In the matter of the *Insurance Act*, R.S.O. 1990 c. I.8 and Regulation 664 as amended.

And in the matter of the *Arbitration Act*, S.O. 1991, c. 17.

And in the matter of an arbitration between:

AVIVA INSURANCE COMPANY

Applicant

and

AIG INSURANCE COMPANY OF CANADA

Respondent

AWARD

COUNSEL

Rebecca Brown Greer, counsel for the Applicant, Aviva Insurance Company (hereinafter called Aviva).

Michael Blinick, counsel for the Respondent, AIG Insurance Company of Canada (hereinafter called AIG).

BACKGROUND

This matter comes before me pursuant to s. 275 of the *Insurance Act* and Ontario Regulation 664 s. 9. This is a loss transfer matter and the parties on consent have appointed me as a private arbitrator to determine the issue in dispute.

This loss transfer claim arises out of an accident that occurred on October 9, 2014. On that day the claimant was travelling eastbound on Mill Creek Drive when a transport truck pulled out of a private driveway and struck the passenger side of her vehicle.

Aviva insured the Applicant's personal car. AIG insured the transport truck.

There is no issue that s. 275 of the *Insurance Act* is engaged in that AIG insured a heavy commercial vehicle as defined under Regulation 664.

In addition, there is no issue with respect to liability. AIG has accepted 100% liability with respect to this accident.

The issue that is brought before me is with respect to the quantum of statutory accident benefits paid to the claimant by Aviva. Specifically, AIG disputes that a lump sum full and final settlement entered into on May 8, 2020 in the amount of $525,500 is reasonable.

The breakdown of that settlement is set out below:

Medical benefits	$275,000
Attendant care benefits	$176,500
Housekeeping and home maintenance	$74,000
Total	$525,500

While initially there were some other aspects of loss transfer indemnification that were in dispute, these issues were resolved prior to my rendering my final decision.

Accordingly, the only issue before me is the "reasonableness" of the lump sum settlement in the circumstances of this case.

PROCEEDINGS

This matter proceeded by way of written submissions. The parties filed an Agreed Statement of Facts (22 pages) and attached to that Agreed Statement of Facts were voluminous documents relating to the claimant's pre-accident medical history, prior motor vehicle accident of March 24, 2012, accident benefit file relating to the October 9, 2014 accident as well as extensive medical reports and clinical notes and records.

The parties also submitted Factums and various Books of Authority. There was no oral evidence although the transcripts of an EUO of the Aviva adjuster who was handling when it settled were filed. That EUO took place on September 19, 2022.

FACTS

General Background

Despite the incredible volume of material submitted by the parties in this matter, there were surprisingly no facts in dispute. Rather, the question is whether on these agreed facts that the lump sum settlement entered into in 2020 would meet the "reasonable test" that has been set down by arbitrators and judges over the course of the years relating to loss transfer claims. However, as each case is driven by the facts to that end I must embark on a detailed review of the relevant facts that I have drawn from the various materials that have been submitted to me. This by necessity must involve an examination of the claimant's pre-accident medical history, the injuries sustained in the two motor vehicle accidents and her subsequent impairments and the file handling by Aviva in specific reference to the lump sum settlement.

The claimant was born on September 19, 1982. At the time of the 2014 accident she lived in

Georgetown.

The claimant was unemployed as of October 2014. Prior to 2012 she had been employed by Shoppers Drug Mart as a beauty advisor. She had recently had a child, a son born February 27, 2013. The claimant was responsible for providing caregiving for her child. She was in a common-law relationship.

At the time of the 2014 accident the claimant's personal vehicle was insured with Aviva . Wisely, she had purchased some considerable optional benefits. She was entitled to:

1. Medical and rehabilitation benefits of $1,100,000: irrespective of catastrophic determination;

2. Attendant care benefits of $1,072: irrespective of catastrophic determination;

3. Income replacement benefits of $600 a week;

4. Optional caregiver benefit; and

5. The optional housekeeping and home maintenance benefit. This latter provided $100 a week for two years if non-catastrophic.

There is also information in the file from Applicant's counsel suggesting that she had purchased the indexation benefit but there were no documents that I could find to substantiate that one way or the other.

Pre-October 9, 2014 Medical History

The claimant had a significant pre-accident medical history. This included complaints of anxiety and depression, some pain-related complaints as well as injuries and impairments that arose as a result of an accident on March 24, 2012.

I will briefly examine her pre-accident medical history prior to the accident of March 24, 2012.

According to Dr. Kayumi's clinical notes and records the claimant's relevant medical history certainly goes back as far as 2007. In 2007 there are notes that the claimant had been unable to work since May 2, 2007. She was noted to suffer from depression and anxiety and was on medication. The note indicated it was uncertain when she would be fit to return to work.

In August of 2008 the manager of the disability program at her employment indicated that she had commenced a medical leave of absence on August 21, 2008 with an expected return to work in September of 2008. This appeared to be due to anxiety.

In March of 2009 a report indicated that the claimant had clinical symptoms consistent with

chronic myofascial pain affecting her upper limb.

In August of 2010 the same doctor noted that she had undergone a bone scan because of these ongoing complaints and the bone scan showed a significant left wrist abnormality with a differential diagnosis being a possible subacute fracture and avascular neurosis.

This then brings us to the accident of March 24, 2012. Aviva was not the insurer providing statutory accident benefits with respect to the 2012 accident. It is relevant to note that at the time of the 2012 accident the claimant was pregnant and she delivered her son subsequent to that accident. She was insured by Unifund.

According to the clinical notes and records of Dr. Lazare which commence in September of 2013, the complaints related to this accident included lower back pain, headaches, neck and back pain, chronic pain, chest pains, depression, irritability, poor sleep and panic attacks. It is unclear whether she was on Cipralex at the time this accident occurred or whether she was placed on Cipralex post-accident. In any event, the notes indicate that Cipralex did improve her mood. The following are some of the relevant entries from Dr. Lazar:

September 2013: Lower back pain, depression, referral to psychiatry, chronic pain since MVA March 2012, headaches, neck and back pain since.

November, 2013: Mood better on Cipralex, neck and lower back pain still - cannot afford treatment. Also getting right leg, neck pain and headaches, taking three Percocets per day.

March 2014: Taking gabapentin and experiencing nausea, getting headaches from Lyrica, back, neck and shoulder pain still there, asking for physio.

June 2014: Follow-up with respect to chronic pain and depression, was okay until three weeks ago. She was moving and her mom was leaving. She is now more depressed, seeing the psychiatrist tomorrow. She is fighting with her husband, crying in the office. She has poor sleep and is forgetful.

The claimant is referred to see a Dr. Manohar, a psychiatrist. His clinical notes indicate that when he saw her in June of 2014 that she had increased anxiety and increased panic attacks. She was involved in significant stressors including marital distress.

Dr. Manohar also forwarded a report to the family doctor, Dr. Lazare in late March of 2014. By that time her son was 13 years old. She was taking various medications which were causing some significant nausea. She was having to take up to five Percocets a day for her pain. Her neck, back and shoulder pain was significantly disabling. He noted that her mood symptoms were characterized by irritability, difficulty tolerating frustration, tearful episodes, decreased energy and decreased motivation. She was unable to function well. He noted, "She feels her life has taken a huge tumble medically speaking." She also reported being scared to drive and petrified that she may be involved in another accident. The diagnosis was major depressive disorder with

features of PTSD as a result of her motor vehicle accident.

By July 16, 2024 Dr. Manohar was still reporting residual symptoms of anxiety and depression. Multiple stressors were affecting her. Her ongoing legal dispute had depressed her. She had recently undergone an examination for discovery.

I now turn to the accident benefit file from Unifund relating to the accident of March 24, 2012.

Accident of March 24, 2012

This accident occurred when the claimant was rear-ended. The reports suggest that it was a high speed collision with the other vehicle travelling approximately 70 km/h. There was no loss of consciousness. She did attend hospital. There were no fractures although there was a concern that she may have one in her left leg and for a while she wore a cast. There is evidence of a tear in her left shoulder.

The file was handled by Unifund on a non-MIG, non-CAT basis. Initially she was placed in the Minor Injury and later taken out.

Over the course of the claim, she sought housekeeping benefits of $100 a week and was found to be entitled to 15 hours per week by a s. 44 insurer's examination.

She also submitted an attendant care Form 1 claiming over $3,000 per month in early 2012. The initial s. 44 assessment concluded in October 2012 that the claimant needed $434 of attendant care. This was incurred but later denied per an insurer's exam on April 29, 2013.

Overall, in terms of treatment the file shows Treatment Plans were submitted including psychotherapy, chiropractic treatment, acupuncture, physio and massage.

At the time this accident occurred, the claimant would have been entitled to med rehab of $50,000 and attendant care of $36,000. I now turn to a more detailed review of what flowed from that accident.

An OCF-1 was submitted dated March 30, 2012. This document indicated that the claimant had been employed full-time at The Bay as a counter manager from August 4, 2010 and she worked part-time at Shoppers as a beauty advisor at the time of the March 2012 accident. Therefore she qualified for income replacement benefits.

A Disability Certificate was submitted by Dr. Bernholtz on April 3, 2012 noting the claimant had suffered a sprained right wrist, left ankle, left knee, ribs, sternum and sprained left hip. There was also a note of prior surgical procedures which included cleft lip and palate surgery when she was younger and some heart-related surgery.

In 2012 Unifund arranged for some s. 44 assessments. A physiatry assessment by Dr. Waseem

on November 2, 2012 noted that she was able to return to work and needed assistance with dressing and showering. He felt she had a cervical, thoracic and lumbar sprain as well as a bilateral shoulder sprain and a bilateral hip sprain. While there were some subjective reports of pain, he did not identify any impairments that would prevent her from returning to her pre-accident employment.

She was also seen by way of a s. 44 assessment by Dr. Zakzanis from a psychological perspective. He noted complaints of depression, anxiety and felt she had an adjustment disorder. Dr. Zakzanis felt that her psychological symptomology was as a result of the accident and sufficient to prevent her from returning to her pre-accident employment.

There was also a chronic pain assessment by Dr. Edward Shane and Dr. Jack Lefkowitz from April of 2013. This dealt primarily with establishing a diagnosis of chronic pain as well as fibromyalgia. Therapy including psychological counselling was recommended. It was noted she had difficulty doing personal care and her pre-accident housework.

There was an OT assessment dated April 24, 2013 with respect to attendant care. This was a s. 44 assessment and it concluded that there was no objective evidence to support that the claimant had an ongoing physical impairment that prevented her from doing her personal care and it was found no attendant care was required.

The last report is a psychological assessment (section 44) from a Dr. Friesen dated November 14, 2013. The claimant still reports ongoing pain, problem concentrating and a problem with poor memory. From a mood perspective she has issues with anger, anxiety, depression and irritability. Despite the earlier attendant care assessment, she reported she could not cook, clean, do laundry or do much of her self-care. Dr. Friesen administered a number of psychological tests and he found that her testing was invalid and that she had an exaggerated response and declined to offer a prognosis.

The Unifund file shows that as of September of 2014 the claimant was still receiving an income replacement benefit. The rationale appeared to be that she was still not cleared from a psychological perspective to return to work due to the invalid testing and the inability to provide a diagnosis. Attendant care had been denied. Formal physical treatment had been denied. A Treatment Plan was submitted September 5, 2014. In addition, a request was made for s. 25 assessments to look into the question of whether the claimant was catastrophically impaired and for the purposes of submitting an OCF-19. This was approved by Unifund on December 5, 2014. However, these CAT assessments never proceeded as the case settled for $40,000 all in July of 2015. The breakdown for the Unifund settlement is set out below:

IRB	$17,500	
Medical	$15,000	
Rehab	$2,500	
Costs	$5,000	
Total	$40,000	all in.

I also note that a total of $68,800 had been paid in IRBs, medical expenses of $21,064, attendant care $13,903 and vocational expenses of $2,500 up to the time of the settlement. There is also reference in various places in the file that the claimant later sued the lawyer who settled this file claiming that it was an improvident settlement.

Therefore, as we move forward to the accident of October 9, 2014 we have a claimant who is continuing to claim an inability to work due to the prior 2012 accident, continues to be on medication and is seeing her psychiatrist, and has been diagnosed with chronic pain and fibromyalgia. In addition, prior to the settlement an OCF-19 had been submitted.

Accident October 9, 2014

In this accident the claimant reported an exacerbation of all her pre-2014 injuries. For the first time she also sought psychological counselling and considered cannabis (medical marijuana) to assist in reducing her reliance on opioids. Although the claimant had many pre-2014 complaints, the records show that these increased significantly post-October 2014. I should note that the pre-2014 complaints were largely to the claimant's left side of the body. Post-2014 we see complaints to the right neck and having right shoulder pain and the claimant did take the position that these were new.

The accident itself occurred when the claimant was driving south on Mill Creek Boulevard. The heavy commercial vehicle collided with her car as it exited out of a driveway. This was a T-bone-style collision towards the rear passenger side. Her airbags deployed. There was no loss of consciousness, no lacerations and there were no fractures.

Police came to the scene and ultimately she was taken to Credit Valley Emergency Hospital where she underwent X-rays. When there was no fractures found, she was discharged.

Aviva received the Application for Accident Benefits: OCF-1 on October 20, 2014. The claimant confirmed she was unemployed but was a caregiver to her young son. She claimed entitlement to a caregiver benefit. She had purchased that optional benefit. Aviva found that she was entitled to the caregiver benefit up to the maximum of $250 a week subject to that benefit being incurred.

An OCF-3: Disability Certificate was submitted by family doctor, Dr. Lazare dated October 11, 2014. The injuries included cervical strain, right shoulder strain, post-traumatic headaches, left shoulder strain, exacerbation of her depression and chest wall pain. He noted that she had similar injuries in a prior motor vehicle accident and all these injuries have been exacerbated together with a new right shoulder problem as a result of the second accident. He supported a non-earner benefit, caregiving benefit and housekeeping benefit. He also noted that she was currently receiving an IRB from Unifund and that her diagnosis from the 2012 accident included cervical strain, post-traumatic headaches and depression. She was noted to be taking Percocet, Cipralex, Wellbutrin and clonazepam prior to October 2014.

A further OCF-3 was submitted by Dr. Lazare on April 15, 2015. In addition to the prior list of injuries, there is now a note about panic attacks. He continues to support a non-earner, caregiver as well as housekeeping benefits.

By May 1, 2015 the claimant had not yet submitted any requests for treatment. Aviva wrote to the claimant on May 1, 2015 noting that the first Treatment Plan was received by Aviva on May 21, 2015 seeking chiropractic treatment, physio, acupuncture, massage in the amount of $2,965. This was approved by Aviva. After this the claimant began to submit Treatment Plans on a more regular basis.

In 2015 Aviva arranged for a multidisciplinary assessment which was conducted through Centric Health. The report is dated July 23, 2015 and it addresses caregiver benefits as well as housekeeping. The assessments were done by Dr. Ko, Physiatrist, Mohammad Nikkhou, Psychologist and Occupational Therapist, Shelley Elliott.

While the physiatry assessor did not find that the claimant met the test of disability for either housekeeping or caregiving, both the psychologist and the occupational therapist supported an ongoing disability.

Dr. Ko noted that the claimant told him that her pre-existing diffuse left-sided body pain still existed but it had improved. She suggested she was independent in toileting but requires assistance in dressing and showers. He conducted a physical assessment and concluded she had a sprain of the neck and a sprain of the right shoulder. He did note an ultrasound that showed a small partial thickness tear of the subscapularis on the right side but he suggested that she was unlikely to have sustained that in a T-bone collision and felt she had more of a strain.

Dr. Nikkhou the psychologist assessed the claimant on May 25, 2015. He had available to him the clinical notes and records of her pre-accident treating psychiatrist Dr. Manohar and therefore was very aware of her pre-existing complaints in relationship to anxiety and depression.

The claimant reported to the psychologist that her anxiety has become worse since the second accident. She is constantly concerned about what may happen in the future, that bad things will happen, their financial issues, inability to return to work and worrying about her son's health. She is constantly fatigued and tearful. She feels her main barriers to resolution are her pain, depression and anxiety. At the time of this assessment she is still receiving income replacement benefits and notes that if they were cut she would have to go onto welfare. She also reports that her physical treatment has been of no benefit. She feels she is 90% disabled.

He provides a diagnosis of an adjustment disorder, somatic symptom disorder with predominant pain, driving phobia and possible subclinical features of post-traumatic stress disorder. He feels this is at least partially as a result of the 2014 motor vehicle accident. He does note her pre-existing complaints both psychological and musculoskeletal. He concludes she has a psychological inability to perform her housekeeping and her caregiving.

The OT assessment took place on July 5, 2015 at the claimant's home. The claimant reported that she continues to perform some caregiving tasks for her son (feeding, changing and grooming) but otherwise her mother comes in daily to assist. She says her son is very busy and she has trouble supervising him. Her mother is coming in five to six hours a day, five days a week. She has not tried to return to work.

The OT concluded that the claimant functionally presents with reduced abilities to cope with routine household tasks and has a substantial inability to complete her pre-accident housekeeping. Recommendations are for housekeeping support of four hours a week. In addition, the OT supports assistance with caregiving of up to 20 hours a week.

According to the Aviva log notes, on May 27, 2015 they received a call from the claimant's legal representative. The legal representative advised Unifund had approved an assessment to complete an OCF-19 in December of 2014. The assessments were being completed by Assessment Rehab in Markham. However, the representative indicated that the reports had not yet been received by her nor by Unifund. She was also not sure under what CAT test the claimant was applying for but it was going to be primarily for psych issues. There was an indication a neuropsych assessment was being completed as part of these assessments. The adjuster asked whether there were any capacity issues and was told there was not.

In the file materials from a chronological perspective there was an Occupational Therapy s. 25 Report completed by Entwistle Power: OT Kristen McGrath. This report is dated October 13, 2015 with respect to an assessment that took place on September 21, 2015. A Form 1 accompanied this report in which attendant care was recommended in the amount of $3,886.67. In addition, housekeeping was recommended of up to 20 hours per week. I will review this report as it is important in terms of chronology to see where the claimant had reached at this point. However, I stress that the evidence indicates that this report was not in fact submitted to Aviva until early 2020 at the time that settlement negotiations began. Accordingly, Aviva never responded to this report or the Form 1. There are no comments with respect to this in the log notes in or around 2015. The log notes also show that there does not appear to be any follow-up by the claimant or her counsel with respect to this Form 1 and report and no attendant care invoices are submitted.

Turning to the report itself, the claimant advises that just before the 2014 accident she had started resuming the majority of her housekeeping activities including making meals for the family, sweeping, dusting, tidying, doing dishes, taking the garbage out and vacuuming. Post-2014 she is now unable to do that. She also reports that she requires daily assistance with her son. She claims she is limited in many aspects of her personal care and has become socially isolated.

With respect to attendant care, the recommendations include assistance with cooking in terms of help lifting and carrying heavy pots, supervision on the stairs due to mobility issues, assistance with cleaning up and tidying the bathroom and bedroom under hygiene due to her shoulder

injury and lifting tolerances. Of particular note is the recommendations under basic supervisory care. According to the OT, she has some concern as to whether the claimant will be able to respond appropriately in an emergency. The OT feels the claimant has a significant level of impairment in attention and concentration and lacks cognitive flexibility based on some testing that she conducted. However, the OT states:

> "It is not clear for my testing whether or not this level of impairment is as a result of increased levels of fatigue and pain or is not the claimant's norm. My testing also does not address other areas of cognition required for an appropriately and timely response in the event of an emergency. Neuropsychological testing is strongly recommended to determine her cognitive abilities and her ability to respond appropriately in the event of an emergency. At this time I recommend basic supervisory care over the evening/night hours until the neuropsychological tests are available. …"

This nighttime supervisory care forms the most significant portion of the recommendations for attendant care. Finally, the OT made some modest recommendations for assistance with bathing and medication. With respect to the housekeeping the claimant notes that she was not responsible for outdoor maintenance prior to the accident and no assistance is allocated there. Otherwise, there are recommendations for assistance with light cleaning, meal prep, heavier cleaning, laundry and groceries. Lastly, in this report there is reference to caregiving with a recommendation of allowance for 46 hours per week. This is primarily for general supervision.

On November 30, 2015 Aviva receives a copy of the claimant's accident benefit file from Unifund. By this time Unifund has settled their claim with the Applicant.

In around February of 2016 a psychological assessment in support of a Treatment Plan was sent into Aviva from Dr. Bonnie MacDonald. According to Dr. MacDonald, the claimant was demonstrating a relatively severe level of psychological distress. She felt the claimant was psychologically disabled with reduced mental focus, low stress tolerance, poor adaptive functioning in addition to her problems with respect to anxiety, depression and pain. The diagnosis was post-traumatic stress disorder, persistent depressive disorder moderate to severe and somatic symptom disorder. Recommendations included cognitive behavioural therapy and relaxation training.

As happened a number of times on this file, Aviva initially planned to decline the Treatment Plan but then engaged in some discussions with Dr. MacDonald who explained her reasoning for the proposed treatment and ultimately the Treatment Plan was approved as are a number of subsequent Treatment Plans. As well, in or around this time the claimant is submits treatment for physio, massage and acupuncture and these did proceed to a s. 44 assessment.

Dr. Derek Lefebvre, a chiropractor was asked to address a physio Treatment Plan in March 2016. Dr. Lefebvre concluded that the Treatment Plan was not reasonable and necessary. He felt that the claimant's injuries were soft tissue in nature and should have resolved and that the duration

of care being proposed far exceeded the recommended care to provide therapeutic benefit. He did not feel any facility-based treatment was warranted. Overall, subsequent physical-based Treatment Plans were denied by Aviva.

Dr. MacDonald provided an updated report to Aviva dated September 13, 2016. Of note is the fact that the claimant told Dr. MacDonald that she had returned to some employment. The claimant reported she was working at least once a week as a beauty demonstrator for skin products at Shoppers Drug Mart. This was the employment that the claimant had been engaged in prior to the 2012 date of loss. By this time her son is in daycare five days a week which is allowing the claimant more opportunity to manage time for her appointments, relax and as noted return to employment.

However, she is only able to do light work and for a few hours. She did work a five-hour shift and felt she could not handle that in any meaningful capacity and certainly not on a full-time basis.

Dr. MacDonald also reported that the claimant is undergoing stress with her spouse which is posing problems. She continues to have driving anxiety. Dr. MacDonald's diagnosis remains the same and treatment recommendations continue.

In late 2016 Aviva decided to assess caregiving and housekeeping. They scheduled s. 44 assessments through Viewpoint and included a physiatry assessment with Dr. Ko on December 13, 2016, a psychological assessment with Shulamit Mor on November 1, 2016 and an OT assessment with Shelley Elliott on November 8, 2016. The physiatry and OT were the same assessors who had previously conducted a similar assessment back in 2015. The outcome of these s. 44 assessments across the board was that from a physical and psychological and functional perspective, the claimant no longer qualified for housekeeping or for caregiving. She was found not to have a complete inability to carry on a normal life as well. As a result of these assessments, Aviva terminated housekeeping and caregiving on January 16, 2017.

Turning briefly to the reports themselves. Dr. Ko noted that this was his second assessment and that the claimant's current clinical presentation is actually worse than her presentation in 2015. He deferred commenting on headaches and dizziness to the appropriate medical profession but otherwise remained of the view she had a sprain to her neck and right shoulder. He noted that with respect to her back pain there was no evidence of any organic pathology and no objective evidence of any ongoing impairment. Therefore, she did not meet any of the tests he was asked to address. She also complained to him of some ongoing right knee pain. This she related to the 2012 accident but noted it had begun to bother her about eight months prior to her assessment with Dr. Ko. He found that was not causally related to the 2014 accident. He also felt ongoing complaints about diffuse left-sided body pain were not related to the 2014 accident.

Dr. Mor the psychologist reported that the claimant advised that she had been encouraged by her psychologist to rejoin the workforce. She reported that in March of 2016 she was working at various Shoppers Drug Mart locations approximately four hours a week doing skin care demonstrations. She advised she was struggling at work in particular due to her medication use

pain and poor memory. She did however agree that working had been emotionally beneficial for her.

With respect to her present child care activities she reported that she is bathing and dressing her son, taking him to daycare and playing with him. In terms of housekeeping, she can prepare food for herself and her son, do dishes, clean and do the laundry but cannot clean washrooms and can only do light grocery shopping.

She describes a typical day which notably is very similar to what is disclosed on surveillance. She gets up at 7:30, makes breakfast, gets her son ready and takes him to daycare. She may then go to treatment or return home or she will go in to work. She then picks up her son at 3:30, prepares dinner and plays with him.

Dr. Mor asked the claimant how much she thought she had improved since October of 2014 emotionally and she reported only a 25% improvement. This was primarily in her level of anxiety and she did advise she was now able to drive.

Dr. Mor felt that the claimant had a complex profile. She had a long history of depression and anxiety which had only improved about 20% from 2012 to prior to 2014 and still was limited in terms of its level of improvement. Dr. Mor felt that given the history and lack of substantial improvement post-2012 accident, that it was virtually impossible to identify the impairments that the claimant sustained in the 2014 accident. She was prepared to accept that given the claimant's history of emotional distress and vulnerability, that this accident would have exacerbated her symptoms. She found she continued to meet the criteria for an adjustment disorder with mixed anxiety and depressed mood and a chronic pain disorder.

Notably, Dr. Mor found that there was a clinically significant impairment but based on the medical history she could not solely relate it to the 2014 accident. Therefore, from a psychological perspective she concluded she did not meet the test.

Of significance in Dr. Mor's report is her comments about what the claimant is presently able to do. She notes that to the claimant's credit she has recently rejoined the workforce doing skin demonstrations. She is preparing food for her son, doing some grocery shopping, taking him to daycare, playing with him and dressing him. Recreationally she reports that she is in contact with one good friend and they visit once or twice a week and may have coffee or go to the mall. She spends time with her son and her mother. She takes her son to music lessons, to the farm, to Toys R Us and reports being independent in self-care. No psychological barriers were described that would prevent her from engaging in her activities of daily living.

The OT looks at the claimant's pre- and post-accident functional status. She notes the following:

- The claimant does not need assistance with bathing or showering.

- She does not need assistance with grooming tasks and can do these independently with

pacing.

- She demonstrated sufficient strength and mobility to perform dressing independently.

- There are no recommendations for assistance with kitchen tasks, bed-making and grocery shopping.

- A lightweight vacuum is recommended and a laundry bag to assist with laundry and vacuuming.

- With respect to caregiving there are no recommendations and the claimant is found to have sufficient strength and functional ability to supervise and care for her son.

As we move into 2017 we see the first Treatment Plans being submitted for medical marijuana. Aviva received a Treatment Plan on August 4, 2017 recommending medical cannabis in the amount of $5,150.29. This was assessed by way of a s. 44 assessment with a general practitioner, Dr. Frank Loritz. In his report of October 13, 2017 he finds the medical marijuana is not reasonable and necessary. Notably, the claimant advises him she has not worked since 2012. As to the medical marijuana he suggests that the cannabis therapy is palliative and would not be expected to provide any long-term therapeutic benefit and is not considered to be an optimal management for current pain symptoms. Aviva therefore denied medical marijuana October 18, 2017.

A LAT application was commenced by the claimant on September 18, 2018 claiming entitlement to cannabis expenses, caregiving benefits, housekeeping and home maintenance expenses. This proceeded to a case conference on February 7, 2019 at which time the issues in dispute were settled. The claimant signed a partial settlement release on February 22, 2019 in which she settled her claim for all past, present and future caregiver benefits as well as housekeeping and home maintenance benefits up to 104 weeks only post-accident for the all-inclusive figure of $20,000. $16,060 was allocated for caregiving benefits with the rest for housekeeping and home maintenance. As part of this agreement, Aviva also agreed to pay the cannabis Treatment Plan for $5,150.29.

In late 2018 a further assessment and recommendations for treatment was provided by Dr. Bonnie MacDonald, the psychologist. The report is dated December 7, 2018. From the report the claimant's symptoms would appear to be either getting worse or certainly not improving. She feels sad and depressed almost every day. She is having crying spells and continues to have anger and irritability. She sometimes yells at people including her mother or her partner. She continues to worry excessively and has guilt figuring she could have done something to avoid this accident. She also feels worthless, lack of social interest and is apathetic. She is having trouble sleeping and has nightmares. If she does not take her medical marijuana she is not able to fall asleep. She is tired throughout the day, lacks sexual interest and has no appetite. There is evidence of psychomotor slowing. She is now beginning to have thoughts of self-harm but she does not have any plan or intent. She has generalized anxiety and continues to have panic attacks

at least two to three times a week that are not as manageable as they were previously. She is able to drive every day but she avoids long trips. She reports feeling 70% disabled from a psychological perspective and 80% disabled from a physical perspective.

Dr. MacDonald notes that the psychometric testing (which was valid) showed problems that may preclude her from being resilient in the face of adversity. She noted "It is estimated that her pre-accident adaptive psychological functioning was compromised and frail and she should be considered a vulnerable individual." Her diagnosis remained persistent depressive disorder but she did note the somatic symptom disorder was in remission.

As to causation, she notes the following:

> "Overall, the claimant was psychologically compromised and fragile at the time of the accident and the additional stressors of this accident taxed her already depleted psychological resources and limiting coping mechanisms adding to her pre-existing psychological impairments. As such, her ability to recover from the psychological impairment sustained in this accident is deemed to be guarded. Lastly the aetiology of her current condition cannot be delineated given the complexity of the situation, however it is with a high degree of psychological certainty that the subject accident has contributed to her current clinical presentation."

Ongoing psychotherapy is recommended.

In late 2018 Aviva arranges for some surveillance to be done. The Surveillance Report is dated December 20, 2018 and the surveillance dates start October 13, 2018 with the last date of surveillance being December 3, 2018. The surveillance shows that the claimant is driving. She takes her son to school in the morning. She is seen going through a Tim Horton's drive-through. On November 26, 2018 she is observed at approximately 11:30 attending work at Shopper's Drug Mart. She is observed inside the store talking to another female employee and explaining some products. She is observed to reach with her arms for products on shelves, crouch down and look at lower shelves. She remains at work until 4:01. She then leaves work and goes to the Georgetown Mall and goes into a variety store. She goes to a UPS store and then drives home returning at approximately 5:30.

On November 30, 2018 she is again observed at work. She arrives at 11:21. She is seen talking to a customer and similar movements to what was observed previously. She remains at work until 3:30. She then goes and gases up and picks up her son at approximately 4:15 and then returns home. Those are the only two days that the claimant is observed at work.

As we move into 2019 the claimant continues to submit Treatment Plans. Despite earlier reports noting that physical treatment was not required, Aviva approved a Treatment Plan in April 2019 for chiropractic, physio and massage. However, in June 2019 they denied a Treatment Plan for physical rehabilitation for $1,400. It went to an insurer's exam with the general practitioner

Dr. Loritz who concluded that passive treatment was unlikely to provide any long-term significant benefit and could create dependency.

Based on Dr. Loritz's report Aviva denied the Treatment Plan on August 27, 2019. However, again it subsequently reconsidered its denial and approved the treatment in full on January 28, 2020. This was based on a report that the claimant was deriving ongoing benefit from the treatment and as well a conversation with her counsel at which time it was agreed that the parties would move forward into settlement discussions. The adjuster noted that approving the Treatment Plan could be important in terms of moving forward with settlement.

Pending these settlement discussions, further Treatment Plans were approved by Aviva, notably a chiropractic Treatment Plan in December 2019 for $1,858.45 and a further Treatment Plan for chiropractic and physiotherapy in the amount of $1,520.76 from February 5, 2020.

On February 22, 2020 Aviva received a Life Care Plan dated February 18, 2020 with a table of costs attached. The Life Care Plan was from Solutions for Living and was being put forward as part of a rationale for the settlement discussions and proposals that would follow. The assessment had taken place on December 19, 2019 and was completed by Ameet Chera, Occupational Therapist. On the issue of medical marijuana the OT noted that the claimant had been dependent upon and reliant on opioids, specifically Percocet. Her Percocet use had increased post-accident of October 2014. She noted that the prolonged usage led to a higher tolerance for its effect and she was now being prescribed a plethora of sedative medications and other opioids such as Tramadol. Considering the claimant's young age, there was concern that prolonged dependency and use of these medications was inappropriate. She noted the claimant had been found to have a narcotic addiction in July 2016. She noted that the claimant had been referred by her family doctor in 2017 and 2019 to various addiction programs, notably the most recent being the Centre for Addiction and Mental Health on May 2, 2019. The claimant had declined to proceed with a detoxification treatment that had been proposed but was trying to decrease dosages on her own. The detoxification was contributing to severe withdrawal symptoms. However, the claimant wanted to get off the Percocet and rely only on cannabis. For these reasons, the OT was clearly recommending the use of cannabis oil and the Future Care Report sets out recommendations for future costs with respect to cannabis. In addition, in terms of other ongoing medical and rehabilitation needs, the OT identifies counselling (both individual, couples and family), various assistive devices, fitness membership, occupational therapy, driver rehabilitation, case management physiotherapy and/or massage therapy.

In terms of attendant care, relying to a large part on the October 2015 OT Report from Ms. McGrath, this OT recommends attendant care of $3,886.67 per month (79.3 hours per week) if catastrophic; if not then $3,000 a month is the maximum. The OT suggests the need for attendant care is to a large extent related to her prolonged use and dependency on Percocet. There is a concern about withdrawal symptoms and that she will struggle to manage her mood so she remains needing basic supervisory care as outlined by the previous OT as well as some assistance in shaving and trimming toenails.

Finally, in terms of housekeeping the OT recommends essentially $100 a week for lifetime ($5,200 per year plus HST = $5,876).

This therefore is the overall picture that was facing the Aviva adjuster as we move forward to the settlement and negotiations that took place and that ultimately resulted in the lump sum settlement of $525,000.

SETTLEMENT DISCUSSIONS AND OFFERS

The adjuster at Aviva responsible for the ultimate settlement took over carriage of the file in October 2019. The adjuster has a two-year insurance diploma from Fanshawe College (graduating in 2000). She also has her CIP. At the time of her EUO in September 2022 her title was senior healthcare claims specialist and she had worked in that role since 2016. She had been employed with Aviva since 2007 but left in 2010. She then returned again in 2014 and had been in various roles up until her current role as described above. She had also worked as an independent adjuster doing all line claims at ClaimsPro.

Her job description included handling complex claims files including catastrophic files and catastrophic risk files.

In or about February 22, 2020 claimant's counsel Mr. Foisy forwarded on to the Aviva adjuster a settlement proposal as well as an analysis with respect to risk. Mr. Foisy outlined some of the claimant's issues as a result of the 2014 accident. He reviewed the life plan recommendations and provided information about the future value of those recommendations through McKellars. The summary provided by Mr. Foisy is set out below:

Medical and Rehabilitation Benefits

Non-catastrophic	$294,282
Catastrophic	$431,466

Attendant Care

Non-catastrophic	$651, 966
Catastrophic	$844,659

Housekeeping and Home Maintenance

Non-catastrophic	$0
Catastrophic	$129,221

Total Summary

Non-catastrophic	$946,248

Catastrophic	$1,405,383

Mr. Foisy pointed out that his client had purchased optional benefits and even on a non-CAT basis she would be entitled to $2,200,000 plus indexation benefit. He also noted his intention to arrange for catastrophic assessments (OCF-19) but that he was prepared to discuss settlement prior to pursuing those catastrophic assessments.

Based on his risk analysis, his offer to settle was:

Med rehab	$300,000
Attendant care	$550,000
Future housekeeping	$75,000
Total	$925,000

While the details of the interaction between AIG's representative and Aviva will be dealt with later in this decision, I do note that in an e-mail of March 29, 2020 the Aviva adjuster set out a detailed synopsis of Aviva's approach to this claim for AIG. This synopsis is helpful as it provides background into how Aviva had developed its authority and their analysis as to their potential exposure.

First of all, the adjuster noted that it had not yet received an OCF-19 and they were unsure as to what claimant's counsel's plans were in that regard. She also noted that there were full optional benefits available that would provide coverage for med rehab and attendant care but that the claimant would need to be catastrophic in order to get housekeeping.

On the issue of catastrophic impairment, the adjuster noted that they were concerned that the claimant might be successful in being found CAT under criterion 8 (mental behavioural disorder). She noted this was a pre-June 1, 2016 date of loss and that the claimant would only need one marked impairment in order to qualify. While she noted that her IEs suggest the 2012 loss was more significant, the adjuster notes that the reports also show that the claimant was vulnerable and that the 2014 accident had exacerbated her existing psychiatric issues.

In terms of housekeeping, it was noted that they had settled housekeeping up to the 104 week mark but that the claimant had hired a housekeeper and was incurring the expense thus suggesting some exposure if catastrophic.

With respect to attendant care, it was confirmed that Aviva had never received a Form 1 until early 2020 when they received the September 21, 2015 Form 1 for $3,886.67. She noted that if Aviva was unable to settle the file that that Form 1 would have to be addressed. She confirmed no formal claims for attendant care benefits had been submitted, incurred or paid yet she seemed concerned in suggesting the claimant was young and pain-focused and did have attendant care optionals available.

Lastly, for med rehab it was noted that the claimant continues to undergo physio, massage,

medical marijuana, goes to the gym and has psychological treatment.

She noted that the claimant was 37 years of age and that Aviva's authority or range of settlement was going to be between $450,000 and $600,000.

On April 15, 2020 Aviva provided a counteroffer to Mr. Foisy's offer of $925,000. The offer was for $376,000 all in. It was sent via e-mail. The e-mail notes that the claimant is being reimbursed for $600 a month for cannabis oil and she seems to concede that this will likely be an ongoing expense for the claimant given various assessor's comments. She also notes that as of that date the claimant has incurred only $33,000 in medical benefits which would be a yearly burn rate of $6,600. Taking all that into consideration and referencing some discount (although no explanation as to what discount), the adjustor offers $200,000 for past, present and future medical and rehabilitation benefits.

With respect to attendant care, she reminds Mr. Foisy that they had not received the Form 1 until 2020. She provides some analysis of the Form 1 noting that basic supervisory care of 10 hours a day seems excessive. There is no reference to the surveillance in the e-mail. She does note that there has been no attendant care incurred and none submitted. The adjustor then does her own calculations with respect to attendant care and provides five hours a day of basic supervisory care for seven days a week ($1,771.71 for basic supervisory care) and then adds back in the other recommendations from the 2015 report and suggests reasonable attendant care would be $2,000 a month ($24,000 per year). She sets out a present value (3% discount) of $614,695 for a lifetime exposure. An 80% discount is suggested and settlement is proposed at $123,000 for attendant care.

With respect to housekeeping, the adjustor goes so far as to acknowledge that Aviva agrees that "there is definitely a risk of a catastrophic determination" and accordingly they are prepared to make an offer for housekeeping and home maintenance. She calculates $100 a week for lifetime with a 3% discount on the present value at $133,174 and then takes a discount of 60% for CAT risk resulting in an offer of $53,000.

Therefore the offer of $376,000 is made up as follows:

Med rehab	$200,000
Attendant care	$123,000
Housekeeping	$53,000
Total	$376,000

Turning back briefly to the adjustor's EUO, she does acknowledge that at no time did Aviva seek an EUO of the claimant. She also acknowledges that the last s. 44 assessment prior to her entering into settlement discussions was August 12, 2019. She was also taken through the e-mail to Mr. Foisy and confirmed that it fairly reflected how she had developed the settlement proposal of $376,000.

The adjuster also confirmed on her EUO that prior to the full and final settlement there had never been an OCF-19 submitted nor an OCF-18 submitted for the purposes of s. 25 CAT assessments. Lastly, she confirmed that she did not retain any external lawyer or in-house counsel to assist with preparing the settlement numbers, reviewing the file or handling the settlement with Mr. Foisy. The settlement (authority) did require approval from her supervisor and her senior manager.

The adjuster was asked on her EUO about the surveillance from 2018. She confirmed that the surveillance had not been sent to any of the assessors that post-dated the Surveillance Report. It had not been produced to opposing counsel. It had not been relied upon in any of their materials submitted with respect to settlement. As to the adjustor's review of the surveillance, she only watched a brief part of the video and could not recall on her EUO if the Applicant was even observed during the surveillance. She stated she did not put any weight on the surveillance even though she had not reviewed it to any significant degree. She stated on her EUO "I didn't put weight on surveillance. The abundance of objective medicals for the assessment of CAT risk on the file is what I looked at when I considered my numbers."

The e-mail making the settlement proposal of $376,000 to Mr. Foisy was sent at 9:47 a.m. on April 15, 2020. Mr. Foisy responded at 8:38 p.m. with a counteroffer of $675,000.

The adjustor responded on April 16, 2020 at 2:16 p.m. She noted that the two parties were $299,000 apart in numbers. Without any real explanation, the adjustor moved from her previous offer of $376,000 to $525,500, an increase of $149,000. She noted that this would be Aviva's top number for settlement.

On April 30, 2020 at 5:21 p.m. Mr. Foisy e-mailed the adjustor confirming his client had accepted the offer of $525,500 as long as Aviva also paid any approved incurred treatment to date.

The breakdown for the settlement according to the Settlement Disclosure Notice was medical benefits $275,000, attendant care $176,500 and housekeeping benefits $74,000. The claimant signed a Full and Final Release and Settlement Disclosure Notice.

INTERACTION BETWEEN AVIVA AND AIG

Aviva initially notified AIG of its intention to seek reimbursement pursuant to s. 275 of the *Insurance Act* on May 27, 2015.

Thereafter Aviva delivered a number of requests for indemnification spanning the timeframe of October 20, 2015 through to the final request for indemnification relating to the lump sum payment which was dated November 24, 2020. All the requests for indemnification that were submitted were paid by AIG. When this arbitration commenced, there were two requests for indemnification dated September 6, 2019 and January 6, 2020 which had been paid and were in dispute. However, the parties resolved this prior to this decision being rendered. Notably, the September 6, 2019 requests for indemnification included multiple payments for cannabis and

psychological treatment. The January 6, 2020 was with respect to the partial settlement at the Licence Appeal Tribunal for $20,000. Therefore, the only request for indemnification that has not been fully indemnified by AIG is the November 24, 2020 with respect to the portion relating to the settlement of $525,000. There were a few medical expenses set out on that November 24, 2020 request for indemnification. Again, some cannabis, Physiomed in Erin Mills and the psychologist. I understand those are no longer in dispute.

As we lead up to the full and final settlement of this case, the first significant e-mail communication between AIG and Aviva is on January 28, 2020. This is from the Aviva adjuster to Sedgwick who is handling the file on behalf of AIG. This e-mail notifies AIG that Aviva is planning to proceed forward with a full and final settlement with Mr. Foisy. Highlights of this e-mail are as follows:

1. Confirmation that the claimant's policy is "fully stocked with optional benefits".

2. That the claimant has not applied for CAT.

3. That housekeeping is settled up to the 104 week mark and would only be available if the claimant is deemed CAT.

4. That Aviva sees the CAT risk on this loss as "high" despite the significance of the 2012 accident.

5. That the adjuster is expecting a settlement proposal from Mr. Foisy and that once Aviva receives that, they will run the numbers that they feel are warranted and can be substantiated and provide them to AIG as they will be seeking reimbursement.

The representative from Sedgwick responded but not until March 3, 2020. She requested a copy of the claimant's medical file and the 2012 accident file and also asked as to the status of the 2012 accident and whether the claimant was continuing to pursue a claim against her prior counsel.

Aviva responds on March 9 advising that the Unifund 2012 claim had been settled but that the counsel was maintaining that it was settled in bad faith but she did not know the status of the litigation.

By this time the Aviva adjuster would have received the settlement proposal from Mr. Foisy set out in his letter of February 22, 2020.

Thereafter, there are a series of e-mail exchanges both between AIG and Aviva, and Aviva and Mr. Foisy's office with respect to getting an authorization that will allow Aviva to provide AIG with a complete copy of their accident benefits file as well as with the Unifund file. Mr. Foisy was advised that the reason for this is that Aviva wants approval from AIG with respect to settlement before it is finalized due to the loss transfer claim being made.

In an e-mail of March 18 from Aviva to AIG the adjuster notes:

> "I will be putting together a 'skeleton' synopsis of where Aviva sees the exposure on this file and the range that we will be presenting to counsel in the hopes of settling this file. As you can appreciate we would ultimately like to have the loss transfer insurer's 'blessing' on our final settlement range."

By e-mail dated March 29, 2020 Aviva provided Sedgwick with its synopsis. It is important to note that when this synopsis was sent that AIG still did not have access to the medical information relating to the claimant.

This synopsis was reviewed earlier in the decision when discussing Aviva's settlement approach. The adjuster did confirm to Sedgwick that this synopsis had been presented to Aviva's senior management for the purposes of procuring settlement authority. That authority range was between $450,000 and $600,000. After providing the detailed examination of the CAT risk, what the exposure was under housekeeping, attendant care and med rehab, the adjuster completed the e-mail with the following:

> "It is our position and we will be entering into negotiations with counsel in hopes of settling this file for a number within a range of $450,000 to $600,000. Kindly advise of your thoughts, as we will be seeking repayment of 100% under the loss transfer procedural rules for not only the settlement monies but also all monies paid to date and not yet requested from your insurer."

A follow-up e-mail was sent via Aviva to AIG on April 6, 2020 as they had not yet heard back asking for their thoughts on the settlement valuation and noting they had not yet formally responded to the settlement demand that had been made.

On April 7, 2020 Sedgwick responded to Aviva advising they needed a copy of the file before they could "recommend such numbers". On that same day Aviva again sought claimant's counsel's authorization to release the file to the Sedgwick/AIG. Mr. Foisy provided authorization on his client's behalf and in that same conversation advised via e-mail that he had received instructions to submit for CAT exposure but he would wait to do so until he had a settlement proposal from Aviva.

Shortly after that e-mail again on April 7 Aviva sent a copy of the claimant's file to Sedgwick by e-mail. In the e-mail to Sedgwick Aviva confirmed that they had just been told that morning that Mr. Foisy intended to apply for catastrophic determination on behalf of his client so that they could anticipate an OCF-19 would be forthcoming. The adjuster noted:

> "There is significant CAT risk on this file … We take the position we have apportioned the necessary CAT risk in our settlement evaluations and can only request that your office see some urgency in responding to our e-mail to you

> regarding 'blessing' on our settlement numbers."

The e-mail goes on to request a response from AIG within a week as Aviva plans to commence settlement discussions with the claimant and her counsel that week.

On April 13 the adjuster from Sedgwick e-mailed Aviva noting they had downloaded 60 documents but they wanted to confirm that there were no insurer's exams beyond 2018 and they also asked if there was any surveillance.

Aviva replied by e-mail dated April 13 that they were not relying on any surveillance and therefore it had not been sent to AIG.

In response also on April 13 Sedgwick noted the following with respect to the surveillance:

> "But it may help you justify your numbers to my client, not relying on it with the claimant is different than your relationship to AIG. Also can you confirm you have not completed any IEs since 2018? Given how aggressively Aviva is publicly about handling claims, this is really surprising to me."

On that same day at 6:47 p.m. Aviva responds. With respect to the surveillance they maintain their position that they are not going to disclose it to AIG. Their position is they are not obliged to release that. As to the comments about Aviva's file handling, the adjuster notes that she is going to stick to objective information when responding to requests from AIG. She also confirms that there were s. 44 assessments in 2019 and that they were included in the materials forwarded on to AIG.

Then on April 15 at close to 10:00 in the morning the Aviva adjuster provides the counter-offer to Mr. Foisy for $376,000. When this counter-offer is made, AIG has not responded in any fashion to Aviva's settlement numbers, analysis or range of authority.

We then have the e-mails later on the day of April 15 from Mr. Foisy with the counter-offer of $675,000 and the final offer from Aviva of $525,000 on April 16, 2020. When this offer was made Sedgwick/AIG had still not provided any response to Aviva's settlement approach nor had Aviva followed up with AIG before making that final offer.

When Mr Foisy accepted the offer of $525,000 on April 30, 2020 there had been no further e-mail communications between Aviva and AIG.

The adjust for AIG in her EUO was asked some questions about the ultimate failure of AIG and Aviva to reach an agreement on the possible settlement of this claim before that settlement was finalised. She was asked why Aviva did not seek AIG's blessing prior to agreeing to the full and final settlement. According to the adjuster it was because there were lengthy delays by the independent adjuster to respond to Aviva's e-mails. She goes on to state (at question 312):

> "At the end of the day Aviva acted on its own good faith obligation to the customer, also acknowledging its exposure to the file and taking into consideration what the loss transfer requirements are."

The adjuster does confirm on her EUO that the figure of $525,000 was never approved or commented on in any fashion by AIG.

POSITION OF THE PARTIES

The parties have significant agreement with respect to the legal principles to be applied to this case. Before turning to summarize their position, I will set out the agreed upon legal principles.

Firstly, the parties agree that the onus of proof with respect to this matter lies with the Respondent, AIG.

The parties agree that indemnification is generally available to the first party insurer by the second party insurer unless that second party insurer can demonstrate that the first party insurer either acted in bad faith or grossly mishandled the claim so that the amounts paid out that it is seeking by way of indemnification will be considered to be grossly unreasonable.

In determining whether the file is being mishandled or payments are grossly unreasonable, the following three areas should be examined:

1. Did the first party insurer act in bad faith?

2. Did the first party insurer make payments that were not covered under the SABS in existence at the date of loss?

3. Generally, did the first party insurer so negligently handle the claim that the payments made were greatly in excess of that which the insured would have been entitled to had the file be managed by a reasonable claims handler? (See decision of Arbitrator Samworth, *Commercial Union Assurance Company v. Boreal Property & Casualty*, decision December 21, 1998.)

It is agreed that while a second party insurer may disagree with steps taken or decisions made in the adjusting of the accident benefit claim, that the second party insurer cannot resist payment under loss transfer solely on the grounds that they may have adjusted the claim differently. The test is much higher than that.

When looking at the actions of the first party insurer, when considering the reasonableness of the actions of the first party insurer in terms of the payments made one must look at the facts that were known to the handling adjuster when the decision was made to pay or dispute the benefits. With respect to a full and final settlement, the claims handler's conduct must be viewed based on the documentation and information available to that person at the time of the

settlement.

With respect to the onus, both parties agree that there is a heavy onus on the part of the second party insurer to establish that the payments were not reasonable and that it is relatively rare incidents or the exception to the normal operation of reimbursement that indemnification be refused.

Position of AIG

While AIG acknowledges that it is rare that indemnification should not be ordered in loss transfer. It is AIG's position that this is indeed one of those rare circumstances.

With respect to all of the benefits that were settled in the full and final settlement, AIG points to the fact that the claimant had been injured in a prior accident in 2012 and that the 2014 accident was primarily an aggravation of these pre-existing complaints. AIG submits that at best the medical reports support that there was a modest exacerbation in her psychological problems from the first accident but that otherwise she sustained some soft tissue complaints with some aggravation of pre-existing complaints. This essentially raises a causation issue and whether or not Aviva discounted the lump sum settlement to reflect that this was not a clear-cut case of impairments flowing from only one accident but was much more complex with the involvement of a previous accident and even before that some other pre-existing complaints.

AIG also points to some failures in file handling leading up to the settlement. It points out that Aviva failed to conduct an EUO that may have clarified the delineation between the 2012 impairments and the 2014 impairments and to clarify exactly what the claimant could or could not do pre- and post-accident of 2014.

AIG also points to the fact that Aviva settled this file on a full and final basis with no updated s. 44 assessments. The last assessment had been at least a year-and-a-half earlier. AIG also raises an issue that Aviva did not follow the recommendations of its s. 44 assessors. For example, it approved treatment (physiotherapy and cannabis) in circumstances where it had opinions from its s. 44 assessors finding that this treatment was not reasonable and necessary. AIG submits that for prolonged medical treatment to be found reasonable and necessary the following must be found:

- The proposed treatment goals must be reasonable.

- These goals are being met to a reasonable degree.

- The overall costs not just financial but investment of time in achieving the goals is reasonable taking into consideration the degree of success and the availability of other treatment alternatives (see *General Accident Assurance Company of Canada v. Dominic Violi*, 2000 ON FSC DRS 117 (CanLII).

AIG submits that while the goal of pain relief is not an unreasonable one for receiving medical care and therapy, that reasonable pain relief measures should also not encourage an inappropriate or indefinite dependency and interfere with other aspects of rehab. (See *Amoa-Williams v. Allstate Insurance Company of Canada*, 2000 Carswell Ont. 5293 FSCO).

AIG submits that if one applies these principles, that then there are questions raised as to whether it is reasonable for Aviva to cost out future medical and rehabilitation benefits that would include long-term use of cannabis.

AIG made specific submissions on each of the categories of benefits that formed the full and final settlement and I summarize these below:

1. Medical and Rehabilitation Benefits

I have already outlined above some of the principles that AIG relied upon in submitting that the settlement for medical and rehabilitation benefits for $275,000 would be considered grossly unreasonable. AIG also referenced the fact that at the time the settlement was entered into Aviva had only paid $33,000 in medical and rehabilitation benefits between October of 2014 and the date of settlement in May of 2020. Further, the majority of those expenses related to the cost of cannabis which AIG disputes would be appropriate to pay on a long-term basis.

In addition, AIG points to the s. 44 reports from Dr. Lefebvre, Dr. Ko, OT Ms. Elliott and Dr. Loritz who concluded that the claimant's injuries were soft tissue in nature and that physical therapy and formal-based treatment were not reasonably required to address any ongoing impairments.

AIG acknowledges that ongoing psychological counselling may have been justifiable but that Aviva had not taken into consideration what treatment she had actually received in terms of counselling in the 5.5 years post-accident and prior to the settlement. AIG points out that the claimant had received less than 30 sessions with her treating therapist and therefore a reasonable amount for future mental health counselling should have been $5,000 to $10,000 only.

AIG also points out and indeed does so in relationship to the other portions of the settlement package that Aviva failed to take into consideration the video surveillance showing the claimant at work, driving and being relatively active. AIG also submits that Aviva did not seek updated medical documentation from the family doctor or any of the treating providers before entering into settlement discussions.

AIG's final point is that just because the Applicant had purchased optional benefits and had potential access to higher limits, that does not justify a settlement that is grossly unreasonable in light of the available medical documentation and evidence in Aviva's possession at the time of the settlement.

2. Attendant Care

AIG disputes that any attendant care should have been paid in terms of the settlement. AIG notes that no attendant care had been paid whatsoever up until the time of the settlement. It notes that the adjuster relied on the OT Report that it received in February 2020 but was completed in October 2015 to justify its settlement range for attendant care. AIG points out that this report was materially out of date and contradicted many of the findings of other assessors who had seen her subsequently. For example, the claimant told Dr. Ko she was independent with self-care. AIG suggests other reports (s. 44), the notes of the family doctor and the notes from the treating psychologist did not suggest that there were any findings or impairments that supported any level of attendant care.

AIG also points out that the surveillance itself does not seem to justify that any attendant care would be required. The surveillance showed her sufficiently capable of working and performing various activities without any difficulty or impairment.

AIG suggests that there should be $0 allocated for attendant care.

3. Housekeeping and Home Maintenance

AIG submits that no payments should have been allocated for housekeeping and home maintenance. The only basis on which the claimant could qualify for that would be if she was found to be catastrophic. No OCF-19 had been submitted. While AIG acknowledges that Aviva had paid $3,940 for incurred housekeeping expenses based on the optional benefits purchased, they pointed out that there were no additional expenses incurred despite the settlement entered into for housekeeping at the LAT hearing.

AIG submits that to allocate $74,000 for housekeeping is grossly unreasonable, inconsistent with the medical reports and represents a failure to properly assess exposure.

AIG notes that the adjuster, in determining risk for housekeeping, assumed a lifetime exposure based on the full amount of the benefit and then only applied a 20% discount. AIG submits that that is grossly unreasonable and that no payment should be made for housekeeping.

Submissions of Aviva

Aviva takes the position that the $525,000 lump sum settlement was reasonable in all the circumstances and that AIG has not met its onus. Aviva also claims pre-judgment interest in accordance with the *Courts of Justice Act*. In addition to the legal principles I outlined above, Aviva also relies on the decision of Arbitrator Bialkowski (*Unifund Insurance Company v. Chartis Insurance Company of Canada* (decision May 13, 2022) wherein Arbitrator Bialkowski held that when looking at a full and final lump sum settlement that you should not simply look at each of the components of that settlement but that the overall amount of the settlement must be looked at. Arbitrator Bialkowski pointed out in that case that the analysis of the individual components in the Settlement Disclosure Notice may not in fact reflect how the overall settlement was arrived

at in the minds of the two involved parties. He points out that it is often the total amount that reflects whether or not the lump sum was reasonable and not how each component is made up. Arbitrator Bialkowski states:

> "To require strict analysis of individual components and not look at the overall settlement as the primary consideration, would result in many cases not being settled and give rise to protracted and costly litigation with the best interests of both parties not being met."

Aviva submits that AIG did not provide in the context of this arbitration any expert or sworn evidence to support its position that the settlement was grossly unreasonable or that Aviva grossly mishandled the claimant's accident benefit file.

Aviva submits that the arguments made by AIG are therefore just arguments and should be given less weight, particularly considering the heavy onus that AIG bears.

While Aviva acknowledges that the claimant did have a pre-accident history, Aviva also points out to s. 44 reports that confirmed the claimant's prognosis was guarded and there were a number of barriers to her recovery (Dr. Syed December 7, 2018 and Dr. Loritz August 20, 2019). Aviva also points to the evidence that the claimant submitted Treatment Plans throughout the claim. She sought physiotherapy, increased her intake of Percocet post-2014 and in fact became reliant on these. Aviva submits that one must also consider the fact that there was some new treatment started after 2014, specifically the psychological counselling and as well the cannabis.

Aviva states that considering the claimant's age (she was quite young, in her 30s). The overlapping injuries, pre-existing history, ongoing need for treatment, optional benefits and potential catastrophic claim made this matter extremely complex, particularly in terms of determining potential future exposure. Aviva says AIG cannot resist payment simply because with the benefit of hindsight they suggest the file could have or would have been managed differently.

Aviva also points to counsel for the Applicant noting that he was extremely experienced, trial ready and would have taken this matter forward. Aviva submits that is a valid consideration to look at when estimating risk and exposure.

Aviva also comments on the surveillance on which AIG relies. Aviva points out that the claimant was observed three out of six days and only seen working two four-hour shifts during that time. This Aviva points out is consistent with the reports made to Dr. MacDonald that she had returned to work in this reduced capacity. There should be no issue with respect to credibility as the claimant reported consistent problems and admitted to her efforts to return to work. Aviva submits that the adjuster's choice to put more weight on the medical evidence than on the surveillance was a choice that the first party insurer had the right to make and does not constitute gross mishandling.

On the issue of attendant care, Aviva submits that it had an obligation to respond to the late submitted Form 1 irrespective of whether the claimant had previously incurred attendant care or not. This was new evidence and new information and the adjuster was obliged to take it into consideration when settling the claim on a full and final basis and it was reasonable to allocate risk to attendant care particularly considering the claimant's age and the fact that she had lifetime coverage for attendant care based on her optional benefits.

With respect to medical and rehabilitation benefits Aviva points to the Life Care Plan that had been submitted that supported medical and rehabilitation expenses between $294,282 (if not CAT) and $431,466 if found catastrophic. The latter increased as there would be increased services, case management and increased hourly rates if found catastrophic. It was not unreasonable for the adjuster to take in consideration the additional treatment modalities proposed on a future basis by the Life Care Plan. She also lacked collateral benefits.

Aviva also addressed the fact that just prior to the settlement being completed that opposing counsel had advised that he would be submitting an OCF-19. This, submits Aviva, was an important factor to take into account. If an OCF-19 had been submitted Aviva would have had to go through the expense of arranging for catastrophic determination with the risk that the claimant could have been found catastrophic at the very least on one class 4 impairment under criterion 8. This would have opened up greater exposure and required Aviva to continue to adjust the claim and ultimately increase any settlement value. Aviva submits that the method that the adjuster calculated future entitlement was reasonable noting that the manner of doing so in the calculations is not consistent in terms of the approach from insurer to insurer.

Aviva submits that there is no evidence whatsoever that it settled the claimant's medical and rehabilitation claims at $275,000 "simply because she purchased optional benefits and had potential access to higher limits." Aviva suggests that a careful read of AIG's submissions on this issue infers that AIG believes it is unreasonable that as a loss transfer insurer it is saddled with exposure to optional benefits when it in fact did not offer those optional benefits. Aviva notes that that exposure has been confirmed by Arbitrator Novick in the case of *Wawanesa Mutual Insurance Company v. Zurich Insurance Company* (decision May 10, 2023).

In terms of calculating the lump sum settlement and its various components, Aviva points to the adjuster's notes that clearly indicate that she took a base for med rehab ($6,000 a year), attendant care ($2,000 a month) and housekeeping ($100 a week), did a present value calculation of those over her life expectancy and then applied a varying discount with respect to each benefit category.

With respect to AIG's argument that Aviva did not consider or follow its s. 44 assessors, particularly on the issue of treatment, Aviva submits that it is not required to accept the findings of its IE assessors when resolving a claim if there is information elsewhere that supports the ongoing treatment.

While Aviva submits that each of the components of the lump sum settlement is reasonable and

consistent with available evidence and risk, it also submits that the overall settlement is reasonable considering the complexity of the claim, the young age of the client, the pre-accident medical history, the potential CAT claim and lifetime exposure based on the available optional benefits.

Lastly, Aviva addresses the failure of AIG to respond in a timely fashion to its overtures to provide approval to its settlement proposals. Aviva notes that AIG had the opportunity to make some input into the settlement. It had been advised more than three months prior to the ultimate settlement that Aviva felt the CAT risk was high and that they would be trying to settle in a range somewhere between $450,000 and $600,000. The complete medical file was provided including the Unifund file and thereafter Aviva submits that AIG chose not to engage with Aviva and participate in the ultimate settlement entered into.

DECISION AND ANALYSIS

The law and how it has been interpreted with respect to the reasonableness of payments in a loss transfer matter is relatively well settled. The submissions of the parties make it clear that there is little dispute between them with respect to that analysis.

The starting point is often the bulletin from the OIC Bulletin No. 11/94 that was issued by the Superintendent of Insurance which set out some of the procedures to be applied to loss transfer. That bulletin provides:

> "The second party insurer is not entitled to dispute the accident benefit claim made by the first party insurer to its insured. The second party insurer is entitled to dispute the reasonableness of the payment and that it should not have to reimburse the first party insurer for that payment. The first party insurer is expected to act reasonably in administering an accident benefit claim where benefit payments will be substantially reimbursed by the second party insurer through loss transfer."

While this bulletin does not carry the force of law, it has always been given substantial weight by arbitrators and judges over time. Both counsel pointed to my earlier decision in *Commercial Union v. Boreal* from December of 1998 (*supra*). That case has been followed by many other arbitrators confirming that when looking at the reasonableness of the payments the enquiry is limited to confirming that the primary insurer did not:

1. Act in bad faith;

2. Make payments not covered under the SABS that were applicable on the date of loss; and

3. To so negligently handle the claim that the payments made were in excess of what an insured would have been entitled to if the file had been managed by a reasonable claims handler.

I have carefully re-reviewed these principles and have applied them in rendering my decision in this matter.

Based on the evidence before me, I could not find any indication that Aviva acted in bad faith. I also did not find that the payments that were made were outside of the Statutory Accident Benefits Schedule. However, I am concerned with respect to the handling by Aviva of the lump sum settlement and I have concluded that the payments made were greatly in excess of what the insured would have been entitled to had the file been managed by a reasonable claims handler.

Keeping in mind Arbitrator Bialkowski's comments to look at not only the individual components of the lump sum settlement but also the lump sum settlement itself, I find that the lump sum settlement overall was excessive and that I have trouble with all three components of the settlement for med rehab, housekeeping and attendant care. I also note that I have kept in mind that the onus on AIG is a strict one but I find that AIG has met its onus in this case.

Before turning to an analysis of each of the components of the lump sum settlement I set out in my with respect to the file handling by the settling adjuster once she came on the file and leading up to the resolution of the claim.

As noted by Arbitrator Stephen Malach in his decision of August 20, 2021 (*Dominion of Canada General Insurance Company v. Royal & Sun Alliance Insurance Company*) it is very important for insurers involved in loss transfer claims to have a continued dialogue between the first party insurer and the second party insurer. The loss transfer bulletins encourage insurers to enter into such conversations and to continue to do so over the course of the claim.

In this particular case the Aviva adjuster clearly reached out to AIG to initiate some discussions and as she indicated she wanted to seek AIG's "blessing" on the settlement. However, while that dialogue commenced it did not continue during the critical time. Having provided AIG with their settlement range and then having provided the relevant documents (medical reports, AB file, Unifund file) to allow AIG to assess the risk, the Aviva adjuster did not try to continue her dialogue with AIG to secure their “blessing” on the settlement. There was no good reason put forward by Aviva for that failure. While I agree the first party insurer was every right to settle the AB file without approval of the second party insurer in this case having sought approval I find it poor file handling not to give AIG the opportunity to weigh in on the settlement range.

The adjuster did not convey any of the settlement offers to AIG. She did not contact AIG to advise them that they were moving forward with settlement. There was no need to rush to settlement as there was no pending LAT application or a hearing. While counsel for the Applicant indicated that if the matter did not settle he would be submitting an OCF-19, he also made it clear that he would not do so until they could see if the matter had resolved. Therefore, there was no pending OCF-19, merely the threat that one might be generated if settlement was not entered into. AIG made it very clear that if settlement was being sought in the range that Aviva proposed, that AIG

would need time to review the medicals and assess the file before they could be in a position to agree to those numbers. I am also concerned that the adjuster for Aviva did not share the surveillance with AIG and in fact declined to do so when requested. Further, she did not use the surveillance in an effort to bring down the settlement numbers. While the surveillance is not "jaw-dropping", a review of it certainly suggests that the claimant is far more functional than she leads one to believe. While she admitted to Dr. MacDonald that she had returned to part-time work, the surveillance confirmed that she was indeed working and continuing to work in 2018. There were no requests made by Aviva for production of employment records or information with respect to how long the claimant had been working or how often she was working. While she was not entitled to an IRB, it was still very relevant information with respect to the claimant's functional ability both from a physical and psychological perspective.

In addition, the surveillance reflected someone who was able to drive, attend the stores, maintain a routine, take their son to and from school and to get dressed up and out of the house on a schedule. This in my view mitigated against the risk of a catastrophic determination even though the surveillance was in 2018. I am also concerned that Aviva did not initiate any further surveillance before deciding on authority.

Aviva did not make any efforts to conduct an EUO. This was a case with two accidents (March 24, 2012 and October 9, 2014) with similar if not identical injuries other than some differentiation between pain on the left side versus pain on the right side. All the reports suggest that the accident of 2012 was the more significant one and that the accident of 2014 exacerbated those injuries. An EUO is a valuable tool in cases of multiple accidents or with individuals who have pre-existing problems to assist in determining under oath a claimant's pre-accident function versus post-accident function so that appropriate direction can be given in terms of determining entitlement to the various benefits to which the claimant may be entitled.

Also in terms of overall handling, I am concerned that the adjuster seemed to accept that the 2014 accident was the "but for" cause of the claimant's impairments. A review of Aviva's s. 44 assessments suggest that that was not at all clear, particularly from a psychological perspective.

Dr. Mor, who saw the claimant in November of 2016 noted that given the history and lack of substantial improvement post-2012 accident, that it was "virtually impossible" to identify the impairments that the claimant had sustained in the 2014 accident. While Dr. Mor was prepared to agree that the claimant was vulnerable and that the 2014 accident would have exacerbated her injuries, she clearly felt that it was impossible to be specific as to which accident caused which problems. In my view, this suggested that there should be a far greater discount with respect to the overall settlement considering the causation issue.

Similarly, Dr. Nikkhou, the psychologist who assessed the claimant in May of 2015, noted that his diagnosis was "at least partially" as a result of the 2014 motor vehicle accident.

I stress that it is not my view that the first-party insurer must show perfection in claims handling. The nature of claims such as this and the complexity of some of the issues that the adjuster was

presented with certainly made it a difficult file to handle. However, as noted by Arbitrator Lee Samis in his decision of April 17, 2012 (*Royal & Sun Alliance v. Wawanesa Mutual Insurance Company*) the first party insurer must be prepared to demonstrate that they conducted reasonably appropriate claims handling. Arbitrator Samis noted that because of the nature of these claims that even a careful and prudent insurer may make mistakes that become visible with hindsight. These types of mistakes are not necessarily the ones that would justify a denial for indemnification in loss transfer.

However I agree with Arbitrator Samis that if the claims handling is so deficient from any standard of due diligence and shows an indifference or disregard of ordinary prudent claims handling procedures, then these should not be sanctioned by blindly ordering full reimbursement at the expense of the responding insurer. I find in this case that Aviva's file handling was deficient and that they did not apply ordinary prudent claims handling procedures such as use of surveillance, conducting an EUO, fully reviewing the available medical evidence to assess risk and giving AIG an opportunity to respond to the proposed settlement attempts.

On the issue of assessing risk, the Aviva adjuster seemed to be of the view that as counsel for the Applicant had "threatened" to submit an OCF-19, that that somehow or other increased the overall value of the claim. However, in this case the claimant had purchased optional benefits. She had a lifetime coverage irrespective of catastrophic determination of $1,100,000 for medical rehabilitation benefits and $1,072,000 for attendant care. While I appreciate the claimant was only in her 30s, considering that she sustained soft tissue injuries and psychological overlay and considering the medical evidence available, there did not seem any risk that the claimant would use up her optional benefit limits. Therefore, even if she were found to be catastrophically impaired, which seemed very unlikely on the evidence, while it would increase her available benefits, it would not increase the risk of payments over and above her optionals. It would open up housekeeping, case management and increased hourly rates but in my view, considering the claimant's burn rate in med rehab ($33,000 at the time of the settlement) no evidence of incurred attendant care and the settlement being entered into nearly six years post-accident, there was little likelihood, whether CAT or not CAT, of significant exposure to future benefits. In reaching her settlement recommendations and ultimately agreed to the settlement of $525,000, I believe that Aviva significantly over-estimated the risk on this file with respect to future benefits and in particular the effect that an OCF-19 application and/or a CAT determination might have on that risk.

I also find it hard to accept Aviva's position as sent to AIG in their e-mails that they saw this as a case with significant CAT risk. A careful review of all the available medical information starting from the 2012 accident and up until the last IE of 2019 does not in my view set out any real CAT risk. Certainly, there is no risk from a physical perspective that the claimant would have qualified under criteria 6 or 7. She sustained an exacerbation of soft tissue injuries.

Aviva seemed to consider that the risk lay primarily under criterion 8 and whether she would have one class 4 impairment from a mental behavioural perspective. A review of the medical evidence, as I have set out earlier in this decision, suggests that while the claimant may have had

some impairments, that none of them reached a marked impairment in activities of daily living, concentration, persistence and pace, social or adaptation. She was able to look after her child albeit with some help from her mother. She was driving. She managed to get back to some part-time work. She was doing some of her housekeeping. She socialized with her family. In addition, there is still the question as to whether the claimant's counsel could even establish that the accident of 2014 was the legal cause of the claimant's impairments.

Aviva's own assessments in 2016 concluded that the claimant did not need help with caregiving or housekeeping and that she was not disabled from a physical, psychological or functional perspective.

Dr. Mor, in her report from 2016, notes that the claimant has rejoined the workforce doing demonstrations, does grocery shopping, takes her son to daycare, plays with him, dresses him, she sees one friend and visits once or twice a week and has some coffee and goes to the mall, she takes her son to music lessons and to the farm and reports being independent in self-care and is able to drive.

I also reviewed the evidence with respect to the other available information to Aviva and what they sought to assist in determining an appropriate settlement quantum. The Aviva adjuster's evidence was that she did not choose to retain or seek any legal counsel. I do not find that to be unusual and agree with Arbitrator Shari Novick in her decision of May 10, 2023 (*Wawanesa Mutual Insurance Company v. Zurich Insurance Company Limited*) that a decision by an insurer not to refer the matter to counsel or get an opinion does not constitute gross mishandling of the claim, particularly in the context of this claim and considering the experience of the Aviva adjuster.

I also note that Aviva did not get a Life Expectancy Report, did not get annuity quotes and also did not get their own Future Care Report. Arbitrator Novick, in the decision noted above, commented that different insurers will take different approaches to resolve claims for future benefits. Whether or not the second party insurer might have collected different information or approached the settlement in a different fashion is not the test. Rather, it is whether the first party insurer grossly mishandled or mismanaged the claim.

Based on my over 40 years of experience as a lawyer, mediator and arbitrator, I note that most accident benefit insurers do not secure their own Future Care Reports when conducting full and final settlements in an accident benefit file. Many also do not get annuity quotes. While those are helpful, applying a present value calculation is also a common and accepted method of looking at risk and future values. The Aviva adjuster in this case did present value calculations and then took discounts and I do not find her method of calculating numbers to reflect any gross mishandling. Rather, it is the base numbers that she used to calculate the future risk and the discount applied that I find problematic.

I now turn to an analysis of each of the benefits that made up the full and final settlement and my comments as to the assessment and settlement.

Housekeeping

The claimant had purchased optional benefits for housekeeping but they only covered for a period of 104 weeks. In order to get housekeeping benefits into the future, the claimant would have to be found to be catastrophically impaired. While there was evidence in the early days post-accident that the claimant incurred housekeeping and home maintenance, I could not find any evidence that that benefit continued to be incurred irrespective of coverage thereafter. While the evidence suggests that the claimant had her mother helping, there was also considerable evidence to suggest that the claimant was managing much of her own housekeeping. One also had to take into consideration that the claimant remained disabled from some of her housekeeping as a result of the 2012 accident. In making a decision about a reasonable settlement, I would have expected Aviva to consider the following:

1. Significant causation issues between 2012 and 2014, particularly from a psychological perspective;

2. Their own OT Report, Psychological Report and Physiatry Report that concluded the claimant, while having some impairments, did not have impairments such that she met the housekeeping test;

3. The fact that no OCF-19 had been submitted and a review of the medicals suggested that it was most unlikely this claimant would qualify for a catastrophic determination; and

4. Surveillance;

5. That Mr. Foisy's first offer for housekeeping was for $75,000.

Aviva calculated the risk for housekeeping at $5,200 per year for 25 years and applied a present value calculation to that coming up with a number of $133,000. In my opinion, the assumption that the claimant would need housekeeping for lifetime at the full amount and would incur it as a result of the 2014 accident constitutes gross mishandling or gross misunderstanding of the evidence. That could have been corrected by applying a significant discount but Aviva applied only a 60% discount. This resulted in the settlement of $74,000. I find that that is grossly unreasonable in the circumstances of this case. I do appreciate that there was a threat for an OCF-19 and that there were some ongoing psychological impairments. I also appreciate that Aviva was dealing with, as their adjuster described it, an aggressive counsel but I feel that $10,000 was the maximum valuation that one would place for a potential claim for future housekeeping and at the same time sufficient to satisfy counsel that some consideration had been given to his arguments, his Future Care Report and the CAT threat.

Attendant Care

I find the assessment of the risk of attendant care and the settlement of $176,500 to be grossly

unreasonable in the circumstances of this case.

Up until 2020, Aviva did not receive a Form 1 nor any indication that the claimant required assistance with attendant care. The first Form 1 and accompanying report came in or around the time of the settlement. However, that report reflected the circumstances of the claimant when the assessment took place on September 21, 2015, less than a year after the accident. A review of the rationale to the Form 1 and the recommendations for significant nighttime basic supervisory care should have been carefully examined by Aviva. The OT recommendations for this overnight care was predicated on the claimant undergoing neuropsychological tests. The OT had concern about concentration and cognitive flexibility. A review of later medical assessments suggested that this was a mild issue. We also have the surveillance showing the claimant working, caring for her son and driving.

As to the remaining portion of the recommendations in the 2015 report, it included supervision on stairs due to mobility, cleaning up and tidying the bathroom and some assistance with lifting and carrying heavy pots. Again, if the Aviva adjuster had reviewed the surveillance and the video in detail, she would have seen an individual who likely had no mobility issues, no difficulty lifting or caring for her son or driving. Subsequent s. 44 reports completed by Aviva's assessors confirmed that the claimant did not need help with housekeeping or caregiving. A review of those reports suggested if you extract their findings that it was also consistent that the claimant would not need assistance with attendant care.

The adjuster did, to her credit, note that the Form 1 had been completed some time ago and had some concerns about it. She therefore reworked the numbers based on her own assessment of the claimant and the Form 1. I find this assessment to be grossly unreasonable. She allowed some basic supervisory care on a daily basis which I can find next to no evidence to support on the documents available to Aviva leading up to the settlement. She then added back in some of the needs set out in the 2015 assessment which included the mobility and assistance with lifting heavy pots. While she reduced the Form 1 from $3,886.67 per month to $2,000 a month, I find that is an excessive amount to assess attendant care based on the evidence and the circumstances of this case.

Aviva then took the $2,000 a month, allowed a yearly amount and calculated a present value for the claimant's lifetime. This came to $614,695.00. It was then discounted initially by 80% which comes to $122,939.00. However the settlement was for $176,500.00. A review of the evidence suggests it was highly unlikely the claimant would be assessed for attendant care for amounts near the CAT monthly limits of $6,000.

It is to be noted that catastrophic risk should have had no effect on attendant care in terms of assessing risk and future exposure due to the available optional benefits. There should have been no enhanced numbers allocated to attendant care on that basis. Further, there did not appear to be any consideration given for the fact that for over six years no attendant care had been incurred. Despite allegedly submitting the OT Report and Form 1 of 2015, neither the claimant nor her counsel ever followed up with Aviva to determine why they had not responded in any

fashion to that report. No invoices were submitted and there is no evidence that the benefit had ever been incurred.

On top of that, the Future Care Report completed at the request of opposing counsel relied largely on the 2015 report. Although they updated some of those comments the recommendations were still in the same quantum as the original Form 1 with really no satisfactory explanation.

Again, taking into consideration the circumstances of the case and all the issues and recognizing the counsel involved, I would have thought the most that would have been put on the table to settle attendant care would be $25,000 considering the availability of optional benefits, the lack of s. 44 assessments addressing the Form 1 and some of the comments from the treating psychologists noting that the claimant did have some impairments of some concern albeit it was hard to determine which accident was responsible.

Medical and Rehabilitation Benefits

At the time the settlement was entered into the claimant had expended $33,000 in incurred med rehab over a six year period. There were numerous reports from a s. 44 perspective that did not recommend any ongoing formal physically-based treatment. There was clear support for ongoing psychological treatment. Aviva had conceded the cannabis issue despite their medical assessments. I do not find that unreasonable, particularly considering the Future Care Report and the note that the claimant had become addicted to opioids and the use of medical marijuana was helping in order to reduce her reliance on the opioids.

Generally, when insurers enter into settlements based on future numbers they rely heavily on the burn rate, their experience and expectations as to what the claimant may need in terms of future care, and of course review the available evidence including any Future Care Reports.

The claimant here had entitlement to optional benefits of $1,100,000 and had only used up $33,000. I find that a settlement for med rehab of $275,000 to be grossly unreasonable in the circumstances of this case taking into consideration all the issues I have already outlined.

However, there was no doubt that there was going to be some ongoing needs for this young lady. She had settled her 2012 accident and her only recourse for treatment was from the 2014 accident. There was support in the Future Care Report for a chronic pain program, Percocet addiction withdrawal, possible nerve blocks, ongoing medical marijuana and ongoing psychological treatment. This was a woman who was continuing to receive treatment at the time of the settlement negotiations and had continued to submit Treatment Plans.

I find that a reasonable settlement for future med rehab would have been $150,000.

FULL AND FINAL AMOUNT

I find that $525,000 was not a reasonable settlement in the circumstances of this case and did reflect a payment in excess of the amount to which I feel the insured would have been entitled had the claim been managed by a reasonable claims handler. I find a reasonable settlement and the amount that is required to be indemnified by AIG to Aviva is:

Housekeeping	$10,000
Attendant care	$25,000
Med rehab	$150,000
Total	$185,000

AWARD

I find that AIG is responsible for indemnifying Aviva in accordance with s. 275 of the *Insurance Act* for a total amount of $185,000. I also find that interest is payable on this amount and is payable on the amounts that remained unpaid when this arbitration was commenced but were paid prior to this decision being released. If counsel cannot agree on the time period for interest and the appropriate rate, then we can arrange for some quick oral submissions on that issue.

With respect to costs, according to the Arbitration Agreement signed May 6, 2024 and February 25, 2025, the costs of the arbitration including the arbitrator's fees, expenses and disbursements are left to the discretion of the arbitrator but generally it is the expectation it will be borne by the unsuccessful party. In this case the results were mixed. AIG took the position that the entire settlement was unreasonable and suggested numbers in a range well below $20,000. Aviva maintained its position that the settlement in its entirety was reasonable and was unsuccessful on that point.

Overall, AIG is the successful party in this matter having met a significant onus of proof to reduce the indemnification from $525,000 to $185,000. Therefore, Aviva will pay the costs of the arbitrator and in accordance with paragraph 10 of the arbitration agreement Aviva will also pay partial indemnity costs of the arbitration to AIG.

If the parties cannot reach agreement on costs, we will set up a further pre-hearing to determine how to address that issue.

DATED THIS 5th day of March, 2025 at Toronto.

Arbitrator Philippa G. Samworth
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