CITATION: Scarlett v. Belair Insurance, 2015 ONSC 3635
DIVISIONAL COURT FILE NO.: 574/13
DATE: 20150605

ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

R.S.J. GORDON, MOLLOY AND D. L. CORBETT JJ.

BETWEEN:	)	
	)	
LENWORTH SCARLETT	)	*Alexander M. Voudouris* and *M. Nicole Correiro*, for the Applicant
Applicant	)	
	)	
– and –	)	
	)	
BELAIR INSURANCE COMPANY INC. and FINANCIAL SERVICES COMMISSION OF ONTARIO	)	*Philippa Samworth* and *Yusra Murad*, for the Respondent, Belair Insurance Company Inc.
	)	
Respondents	)	*Elizabeth Nastasi* and *Mark Bailey*, for the Respondent, Financial Services Commission of Ontario
	)	
	)	
	)	
	)	**HEARD at Toronto:** June 1, 2015

R.S.J. GORDON

REASONS FOR DECISION

Overview

[1] The Applicant, Mr. Scarlett, seeks judicial review of the decision of Director's Delegate Evans made the 28th of November, 2013. The Director's Delegate overturned the interim decision of Arbitrator Wilson dated March 26, 2013.

[2] Arbitrator Wilson had determined by way of a preliminary issue hearing that Mr. Scarlett was not bound by the limit of $3,500 for medical and rehabilitation benefits prescribed in section 18 of the *Statutory Accident Benefits Schedule* ("*SABS*").

[3] Director's Delegate Evans found that Arbitrator Wilson made several errors in his analysis and remitted the matter back to arbitration before a different arbitrator, for a new and full hearing on all of Mr. Scarlett's outstanding claims.

[4] Mr. Scarlett looks to set aside the order of the Director's Delegate and to reinstate the order made by the arbitrator.

Background

[5] On September 18, 2010, Mr. Scarlett was involved in a motor vehicle accident. He applied for and received Statutory Accident Benefits from the Respondent Belair Insurance Company Inc. ("Belair").

[6] From an early date, Belair took the position that Mr. Scarlett's predominant injury was a Minor Injury as defined in section 3 of the *SABS*. The result was that he would be entitled to claim a maximum of $3,500 in medical and rehabilitation benefits pursuant to section 18(1), and would not be entitled to claim for attendant care benefits pursuant to section 14. Belair also rejected Mr. Scarlett's claim of entitlement to more than $3,500 in medical and rehabilitation benefits based on the exacerbation of a pre-existing medical condition (s. 18(2)).

[7] Mediation of the issues in dispute was not successful and the parties eventually applied for arbitration at the Financial Services Commission of Ontario ("FSCO"). As a preliminary issue, Belair brought a motion seeking an order that Mr. Scarlett was suffering from Minor Injuries and was therefore limited in the benefits he could claim. That preliminary issue was heard and determined by Arbitrator Wilson.

[8] Arbitrator Wilson determined that Mr. Scarlett did not fall under the *Minor Injury Guideline -Superintendent's Guideline No. 2/10* (the "MIG") and was entitled to medical and rehabilitation benefits beyond the maximum of $3,500 prescribed in section 18 of the *SABS*. In doing so he interpreted section 18 as an insurance exclusion and put the onus of proof on Belair to establish that Mr. Scarlett was not entitled to the benefits.

[9] Belair appealed the decision of Arbitrator Wilson. The appeal was heard by Director's Delegate Evans on September 10, 2013 and a decision rendered on November 28. He determined that Arbitrator Wilson made several legal errors in his analysis that required the matter be returned for a new arbitration hearing. He decided that rather than having only the preliminary issue addressed at the new arbitration, it would be most just and expedient to have all of Mr. Scarlett's issues addressed in one arbitration hearing before a new arbitrator.

[10] Mr. Scarlett has brought this application for judicial review of Director's Delegate Evans' decision alleging the following:

1. That he erred in finding that the $3,500 limit on medical and rehabilitation expenses contained in section 18(1) was not an exclusion of benefits;

2. That he erred in finding that the term "compelling evidence" in subsection 18(2) means something more than credible evidence;

3. That he erred in finding that the *Minor Injury Guideline* was binding on the *SABS*;

4. That he erred in finding that there was a breach of the principles of procedural fairness;

5. That he erred in finding that the arbitrator failed to address whether or not certain of Mr. Scarlett's injuries were sequelae of his minor injuries and whether Mr. Scarlett sustained an impairment that was predominantly a Minor Injury; and

6. That he erred in determining that the issue of whether Mr. Scarlett's impairment was predominantly a minor injury should be determined only after a full arbitration hearing.

Jurisdiction

[11] The Divisional Court has authority to hear this case under sections 2 and 6(1) of the *Judicial Review Procedure Act*, R.S.O. 1990, c. J-1.

Standard of Review

[12] As provided in *Dunsmuir v. New Brunswick*, [2008] 1 S.C.R. 190, the process for determining the appropriate standard of review on judicial review involves two steps: (1) a determination of whether the jurisprudence has already determined in a satisfactory manner the degree of deference to be accorded with regard to a particular category of question; and (2) Where the first inquiry proves unfruitful, an analysis of the factors making it possible to identify the proper standard of review.

[13] In *Pastore v. Aviva Canada Inc.*, 112 O.R. (3d) 523 (Ont. C.A.) the Ontario Court of Appeal undertook the *Dunsmuir* analysis while examining a decision of the Director's Delegate of the Financial Services Commission of Ontario and concluded that the correct standard of review is reasonableness. I see no reason to depart from this decision.

[14] In particular, I do not agree that any of the issues presented in this application amount to an issue of general law that is both of central importance to the legal system as a whole and outside the Director's Delegate's specialized area of expertise.

[15] The standard of reasonableness as articulated in *Dunsmuir* directs me to consider whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

The Statutory Scheme

[16] Motor vehicle insurance is mandatory in Ontario and is governed by the provisions of the *Insurance Act* R.S.O. 1990, c 18. Section 268(1) of the *Insurance Act* provides that every motor vehicle insurance liability policy shall be deemed to provide for the statutory benefits provided in the *Statutory Accident Benefits Schedule*.

[17] The *Statutory Accident Benefits Schedule* is a regulation passed under the *Insurance Act*. The relevant provisions of the *SABS* are as follows:

> In Section 3, the following definitions:
>
> "minor injury" means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury;
>
> "Minor Injury Guideline" means a guideline,
>
> (a) That is issued by the Superintendent under subsection 268.3(1.1) of the Act and published in The Ontario Gazette, and
>
> (b) That establishes a treatment framework in respect of one or more minor injuries.
>
> In Section 14, the following statement of liability for benefits:
>
> 14. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:
>
> 1. Medical and rehabilitation benefits under sections 15 to 17.
>
> 2. If the impairment is not a minor injury, attendant care benefits under section 19.
>
> In Section 18 the following limitations of coverage:
>
> 18. (1) The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.
>
> (2) Despite subsection (1), the $3,500 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will

> prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.
>
> (3) The sum of the medical and rehabilitation benefits paid in respect of an insured person who is not subject to the financial limit in subsection (1) shall not exceed, for any one accident,
>
> (a) $50,000; or
>
> (b) if the insured person sustained a catastrophic impairment as a result of the accident, $1,000,000.

[18] Section 268.3 of the *Insurance Act* provides that the Superintendent may issue guidelines on the interpretation and operation of the *SABS*. Under the section as it existed when Mr. Scarlett was in his accident it was a requirement that any such guideline be considered in any determination involving the interpretation of the *SABS* (section 268.3(2).

[19] One such guideline issued by the Superintendent is the *Minor Injury Guideline – Superintendent's Guideline No. 02/10 ("MIG").* The objectives of the guideline are to speed access to rehabilitation, improve utilization of healthcare resources, provide certainty around cost and payment for insurers, and be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the *SABS*. Consistent with these objectives, the MIG sets out the goods and services that will be paid for by the insurer without approval if provided to an insured person who has sustained a minor injury.

Analysis

Issue #1 – Do the SABS Provide for Exclusions of Coverage in Sections 14 and 18(1)?

[20] The issue is of importance because it informs the decision of who has the burden of proof. That is, although it is fundamental to insurance law that the burden of proof rests on the insured to establish a right to recover under the terms of the policy, so too is it fundamental that when an insurer relies upon an exclusion in the policy to avoid payment, the onus of proving that the loss falls within the exclusion generally lies upon the insurer.

[21] The Director's Delegate found that there was no exclusion created by either section 14 or 18 of the *SABS*. For the following reasons, I am of the view that his decision was not only reasonable, but correct.

[22] Section 14 of the *SABS* defines the liability of the insurer. It requires the insurer to pay the medical and rehabilitation benefits set out under sections 15 and 17 and, if the impairment is not a minor injury, attendant care benefits under section 19.

[23] The liability for attendant care benefits only ever arises if the insured's impairment is not a minor injury. There is no coverage created that is thereafter excluded. There is no coverage to begin with.

[24] Section 18 of the *SABS* does not create an exclusion to liability, it creates limits on that liability. Accordingly, I am of the view that it was reasonable for the Director's Delegate to find that the effect of sections 14 and 18 is to create three tiers of benefits relating to medical and rehabilitation benefits: (1) A maximum of $3,500 for an impairment that is predominantly a minor injury; (2) A maximum of $50,000 if the impairment is not a minor injury and is not catastrophic; and (3) A maximum of $1,000,000 for an impairment that is catastrophic. There being no exception, the Director Delegate reasonably and correctly held that the burden remains on the insured throughout to establish entitlement to the appropriate level of benefits.

[25] I would also note that Part VII of the *SABS*, entitled "GENERAL EXCLUSIONS", defines the circumstances in which certain benefits, otherwise payable by the insurer, are not payable. In my view, it is these types of exclusion from coverage that will result in a shift of the onus to the insurer to establish that there is no coverage.

Issue #2 – The Meaning of "Compelling Evidence"

[26] Section 18(2) of the *SABS* allows an individual who is suffering from a Minor Injury to claim medical and rehabilitation expenses in excess of $3,500 provided their own health care practitioner determines and provides compelling evidence that the insured's pre-existing medical condition prevents him from achieving maximal recovery if subject to the $3,500 limit and to the goods and services authorized under the *Minor Injury Guideline*.

[27] The Applicant argued that Director's Delegate Evans altered the civil standard of proof by finding that the requirement for "compelling" evidence goes beyond a requirement that the evidence be credible. I do not agree that he did so. A fair reading of his decision reveals no indication that the standard of proof was elevated beyond a balance of probabilities. Rather, he properly recognized: (1) that the word "compelling" is directed at the sufficiency of the evidence required to satisfy that standard and (2) that whether the evidence in a particular case is sufficient to meet the test of "compelling" must be determined on the facts of each individual case having regard to what is reasonable in all of the circumstances.

Issue #3 – Is the Minor Injury Guideline Binding?

[28] The manner in which this issue has been framed is somewhat misleading. Although Director Delegate Evans did hold that the *Minor Injury Guideline* "is as binding as the *SABS*", the real issue is whether the *Minor Injury Guideline* has been incorporated into the *SABS* by reference, and if so, to what extent.

[29] I agree that material may be incorporated by reference into a statute or regulation and that such material then becomes an integral part of the incorporating instrument as if reproduced therein [see *R. v. St. Lawrence Cement Inc.* 2002 Carswell 2541 (Ont. C.A.)].

[30] However, a distinction must be drawn between material which is simply referred to in a statute or regulation and material which, by that reference, is thereby incorporated. Furthermore, one must be careful in defining the breadth of the material which is to be incorporated. This is particularly so when the material in question, like the *MIG*, is a combination of commentary, policy statement, guideline and definition.

[31] In my view, to be incorporated by reference into a statute or regulation, material must be:

1. Referred to expressly in the statute or regulation; and

2. Required for the proper interpretation of that part of the statute or regulation which expressly refers to it.

[32] An excellent example appears in the SABS definition of "authorized transportation expense" which is stated to be: "…expenses related to transportation, (a) that are authorized by, and calculated by applying the rates set out in, the Transportation Expense Guidelines published in the Ontario Gazette by the Financial Services Commission of Ontario, as they may be amended from time to time…". In this example "The Transportation Expense Guidelines" are expressly referred to and the definition of "authorized transportation expense" cannot be determined or interpreted without reference to them.

[33] There is no provision in the *SABS* which expressly incorporates by reference the entirety of the *MIG*. Accordingly, in my view it is necessary to examine each reference to the *MIG* to determine if it is an express reference thereto, and if so, what part of the *MIG* is required for the proper interpretation of the *SABS* provision in question.

[34] For example, Section 18(1) provides that the sum of the medical and rehabilitation expenses payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500 for any one accident, less the sum of all amounts paid in respect of the insured in accordance with the *Minor Injury Guideline*. Clearly the *MIG* is expressly referred to in this section. Just as clearly, reference to the *MIG* is required to determine if amounts paid in respect of the insured were paid in accordance with it. However, this cannot mean that unrelated commentary and policy in the *MIG* is also incorporated by virtue of that reference. Such material is not required to understand or interpret section 18(1).

[35] Similarly, section 18(2) of the *SABS* refers to an insured being "limited to the goods and services authorized under the Minor Injury Guideline". Again, the *MIG* is expressly referred to, and one must refer to the goods and services authorized by the *MIG* to understand and interpret the meaning of the section. However, the remainder of the MIG is not necessary to understand and interpret the section, and therefore is not incorporated by reference.

[36] Let me provide one final example. Section 38 (9) of the SA*B*S provides that if the insurer believes that the *MIG* applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person. The *MIG* is expressly referred to in this subsection, however, the contents of the *MIG* are not required to understand or interpret the subsection. It is simply a

procedural section that requires notice if the insurer believes the *MIG* applies. Accordingly, the *MIG* is not, in this subsection, incorporated by reference. Not in whole. Not in part.

[37] Accordingly, I conclude that the Director's Delegate's finding that "the MIG…is as binding as the SABS", is not reasonable. In each instance in which the *MIG* is expressly referred to in the SA*B*S, one must undertake an analysis of the extent to which, if at all, the *MIG* is required to enable a proper interpretation of the section in question. It is only to that extent that the *MIG* is incorporated by reference.

Issue #4 – Was There a Breach of the Principles of Procedural Fairness?

[38] Director's Delegate Evans found that Belair was denied procedural fairness because Arbitrator Wilson, when rendering his decision, raised argument of his own for the first time, conducted research of his own, and inappropriately applied section 233 of the Insurance Act, all without first raising the matters with counsel and allowing an opportunity for submissions to be made.

[39] The basic principle underlying the duty of procedural fairness is that parties affected by a decision should have the opportunity to present their case fully and fairly, and have decisions affecting their rights, interests or privileges made using a fair, impartial, and open process [see *Baker v. Canada (Minister of Citizenship and Immigration*), 1999 CarswellNat 1124]. In my view, this duty of procedural fairness would include providing interested parties a reasonable opportunity to address caselaw, statutory provisions, and lines of argument which the arbitrator wishes to consider but which were not raised at the arbitration.

[40] Accordingly, the Director's Delegate's decision on this issue falls within the range of possible acceptable outcomes which are defensible on the facts and law.

Issue #5 – Whether Mr. Scarlett Suffered from a Predominantly Minor Injury

[41] The Director's Delegate found fault with Arbitrator Wilson's failure to address whether Mr. Scarlett's impairment was predominantly a minor injury and whether certain complaints were or were not the sequelae of minor injury. However, the arbitrator's decision must be read in context, and particularly in light of his finding that the burden of proof rested with the insurer. Given the burden of proof as he determined there was effectively no need for him to address these issues.

[42] However, as I have determined, the burden of proof was in fact misplaced and an analysis of the injuries and impairments in the context of the wording of subsections 18(1) and (2) will be required when the matter is once again before an arbitrator.

Issue #6 – Preliminary or Full Hearing

[43] At the hearing of this Application, all parties were content that if the matter were remitted for a new arbitration, it be on the preliminary issue of the applicability of sections 14(2) and 18 rather than for a full hearing as ordered by the Director's Delegate.

Conclusion

[44] Save and except as to the binding nature of the *Minor Injury Guideline*, the findings of the Director's Delegate were reasonable. Accordingly, the matter is remitted to an arbitrator other than Mr. Wilson for a new preliminary issue hearing.

[45] In accordance with the submissions of counsel, there shall be no order as to costs.

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R.S.J. GORDON

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MOLLOY J.

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D. L. CORBETT J.

Released: June 5, 2015

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LENWORTH SCARLETT

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– and –

BELAIR INSURANCE COMPANY INC. and
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ONTARIO

Respondents

REASONS FOR JUDGMENT

R.S.J. GORDON

Released: June 5, 2015