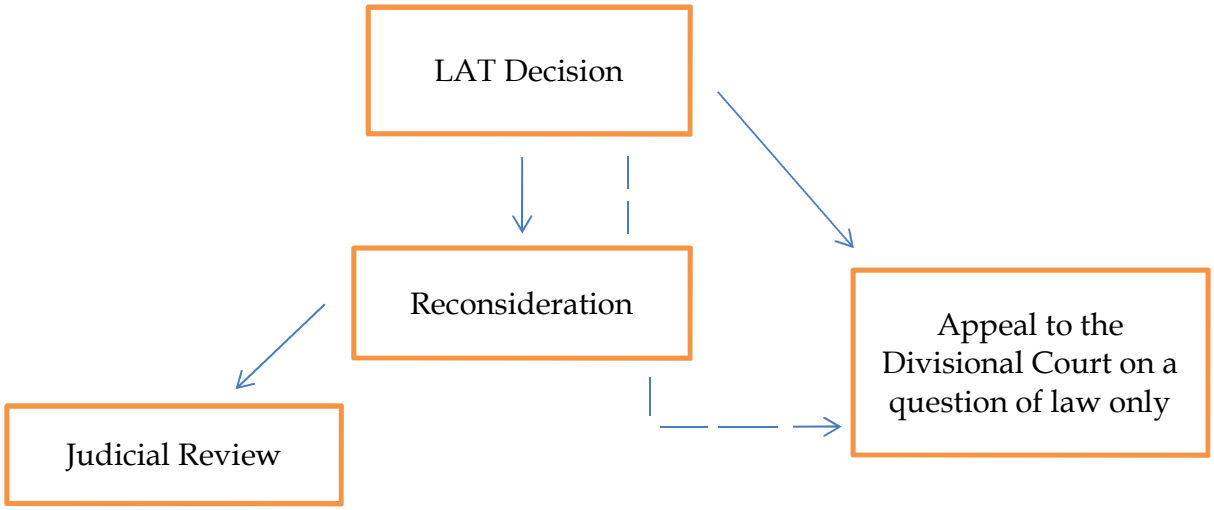
[29] Ibid at para 18.
[30] 2010 ONSC 4273 (Div. Ct.).
[31] Ibid at para 38.
[32] Ibid at para 41, citing *Ackerman v. Ontario (Provincial Police)* [2010] O.J. No. 738 (Div.Ct.) at para 18.




## IV. JURISDICTION – COSTS, SPECIAL AWARD AND EQUITABLE REMEDIES

### A. Costs and Disbursements – An Access to Justice Issue

#### *i. The Legislative Authority to Award Expenses at FSCO*

One of the most significant differences from FSCO to the LAT is the costs that may be awarded. This represents a significant change and, in the opinion of the writers, raises concerns regarding access to justice.

Prior to the amendments to the *Insurance Act* on April 1, 2016, section 282(11) outlined the circumstances where expenses may be awarded by an arbitrator at FSCO, including "all or part of such expenses incurred in respect of an arbitration proceeding as may be prescribed in the regulations, to the maximum set out in the regulations."

Ontario Regulation 664 made under the *Insurance Act*[33] previously set out the expenses that may be recovered pursuant to the now repealed wording of section 282(11) of the *Insurance*

[33] R.R.O. 1990, Reg. 664: Automobile Insurance.

*Act*. This included a range of expenses, such as filing fees, legal fees and disbursements, which were specifically set out in a Schedule attached to the Regulation.

In addition, section 12(2) of the Regulation outlined criteria to consider when deciding whether to award all or part of the expenses at a hearing. This included multiple factors, such as the party's degree of success in the outcome of the proceeding, any written offers to settle and the conduct of the parties. The criteria were also outlined in sections 75-78 of the *Dispute Resolution Practice Code* with the Schedule in Ontario Regulation 664 reproduced in section F – Expense Regulation.

On April 1, 2016 section 282 of the *Insurance Act* was repealed. Section 282 (1) now outlines that the "the Lieutenant Governor in Council may, in accordance with the regulations, assess all insurers that have issued motor vehicle liability policies in Ontario for expenses and expenditures of the Licence Appeal Tribunal relating to disputes described in subsection 280." Section 282(4.1) indicates that the assessment is a debt to the Crown. While there has been little written on this section, it was identified in the debates surrounding Bill 15 as a form of fine to insurers[34] and also assessments against insurance companies that will allow for the funding of the new DRS so as to avoid additional costs to taxpayers.[35]

Amended section 280 now references costs specifically. In particular, section 280(5) states that the regulations may provide for and govern the orders and interim orders that the Licence Appeal Tribunal may make and may provide for and section 280(6) states that, "without limiting what else **the regulations may provide for** and govern, they may provide for and govern orders, including interim orders, to pay **costs**, including orders requiring a person representing a party to pay **costs** personally" (**emphasis added)**.

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[34] See, second reading October 27, 2014, retrieved from: http://www.ontla.on.ca/web/house-proceedings/house_detail.do?locale=en&Date=2014-10-27&detailPage=%2Fhouse-proceedings%2Ftranscripts%2Ffiles_html%2F27-OCT-2014_L019.htm&Parl=41&Sess=1#para772.

[35] See, Standing Committee on General Government, November 5, 2014, retrieved from: http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&Date=2014-11-05&ParlCommID=8998&BillID=3007&Business=&DocumentID=28303#P932_235862.

The amendments to Ontario Regulation 664 also came into effect on April 1, 2016.[36] As part of the amendment, section 12, which set out what the FSCO arbitrator may consider in awarding expenses, was revoked. In addition, the Schedule setting out the expenses payable was also revoked. There is, therefore, no longer any section in the *Insurance Act* or Regulation 664 that specifically identifies the circumstances and type of costs that may be awarded as the expansive list of expenses that were previously articulated, as well as the basis for ordering such expenses, has all been repealed.

### *ii. The Legislative Authority to Award Costs at the LAT*

There is, however, other applicable legislation on the issue of costs at the LAT. In the writers' view, in its present form it is a poor substitute. Subsection 17.1(1) of the *SPPA* states that, subject to subsection (2), "a tribunal may, in the circumstances set out in rules made under subsection (4), order a party to pay all or part of another party's costs in a proceeding."

Subsection 17.1(4) of the *SPPA* outlines that a Tribunal may make rules with respect to "(a) the ordering of costs; (b) the circumstances in which costs may be ordered and (c); the amount of costs or the manner in which the amount of costs is to be determined." Subsection 17.1(3) states that the amount of the costs ordered shall be determined in accordance with the rules made under subsection 17.1(4).

However, a key restriction on when costs may be ordered is also contained in the *SPPA*. Subsection 17.1(2) of the *SPPA* states that the Tribunal shall **not** make an **order** to pay **costs** under this section **unless** the following apply: "a) the conduct or course of **conduct** of a party has been **unreasonable, frivolous or vexatious** or a party has acted in **bad faith**; **and** b) the tribunal has made rules under subsection (4)."

[36] See O.Reg 43/16: Automobile Insurance filed March 4, 2016 amending reg. 664 of R.R.O. 1990.

As such, while the Tribunal may make rules ordering a party to pay all or part of another party's costs in a proceeding, the awarding of costs is limited to circumstances wherein the conduct of a party has been unreasonable, frivolous or vexatious, or a party has acted in bad faith.

In accordance with ss.17.1(4) of the *SPPA*, the rules regarding costs are set out in section 19.1 of the LAT Rules. The rules mirror those in the *SPPA* and outline that, "where a party believes that another party in a proceeding[37] has acted unreasonably, frivolously, vexatiously, or in bad faith, that party may make a request to the Tribunal for costs."

Section 19.5 and 19.6 were added to the LAT Rules when they were updated on October 2, 2017 (the previous rules were known as the Licence Appeal Tribunal Rules of Practice and Procedure). Section 19.5 sets out the factors that will be considered by the Tribunal in awarding costs, such as the seriousness of the misconduct, prejudice to other parties and the potential impact an order for costs would have on individuals accessing the Tribunal system.

Most notably, while the *SPPA* allows an order for a party to pay "all or part of another party's costs in a proceeding", s.19.6 of the LAT Rules outlines that the amount of costs shall not exceed $1000 for each full day of attendance at a motion, case conference or hearing. In this regard, while the LAT had the jurisdiction to allow for the payment of the other party's costs under quite limited circumstances, the LAT exercised its jurisdiction pursuant to ss.17.1(4) to limit even the amount of costs recoverable.

Interestingly, subsection 17.1(6) of the *SPPA* states that, despite section 32,[38] "nothing in this section shall prevent a tribunal from ordering a party to pay all or part of another

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[37] Section 2.17 of the LAT Rules defines the proceeding, as "the entire Tribunal process from the start of an appeal to the time a matter is finally resolved".

[38] Stating as follows: "Unless it is expressly provided in any other *Act* that its provisions and regulations, rules or by-laws made under it apply despite anything in this *Act*, the provisions of this *Act* prevail over the

party's costs in a proceeding in circumstances other than those set out in, and without complying with, subsections (1) to (3) if the tribunal makes the order in accordance with the provisions of an *Act* that are in force on February 14, 2000."[39] It is the writers' view that this section likely explains how FSCO was able to award wide ranging expenses and to consider various factors in doing so, as previously outlined in the since repealed s.282(11) of the *Insurance Act* and Ontario Reg. 664, despite what is outlined section 17.1(2) of the *SPPA* (which also applied to FSCO proceedings).[40]

However, we do not believe that the LAT has the same legislative authority to make a similar cost award since the ability to do so was specifically repealed and is no longer present in the *Insurance Act* or Ontario Regulation 664. In doing so, the Legislature made a clear pronouncement that costs should not be awarded in the same manner as FSCO. As a result, the *SPPA* appears as the only legislative authority for awarding costs. The *SPPA* provides only narrow circumstances in which costs can be awarded and those circumstances are made even more narrow by the LAT Rules, which mirror the *SPPA* but add an additional monetary cap on the amount of costs that can be awarded.

It is the writers' view that an amendment is required and should be made so as to restore the ability for the tribunal to award costs in the manner in which they were awarded previously. As can be seen in the following section, the LAT is clearly aware of the limitation on its ability to award costs.

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provisions of such other *Act* and over regulations, rules or by-laws made under such other *Act* which conflict therewith."

[39] The costs provisions in s. 17.1 of the *SPPA* were proclaimed in force on February 14, 2000 so section 17.1(6) acts as a grandfathering provision – see *Barrington v. The Institute of Chartered Accountants of Ontario*, 2010 ONSC 338, at para 246.

[40] FSCO was seemingly classified as a "Tribunal" since it is defined in section 1(1) of the *SPPA* as "one or more persons, whether or not incorporated and however described, upon which a statutory power of decision is conferred by or under a statute."

### *iii. Tribunal Decisions and the Rare Issuance of Costs*

Decisions of the Tribunal have held that there is no jurisdiction to award costs for anything beyond the specific criteria outlined in section 19.1 of the LAT Rules and 17.1 of the *SPPA*. Furthermore, in the rare circumstance that costs are awarded, it is an exceedingly low amount and unlikely to serve any practical purpose in the opinion of the writers.

In *16-000075 v Wawanesa Mutual Insurance Company*[41] the Tribunal specifically reviewed the legislative authority to award costs. The Tribunal highlighted that subsection 17.1(1) of the *SPPA* empowers the Tribunal to order a party to pay costs according to the rules made under ss.17.1(4). The Tribunal noted that this is subject to the limitation set out in section 17.1(2), which identifies that costs cannot be ordered unless the conduct or course of conduct of that party has been unreasonable, frivolous or vexatious, or the party has acted in bad faith.

Most notably, the Tribunal outlined that, prior to April 1, 2016, an arbitrator at FSCO had wide criteria to consider in ordering costs pursuant to s.282 (11) of the *Insurance Act*. However, since section 282(11)[42] was repealed on April 1, 2016, the Tribunal stated that it is of the opinion that the repeal is "a clear statement of the legislature's intent to limit the circumstances where the Tribunal can award costs in a proceeding".[43]

There have been a select few cases where costs were awarded. For example, in *16-001649 v Aviva General Insurance Company,*[44] the applicant was absent at the start of a hearing and her counsel requested an adjournment despite no notice being provided to counsel or the Tribunal. The adjournment request was granted due to extenuating circumstances but the matter proceeded on the issue of costs. In this regard, the Tribunal noted that a cost award

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[41] 2017 CanLII 35323 (ON LAT).
[42] Incorrectly noted as s.281(12) in one part of the decision.
[43] Supra note 41, at para 17.
[44] 2017 CanLII 69276 (ON LAT).

would not be made lightly and awarded $700, which was identified as an "amount sufficient to discourage similar unacceptable actions in the future."[45]

Costs have been requested and rejected in other decisions for reasons highlighted below:

- Cost awards are meant to "maintain civility and order during proceedings, to deter conduct that threatens the orderly and civil resolution of an application, and to ensure that the Tribunal's process and the other participants are respected."[46]
- "The purpose of costs is not to compensate parties for the cost of bringing or defending claims or to punish."[47]
- "A withdrawal of an application alone will rarely, if ever, be a sufficient basis on which the Tribunal will make a costs order. Access to justice is central to the mandate of the Licence Appeal Tribunal. As such, a costs award will not be granted merely because a withdrawal has caused another party inconvenience."[48]
- "Access to justice is central to the mandate of the Licence Appeal Tribunal. The Ontario Legislature has provided a right of appeal to the Tribunal for applicants who wish to dispute their automobile accident benefits. It will be the rare instance that the Tribunal will order costs against an applicant who chooses to exercise their statutory right of appeal."[49]
- Under Rule 19.1 of the LAT Rules, an award of costs is an "exceptional remedy."[50]
- "Cost awards under Rule 19 are to maintain civility and order during proceedings, to deter conduct that threatens the orderly and civil resolution of an application, and to ensure that the Tribunal's process and the other participants are respected. **They are not to compensate parties for the cost of bringing or defending claims**."[51]
- Costs will not be awarded for a failure to properly adjust a claim in a fair and reasonable manner as costs awarded under Rule 19.1 apply to conduct occurring within the Tribunal's proceeding.[52]
- Even though an insurer may be prejudiced by unreasonable conduct, costs may not be awarded if unreasonable conduct was caused solely by the applicant's legal representative.[53]
- The party failed to "specifically identify any conduct from the applicant in the

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[45] Ibid at para 33.
[46] *16-000284 v RBC Insurance Company*, 2017 CanLII 9816 (ON LAT) at para. 26.
[47] Ibid.
[48] *16-002709 v State Farm Insurance Company,* 2016 CanLII 96160 (ON LAT), at para 17.
[49] *16-001326 v Unifund Assurance Company*, 2017 CanLII 69238 (ON LAT), at para 34.
[50] *16-001142 v RBC General Insurance Company*, 2017 CanLII 35321 (ON LAT), at para 18.
[51] *16-000075 v Wawanesa Mutual Insurance Company*, 2017 CanLII 35323 (ON LAT), at para 35.
[52] *16-002818 v Unifund Assurance Company*, 2017 CanLII 39709 (ON LAT), at para 29.
[53] *16-000546 v Primmum Insurance Company*, 2017 CanLII 46355 (ON LAT), at para 27.

Tribunals proceeding that is unreasonable, frivolous, vexatious, or in bad faith".[54]

Rather ironically, access to justice is cited as a reason costs will rarely be issued against an applicant. While this may indeed improve access to justice in that sense, it is the opinion of the writers that the inability of an applicant to be awarded costs and disbursements for being successful at a hearing serves as a far greater access to justice issue and acts a strong deterrent to bringing an application to the LAT.

Moreover, the spectre of an adverse cost award would also presumably serve to discourage meritless claims and proceedings.

Justice Cunningham's recommendations did not include removing the ability of the DRS to award costs broadly. In particular, accessibility was addressed in recommendation number 8 wherein he noted that a party should not be able to claim costs if they refused a settlement offer that is more favourable than the amount ordered by the arbitrator.[55]

The removal of costs awards similar to that under the old system at FSCO were identified as a significant disadvantage during the debates regarding Bill 15.[56] This continues to remain an issue, particularly since costs for only unreasonable, frivolous or vexatious conduct is very limited in scope and awarded in amounts that the writers believe have very limited impact.

As such, it is the writers' view that, if a party (whether applicant or insurer) is successful at the LAT, reasonable costs (including disbursements) should be awarded. In short, costs should follow the event. This will allow for applicants to properly fund the dispute and concerns about adverse cost awards can be addressed by various considerations, including offers to settle. As it presently stands, there is a disparity in economic resources to fund

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[54] *16-001627 v Aviva Insurance*, 2017 CanLII 56668 (ON LAT), at para 24.
[55] Supra note 7 at p.10.
[56] Supra note 34 wherein the removal of costs and the court option were jointly referred to as "significant disadvantages" by Joe Cimino, NDP MPP.

litigation. If the dispute is on the issue of a catastrophic designation or post-104 IRB's, the amounts at issue can be very significant. An insurer presumably has the resources to retain appropriate experts and hire counsel to engage in the litigation process. If there is no ability to achieve cost indemnity for amounts spent on experts or legal counsel, few applicants will have the resources to fund the litigation and certainly not in a manner congruent with the insurer's anticipated approach. This presents as the potential for a vastly unequal playing field and represents a significant barrier to justice for the very group whose interests the LAT was designed to protect.

In this regard, it is the writers' opinion that appropriate amendments should be made to allow for costs and disbursements to be payable in the same circumstances as existed at FSCO.

### B. No Costs, but the Special Award Remains

While the recovery of costs and expenses was notably repealed in Ontario Regulation 664, the Regulation now includes a provision that permits the Tribunal to order an insurer to pay a **special award**, which was formerly found in section 282(10) *Insurance Act*.

Section 10 of the Ontario Regulation 664 now states as follows:

> If the Licence Appeal Tribunal finds that **an insurer has unreasonably withheld or delayed payments**, the Licence Appeal Tribunal, in addition to awarding the benefits and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, may 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 (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 only difference between this section and the prior one in the *Insurance Act* is that the LAT *may* award the lump sum payment whereas FSCO was required to do so once it was found that the insurer had unreasonably withheld or delayed payments.

The special award has been addressed in various cases at the Tribunal and awarded on two occasions.[57] For example, in *16-002779 v Belair Direct Insurance*[58] the insurer initially denied the benefits sought and the CAT designation. However, at 5:00p.m. the day before the hearing, the insurer accepted the CAT designation and agreed to pay for certain benefits.

The Tribunal found that the withholding of benefits had an emotional and financial impact on the applicant as she testified that she had accrued debt of over $20,000. In calculating the amount of the special award, the Tribunal found that the insurer's payment of benefits as part of the settlement prior to the hearing was a mitigating factor. The Tribunal then calculated the amount of IRBs owed to the applicant and added interest at 1% compounded monthly to this amount. The Tribunal then awarded 30% of this amount to the claimant without any additional interest allocation.

In *16-002861 v Aviva Insurance Company*[59] the Tribunal found that the requested services and assessments were unreasonably withheld and that the 1-3 year delay (depending on the treatment plan) in payment for the treatment plans delayed the applicant's ability to effectively manage his chronic condition. Furthermore, he had to incur the cost of physiotherapy services, which he claimed impacted him financially.

The Tribunal noted that the Regulation states that, if the Tribunal finds that an insurer had unreasonably withheld or delayed payments, the Tribunal, "in addition to awarding the benefits and interest to which an insured person is entitled, may 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 with interest."[60] In calculating the award, the Tribunal awarded 50% of the disputed amount "including interest".

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[57] To November 6, 2017.
[58] 2017 CanLII 70688 (ON LAT).
[59] 2017 CanLII 62160 (ON LAT).
[60] Ibid at para 59.

The method of calculating the special award was outlined by the Divisional Court in *Personal Insurance Company v. Hoang*.[61] In that case, the Court noted that the first step is to determine the benefits owing to the insured person, including interest calculated under the *SABS*. There should then be a decision as to whether the insurer unreasonably withheld or delayed the payment of these benefits and, if so, to determine whether the insurer should be ordered to pay a lump sum amount in addition to the benefits and interest calculated under the first step.[62]

The next step is to determine the maximum award that can be awarded pursuant to the Regulation, which is done by taking the benefits owing and the interest owing and adding the additional interest component of 2% per month compounded monthly. The Divisional Court noted that, "to be clear, this calculation includes interest on the unpaid *SABS* interest" and the "maximum special award is 50% of this total."[63]

The formula to be used in calculating the special award appears to be as follows: 50% x (benefits that were unreasonably withheld or delayed + interest on these benefits calculated under the *SABS* + compound interest calculated according to Ont. Reg. 664).[64]

Once the amount above is calculated, the Tribunal should then consider all relevant factors (i.e. amount and time benefits were unreasonably withheld) to determine the appropriate lump sum special award (not a percentage) that "responds to the facts of the case and bears a reasonable relationship to other special awards, and does not exceed the maximum."[65]

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[61] 2014 ONSC 81 citing the proper approach established by Director Draper in *Persofsky v. Liberty Mutual Insurance Company.*, [2003] O.F.S.C.I.D. No. 11, at para 53.
[62] The test noted by the Divisional Court was that once it is determined that the insurer unreasonably withheld or delayed the payment the insurer shall be ordered to pay the lump sum. As noted above, the current wording of the Regulation places this discretion in the hands of the Tribunal.
[63] Supra note 61 at para 64.
[64] Ibid.
[65] Ibid.

Furthermore, the Divisional Court highlighted that the special award is to "punish an insurer for misconduct and to deter it and others from future similar actions."[66]

As detailed above, outstanding benefits, a special award, interest and modest costs in limited circumstances are likely the only remedies that a Tribunal can award as the Tribunal does not have the authority to award punitive (outside of a special award), aggravated or exemplary damages. As such, it does not appear that the LAT has jurisdiction to award equitable or discretionary remedies.

### C. Equitable Remedies Still Appear Unavailable

FSCO did not have the power to grant equitable relief, although there was a suggestion that equitable principles may be considered in the ordinary exercise of the commission's statutory jurisdiction.[67]

Similarly, the LAT is not a court with the power to grant equitable remedies. The LAT is an administrative body and as such its authority is therefore only presumptively granted by statute. The applicable statutes do not appear to provide the LAT with the power to grant discretionary remedies or equitable relief. As such, it appears that relief and remedies such as waiver and estoppel are presumably not available at the LAT.

The issue of equitable remedies at the Tribunal was recently dealt with in the reconsideration decision of *Y.D. v. Aviva Insurance Canada*.[68] In that case, the applicant argued that it was inequitable to permit the insurer to seek to change the status quo by terminating her attendant care benefits after paying them for many months. As such, the applicant argued that the Tribunal should apply the equitable doctrine of estoppel by convention [conduct] to require the insurer to continue to pay her attendant care benefits.

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[66] Ibid at para 72.
[67] See, for example, *Bersteyn v. Allstate Insurance Company of Canada,* FSCO A01-000858 (December 31, 2002).
[68] 2017 CanLII 84463.

The Tribunal held that it did not have jurisdiction to apply the laws of equity. The applicant requested reconsideration on the basis that the Tribunal erred in deciding that it did not have equitable jurisdiction.

The Executive Chair disagreed with the assertion that the Tribunal should have used equitable jurisdiction to require the insurer to continue paying attendant care benefits. In this regard, the Executive Chair highlighted that the Tribunal properly decided the case in accordance with the *Schedule* and allowing the applicant to rely on estoppel would not only override the *Schedule* but also undermine the very purpose of the provision at issue.

In any event, she noted that, even if she were to accept that "equity could in certain rare instances relieve against a statutory requirement in order to produce a just result",[69] she would not do so in that case. Interestingly, the Executive Chair avoided dismissing outright the potential availability of equitable principles at the LAT.

Nevertheless, it does not appear that there are any grounds to apply such principles given that the governing statutes do not appear to expressly confer such power to the Tribunal and it should therefore be beyond its scope to award such remedies in a proceeding.

## V. TIMELINESS AND NOTABLE DECISIONS – MATTERS ARE MOVING FORWARD AS PREDICTED AND WITH BALANCE

### A. The Cunningham Report Revisited

When the LAT was first launched, the Tribunal indicated that AABS would contact the insurer and request a response within 10 days. A mandatory case conference was to be scheduled approximately 45 days after the response was received, or the date for sending the response had passed. The goal was to have 60 days from the case conference to a hearing and **the expectation was that the total process would be completed within six**

[69] Ibid at para 16.

**months**.[70] As will be discussed further below, it appears the LAT is largely meeting these timeline goals.

The LAT has released data for 2016 and the first quarter of 2017 as part of SLASTO Data Inventory.[71] The data is as follows:

| DATE | APPLICATIONS | CLOSED BEFORE CASE CONFERENCE | CASE CONFERENCE | EARLY RESOLUTION[72] | HEARINGS | ACTIVE CASELOAD |
|---|---|---|---|---|---|---|
| April 1, 2016 to June 30, 2016 | 1073 | 126 | 74 total<br>37 continuations | 18 | | 929 |
| July 1, 2016 to Sept. 30, 2016 | 1918 | 515 | 577 total<br>119 continuations | 366 | 30 total<br>3 continuations<br>5 decisions | 1960 |
| Sept. 30 to Dec. 31, 2016 | 1704 | 704 | 953 total<br>180 continuations | 839 | 69 total<br>13 continuations<br>23 decisions | 2097 |
| Jan. 1, 2017 to March 31, 2017 | 1896 | 840 | 1398 total<br>214 continuations | 1011 | 64 total<br>9 continuations<br>62 decisions | 2080 |
| April 1, 2017 to June 30, 2017 | 2256 | 860 | 1287 total<br>227 continuations | 1148 | 87 total<br>14 continuations<br>48 decisions | 2272 |

According to the above data, the LAT received an average of 750 applications per month in the most recently available quarter, which amounts to 9,000 applications per year. Furthermore, the LAT has advised that there is an average of 82 days from the filing of the application to the case conference (initial goal was for it to be scheduled 45 days from the receipt of the response, which must be filed within 10 business days after the insurer being contacted – this amounts to approximately 60 days) and an average of 68 days from the case conference to the hearing (initial goal was 60 days).

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[70] See: SLASTO - Automobile Accident Benefits Service – Qs & As – January 2016.
[71] Retrieved from: http://www.slasto.gov.on.ca/en/Pages/Governance-Accountability-Documents.aspx.
[72] The LAT advises that "early resolution" is defined as the cases that resolved (withdrawals or settlements) after a case conference but before a hearing.

Based on the statistics provided to us by the LAT, it is taking an average of 150 days from receipt of the application to the hearing, which is in line with the initial goal of completing the entire process within 180 days.

The issue is that the LAT advises that it is taking an average of 88 days from the hearing to release decisions. This is adding an additional three months to the process and taking the LAT outside of its initially projected timelines. Presumably, once the LAT decision writing process becomes more streamlined and the tribunal can rely on its own body of caselaw, this timeline should shorten considerably. It seems conceivable that the decision writing process can be reduced to 30 days so that the LAT can attain its goal of averaging six months from application to resolution.

While the applications at the LAT have been increasing per quarter (and more than doubled from the first quarter to the most recent), the total pending or caseload has remained at around approximately 2000 cases, presumably due to the increasing amount of cases closed before the case conference and those resolving early. This may be explained by the rather condensed timelines and the practical effect that has of pressing counsel to review their file, particularly since hearings are being scheduled very shortly after case conferences and adjournments are granted sparingly.

As discussed above, FSCO received 35,727 applications for mediations in 2011-2012 and 25,329 in 2012-2013.[73] FSCO received 5,260 applications for arbitration in 2011-2012 and 10,511 in 2012-2013.[74] The LAT is receiving approximately 15% less applications and significantly less overall when applications for mediations are considered, which is a process that is no longer available at the LAT. In addition, these pre-LAT figures do not account for the court actions that were launched in the SABs context. This overall reduction in applications at the LAT is likely due to a variety of reasons, such as the removal of a formal mediation process, and the initial reluctance and unfamiliarity with the LAT. In

[73] Supra note 2, at p.11.
[74] Ibid, with the increase likely being attributable to the clearing of the mediation backlog at FSCO.

addition and perhaps most concerning, the significant overall reduction in access to the DRS likely flows from the inability to recover costs and disbursements as canvassed above.

Nevertheless, despite the initial concerns that the timelines were unsustainable, the figures at this stage indicate that the LAT is either reaching or close to reaching its goals regarding timelines and appears on track to accomplish the goal of 6 months from application to resolution provided there becomes a focus on more timely release of decisions. Therefore, the goal of improved expediency, a major impetus behind the transition to the LAT, appears to be largely meeting objectives.

## B. Review of Decisions – A More Balanced Approach

### *i. Decisions – A Statistical Overview*

The LAT has advised that there have been a total of 26 in-person hearings, 64 written hearings and 10 hearings by teleconference. In addition, we manually canvassed 284 decisions on wide ranging issues to November 2017. The following chart represents the select results of our review:

| Issue | Insurer Wins | Applicant wins | Split |
|---|---|---|---|
| Non-earner benefits | 23 | 4 | 0 |
| Income replacement benefits | 36 | 19 | 3 |
| Med/Rehab benefits | 53 | 21 | 13 |
| Attendant care benefits | 19 | 6 | 3 |
| MIG | 38 | 15 | 0 |
| CAT | 1 | 4 | 0 |
| Totals decisions (284) | 154 (54.2%) | 96 (33.8%) | 34 (11.9%) |

The above statistical analysis indicates that insurers are winning the majority of cases (54%), although applicants are winning approximately 80% of the serious CAT cases. As outlined below, a general review of the cases reveals a more balanced and fair approach being taken at the LAT rather than the (at least anecdotally) more claimant friendly FSCO. Furthermore, when mistakes appear to be made, errors are for the most part corrected in reconsideration decisions.

### *ii. Reconsideration Decisions – A Well-Reasoned Approach*

As stated previously, reconsideration is the internal appeal process pursuant to section 18.1 of the LAT Rules wherein a party may appeal to the Executive Chair of SLASTO under specific grounds, including that the Tribunal violated the rules of natural justice or procedural fairness; made a significant error of law; heard false or misleading evidence from a party or witness; or there is new evidence that could not have reasonably been obtained earlier and would have affected the result.

There have been 27 reconsideration cases brought[75] by insureds with decisions in favour of the applicant on only ten occasions.[76] Insurers have had more mixed results and have been successful on seventeen of the reconsiderations (approximately 60%). Applicants have not been as statistically successful on reconsideration, although that may be attributable to other issues, including the nature of the matters brought forward for reconsideration.[77]

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[75] To November 6, 2017.

[76] One decision was mixed but included as a claimant win considering the nature of success on the important issue in that decision.

[77] See, for example, *16-001181 v Wawanesa Mutual Insurance Company* 2017 CanLII 19206 (ON LAT) where the Executive Chair noted that she is not expected to "divine a party's best possible arguments" and *16-000929 v. TD Home and Auto Insurance Company* 2017 CanLII 69239 (ON LAT) where she found that the applicant's argument was essentially that she should reweigh the evidence, which the Executive Chair highlighted is not her task on a request for reconsideration. A similar finding was made against the insurer in *16-001031 v. Aviva Insurance Canada* 2017 CanLII 43880 where she found, at para 26, that "the Tribunal is the ultimate finder of fact and there was ample evidence on the record to support the Tribunal's finding."

Overall, the reconsideration decisions appear well-reasoned and, as outlined below, the lack of statistical success for applicants may be explained by the nature of the cases brought forward for reconsideration.

***Reconsideration Decisions - Insurer Success***

The **first decision on reconsideration** was heard by Executive Chair Lamoureux on December 2, 2016 on the issue of future payment of income replacement benefits.[78] In that case, the Tribunal awarded the applicant weekly income replacement benefits into the future. The Executive Chair ultimately found that the Tribunal made an error in law in awarding the applicant IRBs to a specific future date. She found that the reinstatement of the **IRBs is more accurately deemed to be an "ongoing" benefit** as the insurer has an ongoing obligation to adjust the file and, by setting a specific end date, the Tribunal potentially fettered the insurer's ability to adjust the file.

A similar error was made by the Tribunal in the decision of *16-001144 v Aviva*.[79] In that case, the Tribunal awarded IRBs payable to a future date (the two-year mark). Once again, the Executive Chair held that the Tribunal made a "significant error of law that should be corrected."[80]

She noted that **IRB entitlement is a "point in time inquiry"** as outlined in s.6(1) of the *Schedule*. As such, she agreed with the insurer that the Tribunal's decision should be varied to make clear that benefits are payable from the date claimed and on an ongoing basis so as to allow the insurer to adjust the file accordingly.

A notable error was also at issue in *16-001985 v Aviva Insurance Company of Canada.*[81] In that case, the Tribunal held that the applicant was entitled to interest pursuant to section 46(2)

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[78] *16-000179 v. Old Republic Insurance Company* 2016 CanLII 93137 (ON LAT).
[79] 2017 CanLII 69236 (ON LAT).
[80] Ibid at para 12.
[81] 2017 CanLII 39728 (ON LAT).

of the *Schedule* from the date the amount became overdue at the rate of 2 per cent per month compounded monthly. The Executive Chair found that the Tribunal identified the **wrong interest rate in reference to the old *Schedule*** (O. Reg. 403/96) and found that interest is payable in accordance with s.51 of the current *Schedule* (O. Reg. 34/10).

Another notable error was remedied and reconsideration granted in *16-001066 v. Northbridge Personal Insurance Corporation*.[82] In that case, the insurer brought a successful section 31 of the *Workplace Safety and Insurance Act*[83] Application to the Workplace Safety and Insurance Appeals Tribunal, wherein it was found that the applicant was barred from commencing a tort action. The insurer denied the applicant's entitlement to benefits on this basis and the **Tribunal found as a preliminary issue that the WSIAT decision had no effect on the application to the LAT**, partly on the basis that the primary purpose in commencing the action (i.e. whether it was made primarily for the purpose of claiming benefits under the *Schedule*) needed to be decided with a complete evidentiary record.

The Executive Chair reviewed the appropriate legislation and found that the applicant's purpose in commencing a tort action was irrelevant, as there was no election to make for the purposes of s.30 of the *WSIA* and section 61(2) of the *Schedule*, since the applicant was barred from bringing a tort action. As such, there were no benefits payable pursuant to s.61(1) of the *Schedule* and the **Executive Chair granted the request for reconsideration**, cancelled the Tribunal's decision and dismissed the insured's application.

In *16-001934 v Aviva Insurance Company of Canada*[84] the Tribunal made a clear error in deciding the matter according to the wrong standard. In the reconsideration decision, the Executive Chair granted reconsideration and remitted the matter back to the Tribunal as the Tribunal applied the standard of a "balance of possibilities", rather than the accepted

[82] 2017 CanLII 39671 (ON LAT).
[83] 1997, S.O. 1997, c. 16, Sched. A.
[84] 2017 CanLII 59514 (ON LAT).

standard of a **"balance of probabilities"**, in finding whether the assessment at issue was reasonable and necessary.

***Reconsideration Cases – Applicant's Success***

While applicants may not be as statistically successful as insurers, there have been notable and important reconsideration decisions in favour of applicants. In *G.K. v. Security National Insurance Company*[85] the Executive Chair dealt with a reconsideration brought forth by the insurer in a case where the **Tribunal found** that the **claimant** was a **resident of Ontario** within the meaning of the *SABS* and, therefore, an "insured person" under the *Schedule*.

In that case, the claimant came to Canada on a student visa and moved to Alberta for a work contract in August 2014. The claimant sustained catastrophic injuries while in an accident in Alberta. The Executive Chair reviewed s.3(1)(c) of the *SABS*, which states that an "insured person" means a "person who is an occupant of the insured automobile and who is a resident of Ontario or was a resident of Ontario at any time during the 60 days before the accident, if the accident occurs outside Ontario".

The Executive Chair noted that "resident" is not defined in the *Insurance Act* or *SABS* so a determination turns largely on the facts of each case. The **Executive Chair upheld the Tribunal's decision.** In so doing, she considered each argument raised by the insurer in detail and ultimately denied the reconsideration request on the grounds that the Tribunal "identified the correct law and applied the correct test for residence in accordance with the evidence."[86]

Two additional and important cases in favour of the applicant are canvassed in greater detail in the next section. These decisions, along with the ones discussed above, highlight the well-balanced approach of the Executive Chair.

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[85] 2017 CanLII 81584 (ON LAT).
[86] Ibid at para 47. The writers understand that this case may be under appeal.

## C. An Overview of Cases on Notable Issues to Date

### *i. "Accident" Cases?*

The LAT's handling of the definition of an "accident" pursuant to the *SABS* appears indicative of the balanced approach it takes to issues, including interpreting the definition of accident beyond what would typically be expected.

The interpretation of what constituted an "accident"[87] at FSCO was rather broad. For example, in *Whipple v. Economical Mutual Insurance Company*[88] the applicant suffered catastrophic injuries while attempting a headstand (while inebriated) on a stripper pole in a moving limo bus. While the use of the stripper poll was noted as "unprecedented", it was found by the Director's Delegate that the incident was an "accident" as defined in the *SABS*.[89] The insurer sought judicial review and the application was dismissed.

The LAT has dealt with a number of cases which called for the Tribunal to determine the "accident" issue. The results show a fairly balanced and sensible approach with the Tribunal finding on both sides of the issue.

#### *Claimant in an "Accident"*

In *16-000131 v TD Insurance,*[90] the applicant ran onto the lawn on private property and, as he was running, he tripped over the stone blocks, lost his balance and fell head first towards a vehicle parked on the driveway. The applicant suffered catastrophic injuries as a result and the insurer denied the benefits on the basis that the applicant was not in an accident as defined in the *SABS*.

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[87] Section 3(1), formerly s.2(1) of the *SABS*, defines accident as "an incident in which the use or operation of an automobile directly causes an impairment."
[88] *Economical Mutual Insurance Company v. Whipple*, 2012 ONSC 2612.
[89] As set out in *Amos v. Insurance Corp. of British Columbia,* 1995 CanLII 66 (SCC) and *Chisholm v. Liberty Mutual Group* (2002), 2002 CanLII 45020 (ON CA), respectively.
[90] 2017 CanLII 43837 (ON LAT).

The Tribunal cited the test to determine whether the insured was involved in an accident. This includes the purpose test and causation test. The **purpose test** asks: **Did the accident result from the ordinary and well-known activities to which automobiles are put?**

The causation test includes: **Was the use or operation** of **the vehicle a cause of the injuries?** Furthermore, if the use or operation of a vehicle was a cause of the injuries, was there an intervening act or intervening acts that resulted in the injuries that cannot be said to be part of the "ordinary course of things"? In that sense, **can it be said that** the use or operation of **the vehicle was a "direct cause"** of the injuries?[91]

On the purpose test, the Tribunal held that parking is a well-known use or activity of a vehicle.[92] On the causation test, the Tribunal first found that the use or operation of the vehicle was a cause of the injuries. The Tribunal held that the injuries could not have been caused by contact with the ground, and there was no other explanation before the Tribunal."[93]

The Tribunal then moved to the second part of the causation test and addressed whether the use or operation of the vehicle was the "direct cause" or whether there was an intervening act that cannot be said to be part of the "ordinary course of things". The Tribunal held that the tripping event, was a precipitating event, that was not separate from the chain of causation that ultimately led to the injuries.[94]

As such, the Tribunal found that the applicant was injured as a result of an "accident" as defined by the *SABS*. This is despite the fact that the applicant was trespassing on private property and struck a properly parked vehicle only after tripping on stone blocks while running.

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[91] Ibid at para 9.
[92] Citing as support *Economical Mutual Insurance Co. v. Caughy*, 2016 ONCA 226 (CanLII) wherein, at para 17, the Court found that "parking a vehicle is an ordinary and well-known activity to which vehicles are put."
[93] Ibid at para 44.
[94] Ibid at para 51.

Similarly, in *16-003163 v Intact*[95] the applicant was car-surfing and holding onto the roof rack while the vehicle was in motion. The applicant fell off as the vehicle turned a corner and he sustained a serious head injury. The Tribunal found that, while car surfing is illegal, it did not disentitle the applicant to accident benefits.

It is submitted that the Tribunal's decision is correct as the legality or morality of the act should not impact the analysis of whether the applicant was in an automobile accident for the purpose of threshold entitlement to SABs.

***Claimant Not in an Accident – There are Limits***

There have also been cases where the Tribunal found that the injuries were not the result of an "accident". In *17-000942 v Aviva,*[96] the applicant was dropped off near her residence. She closed the door and took 3-4 steps towards her residence when she tripped over an uneven curb. The Tribunal found that there was a break in chain of causation between the use and operation of the vehicle from which the applicant disembarked and the injuries she sustained due to the intervening act of her tripping on an uneven curb. As such, the Tribunal found that the location, use and operation of the vehicle were not the direct cause of the injuries.

The Tribunal made a similar finding in *16-004096 v. Intact,*[97] wherein the applicant tripped on a pothole a few steps away from her minivan. In that case, the applicant did not meet either the purpose or causation test.

The aforementioned cases demonstrate that there are limits to what the LAT will find meets the definition of accident pursuant to the *SABS*. Nevertheless, cases involving the parked car and car surfing demonstrates that the Tribunal is prepared to apply the definition

[95] 2017 CanLII 69433 (ON LAT).
[96] 2017 CanLII 62174 (ON LAT).
[97] 2017 CanLII 63622 (ON LAT).

broadly, which is consistent with the remedial nature of the *SABS,* and appears indicative of the LAT's seemingly more balanced approach.

### *ii. Causation: "But for" or "Material Contribution"*

The issue of causation also demonstrates a balanced approach, although it is the writers' view that the LAT should recognize the shift away from the "material contribution" test and apply the "but for" test for causation.

The issue of causation in statutory accident benefit cases has caused much confusion in recent years. In *Monks v. ING Insurance*[98] the Ontario Court of Appeal held that the trial judge did not err in applying the "material contribution" test for causation rather than the "but for" test. In particular, the Court held that the "material contribution" test applies to statutory accident benefits cases.[99]

However, the Ontario Court of Appeal in *Blake v. Dominion of Canada General Insurance Co.*,[100] established a clear shift away from the "material contribution" test. In that case, the Court of Appeal upheld the judge's decision to apply the "but for" test regarding the applicant's entitlement to caregiver benefits. Indeed, the Ontario Court of Appeal in *Blake* describes the "but for" as the general test of causation as described by the Supreme Court of Canada in *Clements v. Clements*.[101] Implicit in the reasoning of the Court of Appeal is that the "but for" test should be generally applied unless the decision maker is asked to depart from that test, presumably based on the inability to apply the "but for" test in the manner described in *Clements.*

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[98] 2008 ONCA 269.
[99] *Monks,* ibid at para 85.
[100] [2015] O.J. No. 1218 (ONCA) – see para 71.
[101] 2012 SCC 32. In the tort context, the Supreme Court of Canada in *Clements* concluded that the default causation test in negligence cases is the "but for" test.

The reasoning in *Blake* was subsequently addressed in various FSCO cases. In *Agyapong and Jevco*[102] the arbitrator noted that, since *Monks*, accident benefit's jurisprudence has been "fixated" on using the "material contribution" test. The arbitrator ultimately opined that the "days of the ritual application of the 'material contribution' test in accident benefit matters are numbered at best".[103]

Similarly, in *Ms. K and State Farm*,[104] Arbitrator Richard Feldman held that the primary test for causation in accident benefits cases remains the "but for" test. Most recently, in the September 2017 FSCO appeal decision *State Farm and Sabadash,*[105] Director's Delegate Evans overturned an arbitration decision that used the material contribution test to determine causation. In his decision, he stated that the primary test for causation is the "but for" test. He held that the default test is "but for" and "only in rare situations will the material contribution test be relevant".[106]

***Causation at the LAT***

There have been a number of cases addressing causation at the LAT and there is a tendency to apply both causation tests rather than applying the test as articulated in *Blake*. For example, in *16-000682 v Northbridge Personal Insurance Corp.*[107] the Tribunal defined the "but for" test and "material contribution" test and then, without stating which test should apply, simply concluded that the applicant had proven causation on either standard. In *16-000142 v TD Insurance Meloche Monnex*[108] and *16-000372 v Unica Insurance Inc.*,[109] the

[102] FSCO A11-003445, January 25, 2016.
[103] Ibid at p.13 and 14 where the Arbitrator concluded that the applicant did not meet either test. Delegate Jeffrey Rogers (P16-00014, November 29, 2016) dismissed the appeal but did not state which test applied as he found that the arbitrator applied both tests correctly. This decision is now under judicial review.
[104] FSCO A13-006325, March 22, 2016.
[105] Appeal P16-00029, September 18, 2017. This decision is now under judicial review.
[106] Ibid at p.10.
[107] 2017 CanLII 12608 (ON LAT).
[108] 2017 CanLII 12597 (ON LAT).
[109] 2017 CanLII 15835 (ON LAT).

Tribunal defined both tests but concluded that neither had been proven, again without stating which one applies to the analysis.

In *16-000393 v Pembridge Insurance Company,*[110] the Tribunal noted that there are "two generally accepted tests in the caselaw for determining entitlement to benefits – the 'but for' test and the 'material contribution test' to establish causation."[111] The Tribunal correctly noted that the "but for" test is the "default" test for causation, but then questionably, and without any analysis, concluded that the more appropriate test in that case was the "material contribution" test. The "material contribution" test was simply deemed more appropriate "because of the claim that the accident triggered pre-existing arthritis and back pain resulting in chronic pain."[112]

More recently, in *16-001985 v Aviva Insurance Company of Canada,*[113] the Tribunal held that, "where there are multiple possible causes of an impairment, it is not necessary for an applicant to prove that the motor vehicle accident was the sole cause of the impairment", and that it "is sufficient to prove that the accident 'materially contributed to the impairment." The Tribunal ultimately applied the "material contribution" test.[114] On reconsideration this matter was remitted back to the Tribunal as the wrong standard of proof was applied with no comment regarding the appropriate test for causation.[115]

As outlined above, LAT cases continue to apply the "material contribution" test. It is the writers' view that, further to *Blake*, the default test for causation in accident benefits cases is the "but for" test and there must be strong reasons and a specific request to depart from the general rule as outlined in *Clements*. In this regard, to depart from the default test, the claimant should likely be required to demonstrate that, through no fault of her own, the

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[110] 2017 CanLII 12600 (ON LAT).
[111] Ibid at para 11.
[112] Ibid.
[113] 2017 CanLII 22323 (ON LAT).
[114] Ibid at para 36, citing *Ms. K and State Farm*, FSCO A13-006325, March 22, 2016 at p.10.
[115] *16-001985 v. Aviva Insurance Company of Canada*, 2017 CanLII 39728 (ON LAT).

claimant is unable to show which of a number of possible causes was the necessary "but for" cause of the injury. [116]

As indicated, the Director's Delegate decision in *State Farm and Sabadash* is proceeding to judicial review on the issue of the proper test for causation in SABs cases. Presumably, this decision could resolve the issue as the LAT should be bound by the outcome.

### *iii. Limitation Period and Section 7 of the LATA*

The recent decision of *A.F. v. North Blenheim Mutual Insurance Company*[117] is an important decision in favour of insureds. The reconsideration in that case involved two decisions from the Tribunal that determined that the applications were statute-barred. The Executive Chair decided to reconsider both decisions on her own initiative.

The applicants were denied benefits on June 17, July 24 and August 7 of 2014. The two-year limitation period began to run when the claims were denied. On March 24, 2016 the applicants applied for mediation at FSCO.

Under the old regime, the applicants had 2 years after the insurer's refusal to pay the benefit claimed to commence a proceeding or, if they applied for mediation within that two-year period, then within 90 days after the mediator reported to the parties. The Executive Chair noted that, once the DRS moved to the LAT, the post-mediation 90-day grace period was eliminated from the *Schedule.* As such, the current requirement in s.56 of the *SABS* is for an applicant to commence a proceeding at the Tribunal within 2 years of the denial to pay the benefit claimed.

The applicants applied to the LAT two years after the denial and also beyond the 90 day deadline. On these grounds, the Tribunal found that the claims were barred by the two

[116] See, *Clements,* supra note 101, at para 45.
[117] 2017 CanLII 87546 (ON LAT).

year limitation period in s.56 of the *SABS*, which requires that a proceeding to adjudicate a *SABS* related dispute must be commenced with the Tribunal within two years after the insurer's refusal to pay the benefit claimed. Nevertheless, the Tribunal did not consider section 7 of the *LATA*, which allows the Tribunal to extend time "fixed by or under any *Act* for the giving of any notice requiring a hearing by the Tribunal."[118]

In the reconsideration, the Executive Chair first highlighted that section 56 of the *SABS* is a "limitation of time fixed by or under any Act for the giving of any notice requiring a hearing by the Tribunal", within the meaning of s. 7 of the *LATA*. Furthermore, while the insurer argued that the Legislature did not intend to change the law on limitation periods for commencing a proceeding, particularly since the courts and FSCO did not previously have such discretion, she held that nothing in the wording of s.7 of the *LATA* suggests that s.7 is "limited in its application to only certain types of proceedings."[119] In this regard, she noted that the *LATA* predated the transfer of SABs disputes to the LAT and it was open to the Legislature to amend the section to exclude *SABS* matters. While the Legislature amended other parts of the *LATA* it did not amend that section.

She also dismissed the insurer's argument that section 7 does not apply since other Tribunal proceedings subject to the *LATA* are referred to as "appeals" (as referenced in the section) while AABS proceedings are uniquely referred to as "applications". In this regard, she noted that she was satisfied that nothing turns on the fact that proceedings under the AABS are commenced by application as opposed to appeals.

Furthermore, she highlighted that this section applies to the *Insurance Act*, since it specifically states that the discretion to grant an extension of time applies "[d]espite any

[118] Ibid at para 11.
[119] Ibid at para 18.

limitation of time fixed by or under any Act for the giving of any notice requiring a hearing by the Tribunal" (emphasis in original).[120]

In terms of the applicable test, the Executive Chair further highlighted that the Tribunal, in determining whether to grant an extension of time under s.7 of the *LATA*, generally weighs the following four factors: 1) the existence of a *bona fide* intention to appeal within the appeal period; 2) the length of the delay; 3) prejudice to the other party; and, 4) the merits of the appeal.[121] She further highlighted that, "the four factors are not strict elements that must each be met in order to grant an extension of time. Rather, they are a guide to assist in determining the justice of the case. Whether to grant an extension of time depends on the specific facts of each case."[122]

The Executive Chair ultimately held that the Tribunal made a significant error of law by failing to consider whether an extension of time should have been granted under s.7 of the *LATA*. As such, she ordered a rehearing on the issue.

This is an important and significant case since it allows for the Tribunal to extend the time for the limitation period, which had previously been strictly applied. While the onus is on the party requesting the extension to show that there are reasonable grounds for granting it, this is now an option that was previously unavailable under the old DRS.

### *iv. Sufficiency of Reasons in Denying Medical/Rehabilitation Benefits*

In *M.F.Z. v Aviva Insurance Canada*[123] the Executive Chair followed a FSCO decision outlining the **requirement for insurers to provide appropriate reasons** when denying medical/rehabilitation benefits and the **significant consequences** resulting from insurer's **non-compliance**.

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[120] Ibid.
[121] Ibid at para 28.
[122] Ibid at para 30.
[123] 2017 CanLII 63632 (ON LAT).

In that case, the Tribunal found that the insurer did not inter alia provide medical reasons why it considered the treatment plans at issue not to be reasonable and necessary and was, therefore, non-compliant with s.38(8) of the *Schedule*. In addition, the insurer did not comply with s. 38(9) as it did not advise the applicants that the MIG applied. As such, the Tribunal held that the insurer was prohibited from taking the position that the applicant's impairments fell within the MIG and was required to pay for all the goods and services recommended until it gave the applicants proper notice.

The Executive Chair agreed with the Tribunal's determination that the medical reason provided by the insurer did not comply with s. 38(8). Moreover, while the insurer referenced the $3,500 MIG limit, it did not state that the insurer believes the MIG applies. As such, she agreed with the Tribunal that **the insurer was non-compliant with s. 38(9)** and that the **insurer is prohibited from raising the** MIG in the context of the treatment plans at issue and throughout the entire accident benefits claim (the insurer may still dispute entitlement to future medical benefits on the basis that the treatment is not reasonable or necessary).[124]

This decision highlights yet again the importance of strictly complying with s. 38(8) and s. 38(9) of the *SABS* in order to preserve the insurer's ability to dispute the medical/rehabilitation benefit claimed and also to preserve the right to assert that the claimant's injuries fall within the MIG. A failure to do so will likely result in the insurer being required to pay for the benefit claimed until the deficient notice is remedied.

[124] She did find that the Tribunal made an error with respect to the quantum of entitlement since the insurer had subsequently cured its non-compliance.

## VI. Constitutional Issues: Is the Removal of the Court Option Unconstitutional?

### A. *Campisi v. Ontario*:[125] The Removal of the Court Option is Unconstitutional?

As discussed at the outset of this paper, Bill 15 removed the court option for SABs disputes. As a result, Joseph Campisi, a personal injury lawyer, personally launched a proceeding questioning the constitutional validity of s.280 of the *Insurance Act*. Nevertheless, the constitutional challenge was soundly dismissed by Justice Belobaba in *Campisi v. Ontario.*[126]

While Justice Belobaba found that Mr. Campisi lacked standing, he stated that, if he was wrong on this issue, he would still dismiss the application on the merits. Regarding s. 15(1) of the *Charter* (equality rights), Justice Belobaba found that, while auto accident victims may be seriously injured, the legislation does not discriminate between persons based on physical disability or any analogous ground. The fact that an insured person may be physically disabled, and is required to proceed before the LAT and not a court, is not a distinction on the basis of disability.

Justice Belobaba also addressed the allegation that the legislation breaches s. 7 of the Charter (right to life, liberty, and security of the person). The challenge failed since case law has established that the elimination of a court option does not offend s. 7 of the Charter. Moreover, Justice Belobaba found that there was no violation of s. 96 of the *Constitution Act*, 1867.

In short, having addressed all the issues, Justice Belobaba concluded that Mr. Campisi lacked standing to bring the application and, in any event, the application would fail on the merits. Mr. Campisi is appealing to the Court of Appeal and it is the writers' view that the plaintiff will likely face the same result. While it may be unpopular and pose its own set of (fixable) access to justice issues, the Legislature had the power to remove the court option

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[125] 2017 ONSC 2884.

[126] Some of this commentary was published as part of Rogers Partners LLP In|Sight Fall Newsletter.

and doing so does not appear to be unconstitutional based on seemingly the well-reasoned decision of Justice Belobaba.

In short, the LAT as the "only show in town" as it relates to the resolution of SABs disputes appears to be here to stay. As the writers discovered based on a review of matters from the perspective of two years out, this is not nearly as concerning as was initially feared.

## VII. CONCLUSION

We are now approaching two-years since the implementation of the Licence Appeal Tribunal as the dispute resolution system for accident benefits disputes in Ontario. Despite the vociferous concerns when it was launched, the LAT has proven to be well-balanced in its decision making and efficient in its processes. In this regard, many of the initial concerns have proven unfounded, and the LAT will hopefully improve on the current timing and other (minor) issues as time passes and the Tribunal comes into its own.

Nevertheless, it is the writers' belief that, while it was within the power of the legislature to overhaul the dispute resolution system, there is an access to justice issue arising from the present inability of the LAT to award costs and disbursements in a similar manner to that enjoyed by FSCO. In this regard, we posit that an amendment to the *Insurance Act* should be undertaken to allow for costs to the successful party and to otherwise permit the LAT to deal with costs as FSCO did before it. We believe that this is consistent with the recommendations of Justice Cunningham and will allow for the LAT to serve its stated purpose – to be efficient, well-balanced, but also and perhaps most importantly, ensure access to justice.