IN THE MATTER OF
THE INSURANCE ACT, R.S.O. 1990, c. I.8, as amended,

BETWEEN:

WAWANESA MUTUAL INSURANCE COMPANY

Applicant

- and -

THE COMMONWELL MUTUAL INSURANCE GROUP

Respondent

DECISION

Counsel Appearing

Kathleen F. O'Hara: Counsel for Wawanesa Mutual Insurance Company (hereinafter referred to as Wawanesa)

Linda Matthews: Counsel for The Commonwell Mutual Insurance Group (hereinafter referred to as Commonwell)

Introduction

This matter comes before me pursuant to the *Arbitration Act*: 1991 to arbitrate a dispute between insurers with respect to the quantum of payments arising as a result of the decision on a priority dispute between the two insurers. The .priority dispute came before me pursuant to the provisions of the *Insurance Act* R.S.0. 1990, c. I.8, as amended, Section 268 of the *Insurance Act*, and its Regulation 283/95, as amended.

In an earlier decision I determined that Commonwell was the priority insurer with respect to benefits payable to the claimant arising out of the motor vehicle accident of April 13, 2015. An appeal was launched from that decision, but later abandoned by Commonwell.

This issue before me now is with respect to the amount of reimbursement that Wawanesa is entitled to from Commonwell. There is also a dispute with respect to what interest might be payable.

Commonwell has agreed to pay all past benefits that Wawanesa paid to the claimant including all claims for medical and rehabilitation benefits, income replacement benefits, attendant care and housekeeping. What is in dispute is a lump-sum settlement that was entered into by Wawanesa at a mediation that took place on October 28, 2019. The amount in dispute is $425,000.00. This is broken down as follows:

Medical and Rehabilitation Benefits	$200,000.00
Income Replacement Benefits	$150,000.00
Attendant Care	$50,000.00
Housekeeping	$25,000.00
Total	$425,000.00

Commonwell takes the position that Wawanesa's settlement was grossly unreasonable. Further, Commonwell takes the position that each head of Wawanesa's settlement was in and of itself grossly unreasonable and that it arose from a gross and unreasonable mishandling of the file. Wawanesa disputes that and claims it is entitled to the full amount of the lump-sum settlement by way of reimbursement.

Proceedings

The quantum Arbitration proceeded in writing. Each party submitted a Factum. There is a Joint Book of Documents and a Supplemental Document Brief. By and large the documents were portions of the Accident Benefit file including emails, communications, catastrophic reports, and the settlement documents. I was also provided with a transcript of an Examination Under Oath of an adjuster from Wawanesa who was the file handler both prior to and with respect to the lump-sum settlement.

Books of Authority were also submitted. No witnesses were called.

Issue in Dispute

Counsel agreed that the only remaining issue in dispute is one of reimbursement. I am asked to decide whether Commonwell should pay Wawanesa $425,000.00 with respect to the lump-sum settlement. Commonwell acknowledges that some monies are payable with respect to the medical and rehabilitation benefits. Commonwell submits that no payments are warranted with respect to attendant care, housekeeping or income replacement benefits. This requires an examination of the background of the claimant's file and its handling by Wawanesa, what benefits were paid and how the lump-sum settlement was entered into, and the applicable law

relating to the standard of care that would fall upon Wawanesa as the insurer that received and handled the Accident Benefit claim of the claimant pending a priority determination.

Facts and Summary of Evidence

A. Chronology

It is important to first of all look at the chronology of events from the delivery of the decision finding that Commonwell was the priority insurer up to the settlement at mediation in October of 2019.

The priority dispute which revolved around an issue of dependency, proceeded in October of 2018 and I released my decision in May of 2019 confirming that Commonwell was the priority insurer.

Prior to the issuing of the decision on priority, the claimant, through her counsel, had commenced a LAT Application of December 17, 2017. This Application included a dispute with respect to the denial of income replacement benefits, case management services, and on April 10, 2019 the issue of catastrophic impairment was added to the LAT dispute.

On April 14, 2019, counsel for Wawanesa wrote to counsel for Commonwell with respect to the possibility of Commonwell joining in an informal settlement meeting or a global mediation in an effort to resolve the underlying Accident Benefit claim. With respect to the issue of mediation, the email noted the following:

> "I am reaching out to see whether Commonwell would be agreeable to schedule a global mediation down the road, with the idea being, if the priority decision is released in advance of the mediation date, whichever insurer has priority attends the mediation. If the decision is not released, Wawanesa would attend the mediation, with Commonwell's blessing to settle the claim on a full and final (recognizing that there is CAT risk)"

No response was received to this email prior to the release of the priority decision on May 8, 2019.

On May 25, 2019, counsel for Commonwell emailed counsel for Wawanesa noting that her client had instructed that an Appeal be filed with respect to the priority decision. A request was also made for information about benefits paid to date. Finally, on the issue of the mediation, the following was noted:

> "Sorry I have not responded about the mediation. Has that been scheduled? I have very limited availability before the end of July".

By letter dated June 7, 2019, Commonwell launched an Appeal of the priority decision.

In the meantime, on May 27, counsel for Wawanesa had given the requested breakdown with respect to the benefits paid to date as follows:

Cost of Exams	$52,976.01
Attendant Care	$5,981.14
Medical	$50,000.00
Visitors	$9,620.94
Clothing	$99.00
IRB	$28,909.26

Also in an email on May 25, counsel for Wawanesa had advised counsel for Commonwell that the claimant had not been deemed catastrophic, provided information with respect to the LAT proceeding and the fact that there was a Case Conference scheduled for August 13, 2019. She also noted:

> "Claimant's counsel is eager to settle the file and wanted to potentially schedule a mediation to discuss settlement. I wrote to you about this previously".

While Commonwell's Notice Appeal was served on June 7, the actual date for the Appeal was not obtained until March 2020 and the scheduled date for the Appeal was August 14, 2020.

On August 12, 2019, before the Appeal date had been set, there was a discussion between counsel for Wawanesa and Commonwell. An email was received from Counsel for Commonwell dated August 12, 2019 referencing the telephone conversation that had been held and noting the following with respect to the settlement of the Accident Benefit file and/or the mediation:

> "Further to our conversation this afternoon, we do not think it would be advisable or entirely appropriate for Wawanesa to settle the claimant's file tomorrow, in light of the ongoing priority dispute, our position is as follows:
>
> > The Commonwell cannot pre-approve any settlement at the Case Conference tomorrow and has not been provided full information to be able to do so
> >
> > The Commonwell specifically reserves its right to contest any settlement at a later date
> >
> > The Commonwell requests to be provided with [the claimant's] complete AB file and a current accounting of benefits paid to date"

The email also confirms that they will be proceeding with the Appeal of the priority decision.

The Case Conference proceeded on August 13. Settlement was not discussed. A Hearing date was scheduled from May 11 to 22, 2020. Of note is the fact that the hearing date would take place before the date ultimately scheduled for Commonwell's Appeal.

By way of email dated August 28, 2019, Wawanesa provided to counsel for Commonwell a complete copy of the claimant's AB file.

By email dated September 13, 2019, Commonwell, through their counsel, was advised by Wawanesa that a mediation would likely be scheduled joint tort and AB at the end of the month. There was no response to that email. Specifically, counsel for Commonwell did not request further information with respect to the mediation nor did they seek to attend or have input into any settlement.

The mediation took place with Paul Torrie as the mediator. The AB file settled on a full and final basis at the mediation on October 28 but was subject to Court Approval. The claimant had been found to lack capacity through a Capacity Assessment Report from Louise Silverston dated May 5, 2018.

Court Approval was ultimately secured and a Judgment issued and entered on January 31, 2020.

In July of 2020 Commonwell abandoned the Appeal with respect to the priority dispute.

Wawanesa requested reimbursement from Commonwell with respect to the past benefits paid and the lump-sum settlement. As noted, Commonwell agreed to pay the past benefits but took issue with the lump-sum settlement which resulted in this reimbursement/quantum dispute.

Turning now to the Accident Benefit file of the claimant.

B. Accident Benefit File

The claimant was born on February 26, 1994 making her 21 years old when the accident occurred on April 13, 2015.

The accident was a significant one. She was struck by a motor vehicle while walking across the street. According to the police report, the vehicle failed to stop and struck the claimant travelling at approximately 15 km/hr.

According to the Ambulance Call Report, the claimant was "run over totally by the car and dragged by the back end of the car for approximately 10 m".

The hospital records indicate that she was airlifted to Sunnybrook Hospital and remained there until May 2, 2015. The discharge summary confirms the following injuries:

- Left mandible fracture
- Left-hand first MCP fracture and lacerations
- Scapular fractures
- Left distal radius and ulna fracture
- Rib fractures
- Bilateral pneumothorax
- Left 1-5 bilateral clavicle fracture
- L-3 burst fracture
- A scalp laceration (right temporal)
- Chin laceration
- L-4 wedge compression fracture

Of significance is the fact that the claimant had a seizure while in Sunnybrook Hospital. However, she had a previous seizure disorder secondary to an earlier traumatic brain injury and was on Dilantin. While in hospital she underwent a number of surgeries to deal with her fractures.

At the time of the accident, the claimant was living with her mother. I set out in some detail in my priority decision the background, education, and employment of the claimant. However, for the purposes of this quantum dispute, it is to be noted that she had recently started work through an employment agency as a general labourer/automotive assembler. She was working full-time and had been employed in that capacity for roughly 9 or 10 months. She only had a grade 8 education. It was determined by Wawanesa that she was entitled to an income replacement benefit of $250.59 per week ($13,015.08 per year) (it is agreed the adjuster's math was inaccurate).

A review of the extensive medical documentation produced for the quantum hearing supported that the claimant post-accident was diagnosed with a mild traumatic brain injury super imposed on a pre-existing seizure disorder, an adjustment disorder, soft-tissue and orthopaedic injuries, and scarring. The records suggest that the accident caused some serious emotional problems.

According to the capacity assessment that took place on May 5, 2018 the claimant was dependent for care and activities of daily living on her mother and stepfather. The mother reported significant ongoing pain behaviours, marked personality issues and temper problems that had become unpredictable and out of proportion.

During the course of the assessment, Ms. Silverston noted that the claimant displayed resentful opposition attitude, an extremely argumentative response, and an aggressive stance. While she agreed to participate she was barely able to tolerate the assessment process. There was evidence of extreme symptoms of behavioural dysregulation and disinhibited response with socially inappropriate traits. This was out of keeping with her pre-accident persona.

Ms. Silverston concluded that the claimant was unable to appreciate or understand the role or function of legal counsel. She couldn't' comprehend or understand how she might budget any monies or benefits. She did not understand her accident diagnosis and how that might impact her life. She described the claimant as severely compromised and was not capable of making decisions with respect to her property, decisions regarding Accident Benefits, or other related legal matters. Ms. Silverstone concluded and I quote:

> "The claimant has impaired insight, judgment, and inability to understand how her diagnosis affect her. Her symptoms are also unpredictable, with frequent, daily, unprovoked unreasoned verbal aggression devoid of the understanding she requires to make informed capable decisions or to appreciate the reasonably foreseeable consequences of making or not making requisite decisions at this time".

I note that the claimant appeared before me at the hearing of the priority dispute. Efforts to try to have her attend and provide evidence in a non aggressive and appropriate manner failed. Ultimately, we were unable to proceed with the evidence of the claimant at the priority hearing. Her presentation at the hearing was consistent with the presentation at the capacity assessment.

An occupational therapist prepared an attendant care assessment in advance of the claimant's discharge from hospital which recommended more than $9,000.00 a month in attendant care assistance.

A Section 44 in-home assessment completed in January of 2016 concluded that the claimant only needed $414.65 per month in attendant care. The OT noted complaints of pain, that the accident had taken an emotional toll on the claimant, and that there were memory issues. The claimant's mother told the OT that she did not like to leave her daughter alone. $5,981.14 had been paid in attendant care. The LAT Application claimed entitlement to attendant care in the amount of $2,585.35 per month commencing February 3, 2016.

With respect to income replacement benefits, prior to the settlement the claimant was paid $28,909.26 for income replacement benefits. The benefit had been denied in 2017 based on a series of Section 44 assessments. The assessments were dated June 19, 2017 and included a functional capacity evaluation, an orthopaedic assessment, a transferrable skills analysis, and a psychological evaluation. The assessors concluded that the claimant did not currently meet the post-104 week test as she did not have a complete inability to carry out any employment for which she was reasonably suited by education or training.

The psychological assessment noted that the claimant was still struggling with psychological distress directly attributable to the accident. She had some symptomology of post-traumatic stress disorder. She was diagnosed with an adjustment disorder with mixed anxiety and depressed mood. However the assessor felt that would not be a barrier to the claimant becoming

involved as a retail sales clerk, kiosk sales clerk, care rental agent, news stand clerk, and rental agent, leasing clerk or retail sales clerk.

When the FAE was completed the assessor noted that the claimant described several angry outburst followed by moments of crying. She did not want to continue with the evaluation and wanted to go home and ultimately the evaluation was terminated and questionnaires had to be completed by the claimant after the assessment with the assistance of her mother. Income replacement benefits were in dispute in the LAT Application. Prior to the LAT Application being commenced, the claimant had a report dated August 28 2017 from Rehabilitation Management (proposed case manager) where Barbara Huisman opines that the claimant continues to need assistance with personal care, housekeeping, and remains disabled from returning to work. Ms. Huisman conducted a detailed review of the file and noted that these conclusions were consistent with reports from her treatment providers and her family doctor. Her family doctor, Dr. Maury, had confirmed on July 27, 2017 that due to both physical, psychological, and cognitive problems the claimant was unable to return to work.

On the issue of catastrophic impairment, there were two competing series of reports: one from the insured and one from the insurer. It is to be noted that the clamant had used up her $50,000.00 available medical and rehabilitation limits by August 9 2016, approximately 16 months post-accident.

The insured claimed she met catastrophic impairment on a number of criteria. First of all, she claimed entitlement pursuant to Chapter 14 of the AMA Guides. Based on a report from Dr. Gilman, a neuropsychologist, she claimed entitlement based on a Class 5 impairment in adaptation, and a Class 4 impairment in activities of daily living. This would qualify her under criteria 8 of the catastrophic impairment definition pre-June 2016.

In addition, the claimant had a report from Dr. Waisman, a psychiatrist, who concluded that she had two Class 4 impairments: one in social functioning and one in adaptation.

The claimant also took the position that she was catastrophically impaired based on criteria 7. That is that she had a combined physical and psychological impairment greater than 55% again pursuant to the AMA Guides 4th edition. In that regard the reports suggested she had 62-66% whole person impairment. The breakdown is set out below:

- Neck 5%
- Thoracic spine 5%
- Lumbosacral spine 5%
- Post-traumatic scarring 3%
- Left distal radius and ulna fractures with residual loss of motion/nerve entrapment 14%
- Psychological 49%
- Neurocognitive disorder 8%

The insurer arranged for Section 44 assessments. Their report was completed on October 1, 2018 and concluded that the claimant was not catastrophically impaired based on either criteria. She was given four Class 2 impairments under Chapter 14 of the Guides and a 41% impairment with respect to criteria 7.

The insurer's assessors included a neuropsychologist, orthopaedic surgeon, plastic surgeon, psychiatrist and neurologist. Efforts were made to have an occupational therapist complete an assessment but the claimant was uncooperative and the OT was unable to proceed with the assessment. The OT reports that the claimant began to cry and yell. She said she did not want to participate in any other assessments. She repeatedly asked to discontinue the assessment and ultimately the OT determined that she was not going to be able to complete a proper assessment in light of the claimant's presentation.

The breakdown of the 41% whole person impairment is set out below:

- Spinal impairment 10%
- Skin impairment 9%
- Neurological impairment 1-3%
- Plastic surgeon/left-finger stiffness 3%
- Psychological 5%
- Neurocognitive disorder 16%
- Total 41%

With respect to the issue of housekeeping, as the clamant had not been determined to be catastrophically impaired, there was no housekeeping submitted or denied as it did not become a potential claim until a catastrophic determination.

C. Claims Handling by Wawanesa

The Adjuster for Wawanesa was examined under oath on March 11, 2021.

By way of background, the adjuster had been employed by Wawanesa since 2007 in the capacity of an Accident Benefit adjuster. She had worked in the industry for 20 years as an Accident Benefit Adjuster. She handled this file from its inception through to the settlement.

On the issue of attendant care, the adjuster confirmed that initially there were some incurred expenses from AGTA that were paid by Wawanesa. However, before the settlement was entered into, there were no other invoices submitted establishing that attendant care had been incurred subsequent to the AGTA services in May of 2015.

She was also asked why no Section 44 assessments had been completed on the attendant care issue. The one and only Section 44 assessment that had taken place was in January of 2016 where

attendant care had been assessed at $414.65 per month. The adjuster indicated that as the insurer took the position that the claimant was not catastrophic and 2 years had passed that it was not appropriate to conduct a Section 44 assessment.

Also, she reported that there was a risk in light of the claimant's presentation that if a new Form 1 was requested and a further Section 44 took place that there was a strong possibility that the claimant's attendant care needs would be assessed at greater than $414.65 per month.

On the issue of incurred, the adjuster acknowledged that it was her understanding that attendant care services being provided were by the mother and there was no evidence that would meet the definition of incurred under the *Statutory Accident Benefits Schedule*. It was also relevant that the claimant herself had said she did not want anyone coming into the home to provide attendant care.

As to how the adjuster calculated the potential exposure for attendant care, a log note entitled "AB breakdown of settlement thoughts" dated October 12, 2019 indicates the following:

> "Attendant care – our last Form 1 and I know this would be re-assessed, is $414.65 per month that for a 10 year period is $49,758.00"

The adjuster was asked on her EUO as to why she used a 10 year number. Her answer was "10 years was just a number I used as a compromised number". This was in reference to the potential catastrophic risk, which will be commented on shortly.

The adjuster also pointed out that the Form 1 she used to calculate the potential exposure was the lowest Form 1 and not reflective of the amount being claimed at the Tribunal.

When asked whether she considered the fact that the benefit had not been incurred in 3 ½ years, the adjuster indicated she did consider that and that was reflected in the amount and the time period for which she allocated possible risk. She also reported that her assessment of the risk was based on her experience.

She was also asked what she meant from her log note indicating "I know this would be re-assessed". Her response was that if the claimant was found to be catastrophic at the hearing then in her experience an updated Form would usually follow.

The amount allocated to attendant care in the Settlement Disclosure Notice was $50,000.00 consistent to the range and risk proposed by the adjuster.

With respect to income replacement benefits, the adjuster's log noted above with respect to the income replacement benefit suggests the following:

> "IRB - $250.59 per week (WR $13,030.66) for a 10 year period $161,130.00".

The Settlement Disclosure indicated $150,000.00 for income replacement benefits.

In her EUO, the adjuster was asked about the Section 44 post-104 week income replacement benefits which the insurer had relied upon to terminate that benefit in 2017. The adjuster indicated that the post-104 week test was a harder test for the insured to meet. Her impression about the Section 44 reports were that "they were fine". She did not identify anything of concern to her that might sway an Arbitrator to find the claimant met the test for income replacement benefits. She also gave evidence that from the time those assessments were received in June of 2017 up until the file was settled in October of 2019 that she could not recall receiving any expert reports from the claimants counsel on post-104 week entitlement.

Commonwell's counsel to put the adjuster that at the time the file was settled that Wawanesa's position on the IRB was quite strong as the Applicant had not produced their own report suggesting there were any flaws in her assessor's report. She agreed with that statement.

The adjuster was also examined extensively with respect to her assessment of catastrophic risk, which to some extent was reflected in her choice of the 10 year period that she allowed for attendant care.

The Section 44 CAT reports established that the claimant had a 41% whole person impairment. In the adjuster's opinion, this established a high catastrophic risk. The claimant was young. She had orthopaedic injuries. She had cognitive injuries. The adjuster indicated that she did not feel that the insurer CAT assessments were strong. Her evidence was also that the CAT reports would reflect the potential exposure for income replacement benefits both the reports from the claimant and from the insurer.

With respect to medical and rehabilitation benefits, the adjuster's settlement log note indicates the following:

> "For settlement purposes I have looked at a 10 year period under each category of benefit. 1. Med rehab as the limits were reached I used a number of $2,000.00 per month for a 10 year period $240,000.00 (physio/massage/prescription/rehab/transportation/ case management/psych (the claimant does not have EHC available)".

On her EUO the adjuster pointed out that the claimant had used up her med rehab limits of $50,000.00 approximately a year and a half after the date of the accident. She had been without treatment for sometime. There was a CAT risk and if found to be CAT she would be entitled to $1,000,000.00 under med rehab. Based on her impairments, the adjuster felt that exposed the insurer to case management services. She noted that the claimant smoked a lot of medicinal marijuana. There was also potential for psychological treatment based on her impairments as well as physiotherapy.

With respect to the $2,000.00 a month that was chosen to assess potential future med rehab. The adjuster said for the most part she was relying on her years of experience. As treatment stopped about a year and a half into the claim, there was no regular treatment that one could look at to determine a possible monthly rate. She described her number as a compromise based on her experience and the potential risk. $200,000.00 was allocated for med rehab in the Settlement Disclosure Notice.

Turning to housekeeping, the log note indicated the following:

> "Housekeeping – using a number of $50.00 per week for 10 years $26,000.00".

On the EUO the adjuster acknowledged that other than some housekeeping expenses submitted in June of 2016, that no other incurred housekeeping expenses had been submitted over the course of the 3 years leading up to the settlement. She was asked to confirm there had been no Section 44 assessment to assess housekeeping. She acknowledged there was not and when asked why not she confirmed that she could not do that as the claimant had not been accepted as catastrophic and there was therefore no housekeeping benefit entitlement.

$25,000.00 was allocated to housekeeping in the Settlement Disclosure Notice for the lump-sum settlement.

The adjuster also gave evidence that once she put her thoughts of settlement down after reviewing the file as reflected in her log notes that she then had to go up another step on the ladder to secure approval for her recommended authority. She did do that and total authority rounded up to $500,000.00 was granted inclusive of costs and disbursements.

The adjuster was also asked about why she did not seek approval from Commonwell with respect to the range of settlement she was considering either before, during, or after the mediation. The adjuster responded that it was her duty to continue to handle the claim as it was considered a Wawanesa claim until priority was accepted and priority had not been accepted by Commonwell at that point. The adjuster's evidence was also that she did not believe that she needed to seek approval from Commonwell for the settlement.

The adjuster was also asked whether the fact that the Arbitrator had already ruled that Commonwell was the priority insurer factored into the calculations that the adjuster had made for potential settlement. Her response was "absolutely not". She further went on to say:

> "If this was, umm… if this claim is a Wawanesa claim I would be happy with the settlement that I made on this claim".

Position of the Parties

The parties do agree as to the applicable law with respect to the issue of the reasonableness of the payments made by Wawanesa to the claimant.

Firstly, the parties agree that the onus of proof is on Commonwell. Secondly, the parties agree that the test is whether or not Wawanesa grossly mishandled or was grossly negligent with respect to the lump-sum settlement of the claim. Again, the parties agree that the test of whether a payment or settlement is grossly unreasonable can include the following criteria:

1. The handling insurer acted in bad faith.
2. The handling insurer made payments that were not covered under the Statutory Accident Benefits Schedule in existence at the time of loss.
3. The file was handled generally so negligently so that the payments made were greatly in excess of that which the insured would have been entitled to had the file been managed by a reasonable claims handler.

The parties then apply that test to each of the benefit categories that were the subject matter of the lump-sum settlement. It is the application of the test to the lump-sum payments where the parties differ.

Wawanesa takes the position that the lump-sum settlement was not made in bad faith, that the payments made were covered under the Statutory Accident Benefits Schedule, and finally that the file was not handled in a negligent fashion so that the settlement was not in excess of what it might have been settled for otherwise.

Commonwell takes the opposite position with respect to each category of benefits.

Income Replacement Benefits

Commonwell argues that the income replacement benefit settlement in its entirety should not be awarded to Wawanesa. Commonwell points to the following issues:

1. Commonwell was not consulted with respect to the settlement beforehand nor was its approval sought despite Commonwell having previously advised Wawanesa they objected to Wawanesa settling the file on a full and final basis.
2. Wawanesa had strong Section 44 income replacement benefit assessments that they had based their denial on. The adjuster agreed on her EUO that she thought the reports were strong.
3. Prior to settling the file, Wawanesa did not receive any expert reports from counsel for the claimant which would have challenged Wawanesa's Section 44 assessments.

4. No updated OCF-3 had been received after the Section 44 IRB reports to support the claimant's entitlement to the IRBs even though one had been requested.
5. The use of a 10-year period as a compromise period for settlement was unreasonable and in fact Wawanesa ended up paying $150,000.00 in IRBs, which Commonwell calculates out to 11 ½ years, not 10.
6. The LAT Hearing was not scheduled to start until May of 2020 so there was no urgency to settle the file in October/November of 2019.
7. The degree of risk with respect to the income replacement benefit was low and therefore did not justify paying a 10+ year exposure. There were other alternatives such as settling for less, reinstating benefits, or proceeding to a hearing.

Commonwell submits that no income replacement benefits should be awarded or reimbursed to Wawanesa.

Wawanesa on the other hand submits that the settlement of the income replacement benefits was reasonable in all the circumstances taking into consideration the risk and the nature of the insured's injuries. Wawanesa points to the following:

1. The Section 44 assessments that cleared the claimant to return to work were not strong. The Vocational Assessment noted a grade 8 education only. On assessment, the claimant discontinued the FAE before attempting the test. She did not make eye contact, she was abrupt.
2. The Section 44 neuropsychological report of Dr. Ladowsky-Brooks diagnosed the claimant with a mild neurocognitive disorder. Dr. Ladowsky-Brooks stated that the claimant's adaptation to any work setting at the time of her assessment would be quite poor.
3. While there was not a specific expert report dealing with entitlement to the post-104 week in August 2017, there was a report from the proposed case manager which indicated the claimant was disabled form returning to work. In addition, while not specifically reports for income replacement benefits, the claimant's catastrophic reports indicated she sustained a marked impairment in adaptation which clearly reflects on an ability to work. She also had up to 66% whole person impairment which would reflect on an ability to be employed.
4. The claimant had been found to lack capacity in May of 2018 due to extreme behavioural dysregulation and disinhibited responses with socially inappropriate traits. The assessor found her to have impaired insight and judgment. If a claimant was not capable of making decisions regarding property and related legal matters then Wawanesa raises a question as to whether the claimant would be employable.
5. Wawanesa gave Commonwell an opportunity to become involved in the mediation and/or involved in the possible amount of settlement proposed and Commonwell declined to be involved. Wawanesa's position is that it had the right to enter into a settlement at the mediation irrespective of Commonwell's email telling them not to so proceed.

6. The income replacement benefits had been terminated in June of 2017 and therefore the settlement not only reflected past benefits but future benefits in keeping with the 10 years compromise proposed by the adjuster. Considering the claimant's injuries and risk, the settlement was reasonable.
7. As to the suggestion that an alternative would have been to reinstate the benefit, Wawanesa submits that position is disingenuous and ignores Commonwell's other submission seeking to minimize the nature of the impairments and the risk of taking the matter to a hearing. Settlement is better than reinstatement and a possible hearing later on down the road.
8. With respect to the suggestion that Wawanesa simply proceed to a hearing, Wawanesa points out that there was no undertaking that Commonwell would pay legal fees involved in the handling of the LAT hearing while the appeal was in limbo and also gave no consideration to the risk of success at that hearing.

Catastrophic Impairment

With respect to catastrophic impairment, Commonwell points to the Section 44 assessments completed at Wawanesa's request which concluded that the claimant was not catastrophically impaired.

In its submissions, Commonwell seems to accept that the combined Section 25 and Section 44 reports raised the question of catastrophic risk. Their position is that the level of that risk was not recognised by the adjuster and the 10 year period she chose as a compromise period for catastrophic risk was unreasonable. Commonwell points to the fact that while the claimant did use up her non-CAT limits in 1 ½ years post-accident that in the 2 years prior to the LAT Application, no OCF-18s had been submitted and no medical expenses were submitted suggesting that treatment or other needs was warranted for the 10 year period. The majority of Commonwell's submissions on the catastrophic risk is done on a benefit analysis as opposed to an injury category analysis.

Wawanesa points to the fact that this was a pre-June 2016 accident and that the claimant only needed to suffer 1 marked impairment in one of the four spheres of function to be found to be catastrophically impaired. With its own reports concluding the claimant had 41% whole person impairment, this opened up a second level of exposure based on the other catastrophic criteria. A 10 year potential future exposure was more than reasonable considering the risk that the claimant would be found catastrophic at a hearing.

As with the income replacement benefit, Wawanesa points to the report of Dr. Ladowsky-Brooks, which while not being a specific CAT report did suggest the claimant's ability to adapt to any work setting at the time of her assessment in June of 2017 would be quite poor.

Housekeeping and Home Maintenance

Both parties agree that the claimant would only be entitled to housekeeping and home maintenance if she were found to be catastrophically impaired. Commonwell submits the following basis to support their position that the settlement of $25,000.00 met the "unreasonable test".

1. There was no evidence that housekeeping expenses were ever submitted after June of 2016.
2. There was no evidence that the claimant needed to hire a housekeeper or intended to hire a housekeeper.
3. The adjuster agreed that an OCF-3 would have been required at minimum in order to assess entitlement to a housekeeping benefit and that she did not have an updated OCF-3 at the time of the settlement.
4. There were no functional impairments that clearly were identified in the Section 44 CAT and income replacement reports that suggested a significant housekeeping exposure risk.
5. In assessing risk, the adjuster failed to take into sufficient consideration that the benefit had to be incurred as defined under the Statutory Accident Benefit Schedule for it to be payable.
6. Commonwell submits that where there is no evidence that the benefit actually was or would be incurred then it is not a benefit payable under the Statutory Accident Benefit Schedule.

Commonwell submits that no housekeeping should be awarded.

Wawanesa submits that the $25,000.00 allocated for housekeeping based on $50.00 a week for 10 years is a reasonable compromise taking into consideration the nature and extent of the injuries and the risk of a catastrophic determination. Wawanesa relies on the following:

1. The claimant did initially submit housekeeping. AGTA provided some housekeeping services and an invoice was submitted but not initially paid as the claimant was not found to be catastrophic.
2. It makes no sense to suggest Wawanesa should have requested an updated OCF-3 in the absence of a catastrophic determination, as no housekeeping benefits were payable until there was such a determination.
3. As the settlement was for future benefits, there could never be any evidence that the benefit would be incurred in the future as the very definition of incurred requires that the services has been provided and that an expense has resulted. If to settle a file for future benefits, evidence that it would be incurred in the future is required then no catastrophic files would ever settle on a lump-sum basis.

Medical and Rehabilitation Benefits

Commonwell is prepared to acknowledge that some payment for future medical and rehabilitation benefits would have been reasonable for the purposes of a full and final settlement of the claimant's file. They submit that amount would be $50,000.00 as that would match the amount of payments that had been made prior to the settlement. Commonwell resists the $200,000.00 actually paid. The basis for Commonwell's position is set out below. I do point out that a number of the arguments set with respect to the income replacement benefits for both parties applies equally to all benefits:

1. The 10 year rate is not a reasonable reflection of risk with respect to catastrophic impairment and the need for medical and rehabilitation benefits.
2. The use of $2,000.00 a month for a proposed burn rate which was based on the 8-9 months prior to the non-CAT limits running out, does not fairly reflect a potential future exposure. It is reasonable to assume that the claimant's needs would have been lower as you move forward into the future and to use a burn rate created in the immediate aftermath of the accident is unrealistic.
3. Even if the $2,000.00 per month used by the adjuster is not reflective of any particular burn rate, it still does not reflect a realistic assessment of the claimant's needs on a go forward basis.
4. In considering the type of expenses that would be covered for the future benefit, the adjuster looked at physio, massage, prescriptions, rehab, transportation, case management, and psychological treatment. Commonwell notes that no OCF-18s had been submitted in the 2 years prior to the LAT Application and that there was no medical evidence to support that type of treatment was needed by the claimant ongoing for a period of 10 years.
5. Specifically with respect to psychological treatment, it was noted that Wawanesa had never paid for psychological treatment before and no records were produced from a psychologist or a psychiatrist.
6. Wawanesa should have considered the other option that rather than paying an excessive 10 years of benefits that they could have accepted the claimant as catastrophic and adjusted the file.

Wawanesa takes the position that the $200,000.00 paid is a reasonable settlement and reflects the medical information and risk on the file. Wawanesa points to the following:

1. This was a complicated claim involving a young woman with significant orthopaedic injuries, a brain injury, and mental health problems all fully evidenced through appropriate medical evidence and expert reports. The claimant exhausted the available $50,000.00 in med rehab benefits within 16 months of the accident suggesting significant and ongoing needs.

2. The claimant's failure to attend treatment or to submit treatment plans subsequent to the limits running out can be explained by the unavailability of funds, and her psychological impairments which may have impacted her motivation to attend treatment.
3. The case manager report from August 2017 indicated that the claimant needed ongoing physiotherapy, occupational therapy treatment, psychological treatment, and treatment with a physiatrist with an expertise in brain injury.
4. If the claimant had been found CAT a note should be made of the fact she lived in a remote rural location in Melancthon and therefore would have some significant transportation needs to access treatment.
5. Considering that if found CAT the claimant would have access to $1,000,000.00 a settlement of $200,000.00 was reasonable.

Attendant Care

Commonwell takes the position that the amount being claimed by way of reimbursement for attendant care of $50,000.00 is not reasonable and should not be reimbursed at all. Commonwell's position in that regard relies on the following:

1. Up to the time of settlement a total of $5,981.14 had been paid from the available $36,000.00 limits for attendant care.
2. There was no evidence that the claimant incurred any attendant care expenses after the expenses paid noted above up until the time of the settlement.
3. The adjuster calculated the attendant care exposure based on a Form 1 in the amount of $414.65 per month that was from 2016. This did not fairly reflect the claimant's current needs and should not be relied upon to reflect future needs.
4. Wawanesa failed to request an updated Form 1 or arrange for a Section 44 assessment before completing the settlement.
5. In calculating the future and relying on the 10 year period with respect to a risk analysis the adjuster failed to take into consideration the need that the benefit had to be incurred in order for there to be a future payment.
6. The adjuster admitted on her EUO that the assessment of risk was not based on any recent OT assessment or anything from the family doctor to suggest that the claimant required that level of care.

Wawanesa says the $50,000.00 is a reasonable settlement taking into consideration catastrophic risk, the claimant's impairments, and potential attendant care needs. Wawanesa relies on the following:

1. The claimant did actually incur attendant care early on.
2. There was a Form 1 in place at the time of the settlement approved by Wawanesa in the amount of $414.65 per month.

3. In light of what had occurred subsequent to that Form 1 being generated in 2016, there was a high risk if a new Form 1 had been requested that it would have come in at a higher amount.
4. Commonwell's position that future benefits have to be incurred does not make sense as a benefit cannot be incurred until the person actually receives the services.
5. While evidence of past incurred may be instructive in some cases, it does not always dictate potential future incurred expenses particularly on a file where there is significant CAT risk.
6. Given that the claimant had been found to lack capacity due to her behaviour, it was possible, if not likely, that a significant increased Form 1 would have been submitted that included 24-hour supervisory care.

Decision and Analysis

The law with respect to whether or not a payment is reasonable in the context of a priority dispute now seems to be reasonably well settled. As noted earlier, the submissions of both Commonwell and Wawanesa suggest that there is no dispute between them as to the applicable standard of care.

The inquiry into whether or not the payments made are reasonable, the following questions are to be asked:

1. Did the handling insurer (Wawanesa) act in bad faith.
2. Did the handling insurer make payments that were not covered under the Statutory Accident Benefits Schedule that were in existence at the date of loss.
3. Did the handling insurer deal with the claim so negligently that the payments that were ultimately made were greatly in excess of what the insured might have been entitled to had the file been managed by a reasonable claims handler.

This was set out in my decision in *Commercial Union Insurance Company of Canada v. The Boreall Property and Casualty Company* 1998 CarswellOnt 7744. It has been followed in a number of decisions. It is helpful to review some of those decisions and apply their analysis to the facts of this case. #1 is that of Arbitrator Lee Samis in *Royal and Sun Alliance v. Wawanesa Mutual Insurance Company* decision dated April 17, 2012. While this was a loss transfer case, some of Arbitrator Samis's comments apply equally to a reimbursement decision as between two insurers in a priority matter. He noted that when looking at the claims handling decision in cases such as this they must be looked at realistically. He stated:

> "Perfection is unrealistic. Well informed claims experts will often disagree about claims decisions. The existence of such disagreement surprises no one and is far from sufficient to negate an insurer's statutory right to reimbursement.

> At the other end of the spectrum, claims handling that is so deficient from any standard of due diligence, showing an indifference or disregard of ordinary prudent claims handling procedures should not be sanctioned by blindly ordering full reimbursement at the expense of the responding insurer. That insurer has had no opportunity for input in the claims handling decisions".

I also reviewed the decision of *Jevco Insurance Company v. Gore Mutual Insurance Company* (Shari Novick February 2013). This also involved a loss transfer claim. In that case it was alleged that Jevco had failed to suspend benefits when the insured did not comply with the statutory requirements, it had failed to conduct Section 44 assessments with respect to income replacement benefits, and failed to follow up on recommendations with respect to retraining and vocational assistance. Arbitrator Novick found that Jevco had acted unreasonably and limited reimbursement accordingly.

Her decision was appealed to Justice Stewart who upheld the decision (2014 ONSC 3741 CanLII). Justice Stewart noted that the onus is on the second party insurer resisting the reimbursement to prove the payments made were unreasonable. Justice Stewart noted that the onus is a strict one. The second party insurer must demonstrate that either there was bad faith in the handling of the claim by the first party insurer or that the first party insurer grossly mishandled the claim so that the amounts that it is seeking to recover will be considered grossly unreasonable.

#2 Cases that I found of assistance were two decisions of Arbitrator Bialkowski. The first is in the case of *Intact & Aviva* (decision October 16, 2020) and the second a very recent decision in *Unifund Insurance Company & Chartis Insurance Company of Canada* (May 13, 2022.). In regards to the latter decision this was released after counsel had made submissions. I provided them with a copy and gave them an opportunity to make submissions and both counsel did so.

The first decision of Arbitrator Bialkowski's referred to above was a reasonableness of payments in a priority dispute context. The second one was with respect to loss transfer. I note that Arbitrator Bialkowski adopted the 3 stage process for considering the reimbursement of priority disputes that was established in my decision of *Economical Mutual Insurance Company & Echelon General Insurance Company* (decision dated December 7, 2017).

Arbitrator Bialkowski found that there was a heavy onus on a party that disputes the reasonableness of payments whether we are looking at a priority or loss transfer dispute. However, each case has to be decided on its own facts. I agree with Arbitrator Bialkowski.

In the Unifund and Chartis case the issue involved a full and final settlement made at a private mediation in the amount of $630,000.00 on February 7, 2019. As in this case, up until the time of settlement, all previous requests for indemnity had been paid by the respondent. Chartis took the position that the settlement constituted bad faith or gross mishandling. In that case contrary to the one before me, Unifund had produced the legal opinion it had secured in advance of the full and final settlement of the mediation to support its position that the settlement was a

reasonable one. In this case, while there may have been such an opinion it was not before me nor was it provided to Commonwell. However, I do note that Wawanesa was represented by counsel at the mediation. In his decision, Arbitrator Bialkowski looked at each of the various benefit headings that made up the full and final settlement. He looked at the medical evidence, whether there was conflicting medical evidence, and he looked at potential risk. He also applied his 46 years of experience as counsel, mediator, and Arbitrator with respect to how Accident Benefit files are commonly settled on a lump-sum basis. I do the same here.

It is also relevant to note in Arbitrator Bialkowski's most recent decisions that arguments were made before him as to whether one should look at each individual component of the lump-sum settlement on a per benefit basis to determine whether it was reasonable or to look at the total amount of the settlement in the factual context.

Arbitrator Bialkowski concluded that when assessing the reasonableness of payments in the context of a full and final lump-sum settlement of Accident Benefits, it is the overall amount of settlement that must be looked at rather that the individual components. He noted that to do otherwise could result in lump-sum cash outs leading to protracted it and costly litigation. In assessing this issue one should not be bound by the amount that is shown on a Settlement Disclosure Notice as that is not necessarily the statement of the consensus reached by the parties with respect to any particular component. Arbitrator Bialkowski found that it is the consensus of the overall settlement number that is relevant and if that is reasonable then that should be sufficient. He concluded and I quote:

> "I must agree that to require a review of the "reasonableness" of each component of the full and final settlement of an Accident Benefit claim as set out in a Settlement Disclosure Notice would severely restrict an insurer's flexibility and general ability to resolve matters and consequently lead to a disservice to claimants who would like their claims resolved once consensus has been reached on an overall settlement number. Accordingly, I find that when analyzing the reasonableness of payments of a lump-sum full and final settlement on an Accident Benefit claim, the reasonableness "of the overall settlement ought to be the consideration rather than the analysis of the individual components set out on the standard Settlement Disclosure Notice which may not be reflected of how the overall settlement was arrived in the minds of the 2 involved parties".

He concluded that in the case before him that the overall settlement was reasonable and could not amount to a gross mishandling. I agree with Arbitrator's Bialkowski's analysis and while I will review each individual component of the settlement entered into here, it is the overall lump-sum settlement and its reasonableness at the end of that analysis that will determine the outcome.

It is my decision, based on the above law, the applicability of the law to these facts, and my analysis that is set out below that the settlement in this case of $425,000.00 was reasonable and that Commonwell has not met its strict onus.

Catastrophic Impairment

I carefully reviewed the catastrophic reports from both the insured and the insurer I agree with Wawanesa that there was a significant catastrophic risk that the claimant would meet the test based on a class 4 impairment in adaptation. The fact that the claimant had been found to lack capacity, and the comments of the Section 44 neurophysiologist with respect to the question of adaptation in my view really set the scene for a finding by an Arbitrator that the claimant would be found catastrophic. Also in support of this is my impression of the claimant when she came before me as a witness in the priority hearing. She presented as a young woman with extreme emotional dysregulation, an inability to understand her circumstances, and how to present herself in a formal proceeding. In my view, she presented as I would expect an individual with a catastrophic impairment in the mental behavioural category.

I find that the risk of a catastrophic determination was heavily weighed in favour of the claimant. I find that the 10 year risk analysis applied by the experienced adjuster for Wawanesa was more than reasonable in the circumstances.

My analysis with respect to catastrophic impairment risk should be kept in mind when looking at the various benefit categories.

Medical and Rehabilitation Benefits

When this case settled the claimant was only in her mid-20s. She sustained significant injuries. She used up her med rehab available limits of $50,000.00 in approximately 16 months.

I do not agree with Commonwell that whether or not she submitted treatment plans in the 2 years prior to the settlement is a significant consideration. There were no funds available for medical and rehabilitation benefits other than through the OHIP system. The claimant did seem to be treatment resistant based on the medical information before me and she lived in a rural area.

In my view, Wawanesa was exposed to a potential lifetime claim for med rehab. This would include an occupational therapist, a case manager, a psychologist, possibly social worker. I find the burn rate of $2,000.00 that was used by the Wawanesa adjuster to have been reasonable. Possibly, it was even light. There was a distinct chance that if the claimant was found catastrophic that there would be a "front end loading" with respect to treatment to make up for lost time and the burn rate could have been much higher in the first 5 years albeit dropping off as time moved forward.

Overall, I find that the settlement of $200,000.00 was imminently reasonable in the circumstances of this case and I find that Commonwell is responsible to reimburse Wawanesa for the full $200,000.00.

I also consider here Commonwell's argument that when looking at all the benefit and the lump-sum settlement that reimbursement should be resisted because Wawanesa went ahead with the settlement despite Commonwell indicating in their email of August 12, 2019 that it would not be advisable or entirely appropriate for Wawanesa to settle the claimant's file tomorrow. I note that tomorrow was with respect to the Case Conference. Commonwell indicated it could not pre-approve any settlement for the next day because it did not have the full information to do so and that was certainly true. Commonwell did not comment in this email or in others as to whether it was prepared to attend a mediation as opposed to agree on some settlement before the Case Conference. The email of August 2, 2019, alludes to Commonwell reserving its right to contest any settlement at a later date and that right was reserved. The email, however, did not offer any hope to Wawanesa that Commonwell had any interest in participating in any settlement discussions or a mediation. In fact 2 emails with respect to the proposed mediation went unanswered.

The Case Conference date came and went on August 13, 2019. A follow up email was sent to Commonwell from Wawanesa's counsel (September 13, 2019) advising that a mediation was going to be scheduled at the end of the month. There was no response to that email.

I can find <u>no fault</u> in Wawanesa in these circumstances with proceeding forward to the mediation. They had an experienced mediator. They were faced with a hearing coming up the next year. They had no response from Commonwell with respect to whether or not they would approve any settlement or come to the mediation. Further at the time of the mediation, Commonwell was maintaining their position that they were not the priority insurer and that matter was under appeal. To find that Wawanesa could not proceed to a mediation in these circumstances would, as other Arbitrators have suggested, restrict an insurer's flexibility and general ability to resolve matters. Further, it would lead to a disservice to a claimant who reasonably wants to settle his or her file with the insurer that at the time is the one handling their accident benefit file.

Commonwell did not provide any case law to support their position that the insurer who is paying the benefits as the priority insurer has no right to proceed to settle that file in the absence of approval from the insurer against which they are claiming priority. In this case the fact that a priority decision had already been rendered finding Commonwell as the priority insurer is irrelevant. That was under an appeal and the appeal date was a number of months away and scheduled to take place after the hearing on the Accident benefit file. If I found that Wawanesa did not have the right to proceed with such a settlement it would severely tie the hands of first party insurers in getting files settled in situations such as this and result in unnecessary litigation and unfairness to the claimants.

Housekeeping and Home Maintenance

I find the modest settlement of housekeeping at $25,000.00 also to be more than reasonable. This was based on a 10 year period at $50.00 a week. The maximum of $100.00 a week was not used. While I agree with Commonwell that there was no evidence that the claimant would

actually incur these benefits into the future, I find that is not a requirement. As long as the medical reports established that there was a reasonable prospect that the claimant would require housekeeping services on the basis of entitlement to the benefit, I find it not unreasonable that an insurer would assume on acceptance of catastrophic risk that such a benefit would be incurred. I also agree with the adjuster's approach that in allowing the housekeeping benefit for only 10 years rather than lifetime that, that already discounted the potential exposure and would reasonably reflect a discount of entitlement flowing from the question as to whether or not it might be incurred.

I agree with Wawanesa that adjusters are entitled to exercise reasonable discretion in settling claims. As Arbitrator Samis pointed out, to expect perfection is unrealistic. I agree with Wawanesa's submissions that for future benefits to have to be "incurred" to be a benefit recoverable under the *SABS* for the purposes of reimbursement does not make a great deal of sense. Future benefits cannot actually be incurred until the claimant has actually received the services. In my 40+ years of experience, and in particular more recent experience as counsel in catastrophic cases dealing with the issue of incurred these cases of catastrophic risk are often if not, routinely settled on the assumption that the benefit might be incurred, in the future even if it was not incurred in the past but then an appropriate discount be applied to that benefit based on the risk it may not be incurred. I find that is what the adjuster did in this case. I find that the $25,000.00 allocation for housekeeping is reasonable.

Income Replacement Benefit

While Commonwell is right that the adjuster on her EUO gave evidence that she thought the insurer's exams relating to income replacement benefits that had resulted in the termination were good or strong reports, I find that there remained a significant risk that the claimant would be found to meet the post-104 week test. The IRBs were denied in 2017 based on reports dated June 19, 2017. A capacity assessment took place on May 5, 2018, and in my view that changed the landscape with respect to potential exposure for income replacement benefits. The capacity assessor noted that the claimant was barely able to tolerate the assessment process and had extreme symptoms of behavioural dysregulation with disinhibited response and socially inappropriate traits.

We then have the Section 25 catastrophic reports from 2018 and the Section 44 reports from October of 2018. Again, these all post dated the IRB termination. The Section 25 reports found she had a Class 4 impairment in adaptation. She had a psychological impairment of 49%. She had a 62% to 66% whole person impairment. Even the insurer's assessors had her at a 41% whole person impairment. This again, in my view, is inconsistent with someone with this lady's background, education, and experience in being employable as a retail sales clerk, kiosk sales clerk, car rental agent, newsstand clerk, or rental agent clerk. All of these jobs identified by the vocational assessor in the post-104 Section 44 reports involved interaction with the public. Based on my review of the claimant, she would not be employable in that capacity.

I therefore find that the settlement for the income replacement benefits was fair and reasonable and that there was no evidence that it was made in bad faith or that the adjuster was grossly negligent in her approach and assessment of the file.

I also want to comment on Commonwell's suggestion that it would have been better for Wawanesa in the circumstances in this case to either go to a hearing or to accept the claimant as catastrophic and/or reinstate income replacement benefits. In my experience, and as indicated by the adjuster in her EUO, this is really a last resort by an insurer. If one reinstates benefits it is always hard to initiate a termination again. An acceptance of catastrophic impairment opens the door to potential exposure for increased benefits over and above what may be contemplated by a settlement particularly in someone of a younger age. Lastly, to suggest that proceeding to a hearing instead of settlement is not tenable in these types of cases. That would expose both Wawanesa and the claimant to legal expenses that are not recoverable at the Licensing Appeal Tribunal for either party. Settlement is always preferable rather than proceeding to a hearing with an unknown result and at some significant cost.

Attendant Care

I also find the amount of the attendant care settlement to be reasonable. Once again my analysis above is relevant in terms of the attendant care settlement both with respect to potential catastrophic risk, the use of the 10 year period, and the compromise or discount for the potential issue of incurred.

In this case much was made by Commonwell of the fact that Wawanesa had relied on an old Form 1 from 2016 in the amount of $414.65 per month. I find that to be reasonable approach. I agree with the adjuster that if the claimant was found to be catastrophically impaired, or if the adjuster had asked for an updated Form 1 that the likelihood is it would have come in with much higher amounts considering what had occurred since the Form 1 in 2016. Once again, we have a claimant lacking capacity. We have a claimant with behavioural problems. I agree with Wawanesa that one could argue that a new Form 1 could have required 24 hour care.

I have already commented that I disagree with Commonwell with respect to whether or not proof was required that the attendant care benefit would be incurred into the future. In the circumstances of this case I find the settlement of attendant care at $50,000.00 to be imminently reasonable and I award that reimbursement.

Overall Settlement

I have already found that each of the components of the settlement was reasonable but I also want to comment on the totality of the settlement at $425,000.00. A review of the claimant's injuries, her age, and her impairments at the time the settlement was entered into, and the pending hearing all point to the efficacy of entering into a settlement at the mediation in October

of 2019. There was an experienced mediator present. After the settlement of $425,000.00 was entered into, it proceeded forward to court approval which was later secured.

I find that $425,000.00 is within the expected range of settlement for an Accident Benefit file in the circumstances of this case.

I do not find there was any bad faith or gross mishandling of the file with respect to the development of authority or the settlement of the benefit at the mediation.

On the evidence before me, I conclude that the overall settlement was reasonable and that Commonwell did not meet its onus to demonstrate either gross mishandling or bad faith.

I therefore find that Wawanesa is entitled to indemnity for the full amount of the disputed claim of $425,000.00.

Interest

Wawanesa claims pre-judgment and post-judgment interest on the amount that was not in dispute in this hearing and that was paid by Commonwell after it chose not to proceed with an appeal on the priority decision. That amount was $153,833.50. Wawanesa claims pre-judgment interest on that amount at 1% up to May 8, 2019 from the date the cause of action arose. It then claims post-judgment interest on that amount after May 8, 2019 based on the Order that concluded Commonwell was the priority insurer. Wawanesa's position is that once it was determined by me that Commonwell was the priority insurer that post-judgment interest flows.

With respect to the amount that was paid of $153,833.50, Commonwell's position is that only pre-judgment interest is payable. It submits that there was no Order made in May of 2019 that Commonwell owed Wawanesa any monies. The Order was only with respect to determining that Commonwell was the priority insurer. Commonwell submits that in the absence of an Order specifically for the payment of money that only pre-judgment interest runs. Post-judgment interest would run from the date of this Order with respect to the lump-sum. With respect to the $153,833.50, if I understand Commonwell's position, they say that pre-judgment interest would be payable from the date the cause of action arose at 1% to the date that the payment was made. No post-judgment interest would be owing as there was never any Order.

With respect to the issue of interest, I agree with Commonwell.

The *Arbitration Act*, 1991, S.O. 199, c. 17 Section 54(1) and Section 57 provides an Arbitrator with discretion to award interest. Section 57 states:

> "Sections 127 to 130 (prejudgment and postjudgment interest) of the Courts of Justice Act apply to an arbitration, with necessary modifications".

We therefore turn to the *Courts of Justice Act,* R.S.O., 1990, c. C43 Section 127 which provides the definition for pre and post-judgment interest.

Pre-judgment interest is defined as follows:

> ""Prejudgment interest rate" means the bank rate at the end of the first day of the last month of the quarter preceding the quarter in which the proceeding was commenced, rounded to the nearest tenth of a percentage point.
>
> "Postjudgment interest rate" means the bank rate at the end of the first day of the last month of the quarter preceding the quarter <u>in which the date of the order falls</u>, rounded to the next higher whole number where the bank rate includes a fraction, plus 1 per cent".

Therefore post-judgment interest is predicated on the date of the Order while pre-judgment interest is predicated on the date the proceeding was commenced.

Section 128(1) of the *Courts of Justice Act* provides with respect to pre-judgment interest the following:

> "A person who is entitled to an order for the payment of money is entitled to claim and have included in the order an award of interest thereon at the prejudgment interest rate, calculated from the date the cause of action arose to the date of the order".

In the materials provided by Wawanesa, was included an extract from the Ontario Government page discussing pre-judgment and post-judgment interest rates. With respect to pre-judgment interest the article indicated that it's calculated from the date the cause of action happens until the date the court makes an Order about the money you should receive.

With respect to post-judgment interest the article says that if the person's claim is successful and the court makes an Order "that says you are owed money" post-judgment interest starts accumulating automatically on the amount you are owed starting on the date when the court makes the Order and ending on the date you receive payment.

In my decision that was issued May 8, 2018, the award specifically reads"

> "The Commonwell Mutual Insurance Group is the priority insurer with respect to the statutory accident benefits payable to ST with respect to the motor vehicle accident of April 13, 2015".

The only issue before me in that hearing was who the priority insurer was. All counsel agreed that questions with respect to quantum of any potential reimbursement would be dealt with later. I agree with Commonwell that my award of May 2018 is not an award with respect to benefits to be reimbursed.

However, there was no issue before me in this hearing with respect to the amount Commonwell agreed to pay: the $153,833.50. It was not the subject matter of any Order. There was no dispute between the parties with respect to that. Accordingly, I find that pre-judgment interest is payable form the date the cause of action arose to the date that the payment was made. If counsel cannot agree on what those calculations are we will schedule a further pre-hearing to deal with the question of interest on the payment that was not in dispute.

With respect to the lump-sum payment that clearly was in dispute before me in this hearing I consider this award to be the Order that starts the running of post-judgment interest. Therefore, for the lump-sum payment of $425,000.00, I find that pre-judgment interest is payable as agreed between the parties at 1% from the date the cause of action arose to the date of this Order. Thereafter, Wawanesa is entitled to post-judgement interest. Again, if the parties are unable to reach agreement as to what these amounts are, I can be contacted and we will schedule a further pre-hearing to set down an opportunity for some brief written submissions together with calculations from accountants if required.

Costs

Wawanesa has been entirely successful in this claim with a very modest exception of the issue of pre vs post-judgment interest.

I do not know whether any offers settle have been made. Subject to an offer to settle that would change the landscape of a potential costs claim, I find that Commonwell is responsible for paying the Arbitration costs as well as the legal costs of Wawanesa. If there is an offer to settle, I would ask the parties to let me know and we can schedule submissions with respect to the effect of that offer.

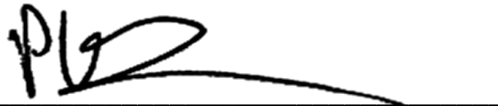
If the parties cannot reach an agreement on the quantum of costs or disbursements, again, I am to be advised and we will schedule a quick pre-hearing on that issue.

Final Award

1. Commonwell Mutual Insurance Company is to pay the Wawanesa Mutual Insurance Company $425,000.00 with respect to reimbursement for Statutory Accident Benefits paid by Wawanesa to the claimant arising out of the accident of April 13, 2015.
2. Commonwell is to pay pre-judgment interest on the above amount from the date the cause of action arose to the date of this decision and post-judgment interest thereafter.
3. With respect to the non-disputed amount of $153,833.50, Commonwell is to pay Wawanesa pre-judgment interest from the date the cause of action arose to the date that reimbursement was made.
4. Subject to any offers to settle and subsequent submissions relating to that, I find that Commonwell Mutual Insurance Company is to pay the costs of this Arbitration and the

legal costs of Wawanesa Mutual Insurance Company relating to this quantum dispute, on a partial indemnity basis.

DATED THIS 6th day of July 2022 at Toronto.



Arbitrator Philippa G. Samworth
DUTTON BROCK LLP