Appeal P13-00014

OFFICE OF THE DIRECTOR OF ARBITRATIONS

BELAIR INSURANCE COMPANY INC.

Appellant

and

LENWORTH SCARLETT

Respondent

BEFORE:	David Evans
REPRESENTATIVES:	Philippa Samworth and Yusra Murad for Belair Insurance Company Inc. Nicole Corriero and Alexander M. Voudouris for Mr. Lenworth Scarlett
HEARING DATE:	September 10, 2013

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. The appeal of the Arbitrator's order dated March 26, 2013 is allowed and the decision is rescinded.

2. The determination of whether Mr. Scarlett sustained an impairment that is predominantly a minor injury and all other matters at issue in the *Application for Arbitration* shall be made at a full hearing before another arbitrator.

3. If the parties are unable to agree on the legal expenses of this appeal, an expense hearing shall be requested pursuant to the *Dispute Resolution Practice Code* (Fourth Edition, Updated - August 2011), but as set out below and within sixty days of the date of this decision.

November 28, 2013

David Evans
Director's Delegate

Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

This appeal concerns the monetary limits set by section 18 of the *SABS–2010*[1] and the *Minor Injury Guideline*, the MIG.[2] Belair Insurance Company Inc. appeals Arbitrator John Wilson's March 26, 2013 preliminary issue order that Mr. Lenworth Scarlett's medical and rehabilitation claim is not subject to the $3,500 limit for minor injuries. It appeals on the basis that the Arbitrator failed to apply the appropriate tests, inappropriately placed the burden of proof on Belair, and breached procedural fairness. It seeks either an order that Mr. Scarlett is subject to the limit, or that a new arbitration hearing be ordered before a different arbitrator.

The law, briefly, provides that

- a 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 [*SABS*, s. 3(1)]
- an insured who sustains an impairment that is predominantly a minor injury can receive no more than $3,500 towards medical and rehabilitation expenses (including assessments) [*SABS*, s. 18(1)]
- an exception for pre-existing conditions may apply based on "compelling evidence" [*SABS*, s. 18(2)]

With respect to the test of whether or not Mr. Scarlett's injuries were minor, the Arbitrator found that Mr. Scarlett's chronic pain, depressive symptoms and temporomandibular joint (TMJ) disorder were separate and distinct from his soft tissue injuries and were not the sequelae thereof. However, I find that the Arbitrator failed to address why this was so.

[1] *The Statutory Accident Benefits Schedule — Effective September 1, 2010,* Ontario Regulation 34/10, as amended.
[2] *Superintendent's Guideline No. 02/11*, Financial Services Commission of Ontario.

With respect to the $3,500 limit itself, the Arbitrator simply found the totality of Mr. Scarlett's injuries put him outside of the MIG. I find that he did not direct his mind to the relevant test of whether Mr. Scarlett's impairment was *predominantly* a minor injury.

The Arbitrator also dealt at length with the burden of proof, finding that the burden of proof lay on the insurer to show that Mr. Scarlett was subject to the MIG. However, I find that the burden of proof always rests on the insured of proving that he or she fits within the scope of coverage.

Although the Arbitrator found that, if the MIG had applied to Mr. Scarlett, his injuries did not fit within the exception for pre-existing conditions, he nevertheless found it necessary to discuss the meaning of "compelling evidence." He found that "compelling evidence" simply means credible evidence. I find that "compelling evidence" means more than that.

The Arbitrator found that although the MIG is incorporated into the *SABS*, it is only advisory because it is issued pursuant to s. 268.3 of the *Insurance Act*. However, I find that the MIG is binding precisely because it is specifically issued pursuant to s. 268.3(1.1) of the *Act*, the definition of MIG in the *SABS* refers to s. 268.3(1.1), and the MIG is then applied in s. 18(1) and s. 18(2), thereby incorporating the MIG into the *SABS* by reference.

Finally, I find that the Arbitrator's research and reliance on cases and statutory provisions he raised of his own accord after the arbitration hearing without providing notice to the parties or an opportunity to respond, instances of which are noted below, was a breach of procedural fairness.

II. BACKGROUND

Mr. Scarlett was injured in a motor vehicle accident on September 18, 2010. He sought medical and rehabilitation benefits that he applied for and received from his insurer, Belair, under the *SABS–2010*. Other benefits he sought included non-earner benefits, attendant care benefits, payments for housekeeping and home maintenance services, and the cost of a medical assessment.

Belair's position was that Mr. Scarlett's injuries limited his med/rehab benefits to the $3,500 limit. The Arbitrator stated that Mr. Scarlett "maintained that although he indeed suffered strains

sprains and whiplash related injuries, he also suffered from pre-existing conditions and subsequent psychological disabilities that take him out of the MIG constellation."

The main evidence before the Arbitrator included the following:

The disability certificate by Dr. Rahim Jessa, chiropractor, dated October 6, 2010, indicated that Mr. Scarlett sustained various sprains and strains to the joints and ligaments of the lumbar and cervical spine as well as headaches and acute stress reaction.

The report of Dr. John Crescenzi, chiropractor, in an insurer's examination (IE) dated November 25, 2010, noted that aside from soft tissue injuries there were no signs of neurological compromise, fractures or dislocations, or mention of significant pre-existing conditions, so he found the MIG applied. In a later report dated November 14, 2011, Dr. Crescenzi reiterated his view that the MIG applied.

After Dr. Crescenzi's initial report, a dental surgeon, Dr. Edwin Lewandowski, submitted an OCF-18 proposing a temporomandibular joint assessment. In an IE dated May 25, 2011, Dr. Aviv Ouanounou, a dentist, found a lack of evidence of TMJ problems meant the assessment was not reasonably required. Nonetheless, Dr. Lewandowski reported on September 15, 2011 that Mr. Scarlett suffered from a TMJ disorder.

Another IE report dated May 25, 2011, is that of Dr. Shulamit Mor, psychologist. Dr. Mor concluded that "based on his narrative and presentation Mr. Scarlett's symptoms do not meet the criteria for any psychological diagnosis."

On December 12, 2011, an orthopaedic surgeon, Dr. Franco Tavazzani, observed a depressed affect, restricted range of motion in the lumbar spine, and signs indicating "an adverse psychological and emotional response to injury and a poor prognosis for recovery."

Dr. Judith Pilowsky, a psychologist, assessed Mr. Scarlett and prepared reports dated January 19, 2012, and January 17, 2013. In the latter she contended that due to the severity of the

psychological symptoms stemming from Mr. Scarlett's accident, his symptoms should not be considered a minor injury.

In this preliminary issue hearing based on document briefs, together with an agreed statement of facts and oral submissions, the Arbitrator found that, although the MIG is incorporated into the *SABS*, "it remains a non-binding interpretative aid in deciding specifically whether Mr. Scarlett comes within the MIG." He found that Mr. Scarlett did not come within the MIG.

Accordingly, the Arbitrator ordered that "Mr. Scarlett is not precluded from claiming housekeeping, attendant care, as well as medical and rehabilitation expenses, beyond the $3,500 limit within the *Minor Injury Guideline*."[3]

In a decision dated August 1, 2013, I accepted this appeal of a preliminary issue and stayed the Arbitrator's order that Mr. Scarlett is not subject to the MIG because of the novelty of the issue and the parties' agreement to have it heard. I also found there were substantive reasons for the appeal, including the findings on the effect of the MIG, the burden of proof, and the issues of due process.

III. ANALYSIS

For the reasons set out below, I find that this matter must be remitted for a new hearing before a different arbitrator. However, I find that it would be inefficient to simply remit this question for a further preliminary issue hearing. Rather, I find that the issue of whether Mr. Scarlett is subject to the $3,500 limit for minor injuries should be determined at a full hearing before a different arbitrator, along with all the other matters at issue in the *Application for Arbitration*.

Regarding the initial test of whether any particular injury is a minor injury, I find that the Arbitrator failed to address why Mr. Scarlett's chronic pain, depressive symptoms and temporomandibular joint disorder were separate and distinct from his soft tissue injuries and were not the sequelae thereof.

[3] The MIG does not apply to housekeeping or attendant care expenses.

The Test for Minor Injury: any clinically associated sequelae

Under s. 3(1) of the *SABS*,

> "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.

Since this matter will go on for a determination of whether Mr. Scarlett is entitled to benefits beyond the $3,500 limit, I will not go into the evidence in any further detail. That said, I find that the Arbitrator should have addressed why impairments like the TMJ syndrome, chronic pain and psychological impairments were not "clinically associated sequelae" to Mr. Scarlett's minor injuries.

Unfortunately, in finding Mr. Scarlett's alleged chronic pain and psychological impairments were not sequelae, the Arbitrator put the burden of proof on the insurer, when I find it lies upon Mr. Scarlett. He also discounted Dr. Mor's psychological report because s. 233 of the *Insurance Act* was supposedly not followed, when I find s. 233 is irrelevant. The Arbitrator similarly found that a TMJ disorder, such as that diagnosed for Mr. Scarlett, necessarily falls outside the MIG. While the Arbitrator stated that "the TMJ issue would not appear to arise as a sequela to a soft tissue injury," I find no reason why that should necessarily be so. Finally, I find the MIG is binding, and that it provides for what are clinically associated sequelae to a minor injury. I find that this is within the purview of the MIG, as set out in s. 268.3(1.1) of the *Act*.

But first, even if some injuries are not clinically associated sequelae, Mr. Scarlett is still subject to the limit for medical and rehabilitation benefits if the impairment is *predominantly* a minor injury. I find that the Arbitrator never directed his mind to that test.

The Test for med/rehab benefits: predominantly a minor injury

The term "minor injury" is applied in Part III of the *SABS* entitled Medical, Rehabilitation and Attendant Care Benefits. Section 14 sets out the insurer's liability to pay 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[4] as a result of an accident:
>
> 1. Medical and rehabilitation benefits under sections 15 to 17.[5]
>
> 2. If the impairment is not a minor injury, attendant care benefits under section 19.

Thus, s. 14.2 provides that attendant care benefits are not payable if the impairment is a minor injury. Medical benefits (s. 15) and rehabilitation benefits (s. 16) are subject to s. 18, entitled "Monetary limits re medical and rehabilitation benefits." These limits include the $3,500 limit in s. 18(1) "in respect of an insured person who sustains an impairment that is predominantly a minor injury." The relevant test is thus whether the impairment is *predominantly* a minor injury, not simply whether any particular injury is a minor injury.

The Arbitrator found that "Belair has not met its burden of showing that Mr. Scarlett's claim is restricted to the parameters of the *Minor Injury Guideline*" and that

> Mr. Scarlett does not deny that he has some minor injuries, and injuries that come within the MIG. He also has significant other problems arising from the accident that are not necessarily consequent to soft tissue injuries. When the totality of his injuries is assessed, they come outside of the MIG.

I find that the Arbitrator failed to address the fundamental question of whether Mr. Scarlett sustained an impairment that is *predominantly* a minor injury. For that reason, I find that another hearing is necessary to determine the issue, although for the reasons set out at the end of this decision, I find that it should be a hearing on all of the issues.

But beyond that, the Arbitrator put the burden of proof on the Insurer, when I find that the burden of proof for entitlement to benefits lies on Mr. Scarlett.

[4] Defined in s. 3(1) as meaning "a loss or abnormality of a psychological, physiological or anatomical structure or function."

[5] Section 17 is not relevant to the minor injury discussion, as the case manager services it provides are only payable if the insured suffered a catastrophic injury or had optional benefits available.

Burden of Proof: General Principles

I find that case law at the Commission has established that the legal onus always remains on an insured: on a claim for payment under an insurance policy, the claimant has the burden of proving that he or she fits within the scope of coverage: *TTC Insurance Company Limited and Wootton*, (FSCO P04-00004, November 2, 2004).

I find that the Arbitrator therefore erred when, after citing s. 14, he stated: "Barring exceptions, then an insurer is obliged to make payments of medical and rehabilitation benefits to an insured who sustains an impairment as a result of an accident." I find that he erroneously treated the opening phrase of s. 14, "Except as otherwise provided in this Regulation," as creating an *exclusion*, such as an exclusion for driving without consent. One of the cases the Arbitrator cited to support his view, without giving the parties an opportunity to provide submissions, was *Calverley v. Gore District M.F. Ins. Co*., [1959] O.J. No. 662 (CA), but *Calverley* dealt with exclusions similar to those under s. 31 of the *SABS*. I find that *Calverley* is irrelevant. Therefore, I find that the Arbitrator erred when he stated that "once an insured has satisfied the burden of proving that he or she is an 'insured' and has suffered an impairment as a result of an accident, it is then incumbent for an insurer to prove that the insured then comes under a specified exception that would justify non-payment either in part or in full."

To the contrary, I note that medical and rehabilitation benefits are subject to limitations beyond the monetary, as they are only payable if they are "reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for" listed medical benefits [s. 15(1)] or "reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking" various listed activities and measures [s. 16(1)].

Therefore, I find it is not incumbent on an insurer to pay medical and rehabilitation benefits simply because an insured sustained an impairment: the expenses have to be reasonable and necessary, and for the items or purposes listed. Otherwise, it would put the burden on the insurer to show that the expenses were not reasonable and necessary.

Interestingly, the Arbitrator stated in a footnote that "with regard to catastrophic impairment … the wording of the section makes it clear that the burden is on an insured to show entitlement to enhanced benefits – standard benefits being the policy default." The Arbitrator was presumably referring to s. 18, the section setting out all the monetary limits for medical and rehabilitation benefits. However, I find that s. 18(1), dealing with the minor injury limit, and s. 18(3), dealing with the other limits including the one for catastrophic impairment, are worded alike:

> 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.
> ...
> 18(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.

I find that s. 18 thus sets out three tiers of coverage, namely

- $3,500 for "an impairment that is predominantly a minor injury"
- $50,000 if the impairment is not a minor injury and is not catastrophic
- $1,000,000 for a catastrophic impairment.

I find that there is no difference in principle between these tiers, that the $50,000 is not some sort of default coverage, and that the burden of proof remains on insureds throughout to show that they are entitled to benefits at whatever level.

Section 38, a section not discussed by the Arbitrator, reaffirms this point. It deals with making claims for medical and rehabilitation benefits. As set out in s. 38(1)(a), "This section applies to … medical and rehabilitation benefits *other than* benefits payable in accordance with the Minor Injury Guideline…" [Emphasis added.] In order to show that the MIG does not apply, the insured must provide a treatment and assessment plan completed and signed by a regulated health professional stating that the insured person's impairment is not predominantly a minor

injury: s. 38(3)(c)(i)(A). I find that the burden of proof is thus on the insured to show that the MIG does not apply. While the insurer is then given an opportunity under s. 38(12) to have the person assessed to see if the MIG applies, that does not change the ultimate burden of proof.

I note that the sufficiency of proof may shift, of course. As was stated in *El-Saikali and Co-Operators General Insurance Company*, (FSCO P01-00059, March 13, 2003) and cited in *Wootton*, Delegate Makepeace wrote

> The appropriate approach is a flexible, fact-based one, in which, while the legal onus always remains on the insured, the sufficiency of the proof depends on what is reasonable in the circumstances. This involves consideration of the evidence presented by both parties, including the nature of the individual's condition and extent of the disability…

Nonetheless, I find that the ultimate burden always rests on the insured. As was stated in *Wootton*, "The situation does not change simply because the insurer challenges the facts upon which the claim is based." Therefore, I find that the law is not that insureds shift the burden to insurers to prove that the MIG applies simply by submitting a treatment and assessment plan that says the injury is not predominantly a minor injury.

I find that the burden of proof is significant here because at the end of his decision, the Arbitrator stated that "The only way to fully reconcile the conflicting [expert] reports with any certainty would be to undertake a full trial of the issue with all experts subject to cross-examination." Having put the burden of proof on Belair, he therefore found in favour of the insured, given the differences in expert opinion, but I find that he should have done the opposite, as the burden lay on Mr. Scarlett.

I find that the Arbitrator's discussion of the burden of proof is also significant because it affected his conclusions about the MIG and whether or not it is binding.

The Minor Injury Guideline

"Guideline" is defined in s. 3(1) of the *SABS* as meaning "a guideline, including the Minor Injury Guideline, issued by the Superintendent under subsection 268.3 (1) of the Act and published in *The Ontario Gazette*."

There is also a specific definition in s. 3(1) of "Minor Injury Guideline" as meaning a guideline

> (a) that is issued by the Superintendent under subsection 268.3 (1.1)[6] of the Act and published in *The Ontario Gazette*, and
>
> (b) that establishes a treatment framework in respect of one or more minor injuries.

As discussed below, while the Arbitrator conceded that these provisions incorporate the MIG into the *SABS*, he found it is nevertheless not binding. However, I will first continue my discussion about the burden of proof. Thus, after finding that, "barring exceptions," an insured is entitled to benefits unless the insurer proves otherwise, the Arbitrator stated

> At first glance, it would appear that the *Minor Injury Guideline* stands this on its head and proceeds with the burden of proving the exception on the insured. If this indeed is the case, then to understand the extent of this burden it is necessary to explore the meaning of "compelling evidence" in the context of this Guideline.

– **"compelling evidence"**

I do not understand why the Arbitrator discussed the "compelling evidence" criterion. It is only relevant if an insured is found to be subject to the MIG: the Arbitrator found that Mr. Scarlett was *not* subject to the MIG. Oddly, the Arbitrator seems to have recognized that in a footnote to the citation above, where he wrote "The requirement of 'compelling evidence' is also inserted into the *Schedule* at section 18(2) dealing with provision by the health practitioner of evidence relating to a pre-existing condition." That, of course, is the key point: the requirement *comes from* the *SABS*, yet the Arbitrator only discusses the MIG.

To go back to the *SABS* and the requirement for compelling evidence, s. 18(2) provides that an insured otherwise subject to the MIG may access the exception where, on the basis of compelling evidence, a pre-existing condition would limit recovery if only $3,500 is available:

> Despite subsection (1) [the limit in respect of an insured person who sustains an impairment that is predominantly a minor injury], 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 will prevent the insured person from achieving maximal recovery from the minor injury

[6] This is the more specific provision in the *Act* mentioned above; it was not discussed by the Arbitrator.

> 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. [Emphasis added.]

As for the application for medical and rehabilitation benefits under s. 38, if the insured did sustain an impairment that is predominantly a minor injury but seeks to avoid the MIG, s. 38(3)(c)(i)(B) requires the insured to provide a treatment and assessment plan completed and signed by a regulated health professional echoing the requirement for compelling evidence in s. 18(2).

Again, I find that the burden is on the insured to provide the evidence.

The Arbitrator cited the following from the MIG under the heading **Impairments that do not come within this Guideline**:

> An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on **compelling evidence** provided by his or her health practitioner, the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit referred to in section 18(1) of the SABS or is limited to the goods and services authorized under this Guideline. [Emphasis added.]

I find that this paragraph is drawn straight from the legislation. However, the Arbitrator did not refer to the use of "compelling evidence" in s. 18(2) and s. 38(3)(c)(i)(B) beyond the footnote mentioned above. Moreover, he seems to have treated the phrase as applying both to the first question – whether an insured is subject to the MIG – and the second question – whether an insured subject to the MIG can access the exception. The Arbitrator then engaged in a discussion about the meaning of "compelling evidence," focused on the French version of the MIG but without considering the French versions of s. 18(2) and s. 38(3)(c)(i)(B).

– French version

Regarding the French translation of "compelling evidence," I find this is yet again an area where the Arbitrator made findings without seeking any submissions from the parties. He looked at the translation of "compelling" in the MIG, which is "convaincant," and stated, in considering the equal authenticity rule,

> Firstly the French version which is equally authoritative uses the phrase "La preuve convaincante devrait être fournie" in relation to the provision of information supporting an exception to the MIG. Any proof that is accepted by an adjudicator can always be called "convincing" since it persuades the adjudicator to make a certain decision. As a word it lacks the potential force of the word "compelling" in the English version and suggests to me that the authors intended that credible evidence be submitted to take an insured out of the MIG.

It is not obvious to me why "convincing" is less forceful than "compelling." Second, it seems the syllogism the Arbitrator is using is a kind of word ladder, in that the translation of "compelling" is "convaincant," but "convaincant" translates as "convincing," so therefore "compelling" means "convincing." However, the procedure could equally well be reversed. That is, "convaincant" is translated as "compelling," but "compelling," regarding evidence, and according to my HarperCollins 2002 French-English dictionary,[7] translates as "incontestable," so therefore "convaincant" means "incontestable." Third, while the Arbitrator finds that "convincing" should be read down to mean merely credible, I note that under the *SABS-1994*,[8] on the question of whether an insured has withdrawn from the work force, s. 11(6) provides that "the insurer has the burden of proving on clear and *convincing evidence* that the insured person had … withdrawn." The French version reads "il incombe à l'assureur de démontrer, sur la foi de *preuves* claires et *convaincantes*, que la personne assurée s'était retirée…" According to the Arbitrator's logic, then, all an insurer had to provide was credible evidence that there was a withdrawal.

Aside from this, the Arbitrator did not look at the *SABS* itself, which in s. 18(2) and s. 38(3)(c)(i)(B) translates "compelling" as "probant." However, I note that if you translate "probant" back to English, with respect to "preuve" or proof, it is translated as "conclusive," and, as an example, *une pièce probante* is a piece of conclusive evidence.[9]

The Arbitrator then went on to say

[7] *The Collins Robert French Dictionary: French-English, English-French*. 6th ed. Glasgow; Paris: HarperCollins Publishers, 2002.

[8] The *Statutory Accident Benefits Schedule - Accidents After December 31, 1993 and Before November 1, 1996*, O Reg 776/93, as amended.

[9] *The Oxford-Hachette French Dictionary: French-English, English-French*. 2nd ed. Oxford; New York: Oxford University Press, 1997.

> Likewise, the use of the conditional "devrait" departs from the usual legislative convention where in the words of the federal *Interpretation Act*, "L'obligation s'exprime essentiellement par l'indicatif présent du verbe porteur de sens principal et, à l'occasion, par des verbes ou expressions comportant cette notion." Thus it is hard to see the French version as mandating the provision of compelling evidence, instead of merely encouraging it.

I do not know why the Arbitrator cited the federal *Interpretation Act*, why he cited it exclusively in French when that is of no use to most readers, how "devrait" should otherwise be translated, or why he did not look at the French version of s. 18(2), in which the present tense is, indeed, used: "if his or her health practitioner *determines* and provides *compelling evidence*…" – "si son praticien de la santé *détermine*, en fournissant des *preuves probantes*…"

I find that the French version of the *SABS*, just as much as the English version, goes beyond merely *encouraging* the provision of compelling evidence. More to the point, the Arbitrator did not give the parties an opportunity to make submissions on the French version. He also did not apply the shared meaning rule that is concomitant with the equal authenticity rule, as set out in *R. v. Dickson*, 2013 CarswellMan 271 (Man.C.A.) at para. 37:

> The two fundamental rules of interpretation applying to bilingual legislation are described in The Honourable Mr. Justice Michel Bastarache et al., *The Law of Bilingual Interpretation* (Markham: LexisNexis Canada Inc., 2008), as follows (at p. 15):
>
> > The bilingual model is based upon two fundamental principles, which we will discuss in this section. The first principle is the Equal Authenticity Rule. According to this rule, both the English and French versions of a statute are equally authentic statements of legislative intent, and neither one is supreme or paramount over the other. The second principle is the Shared Meaning Rule. This rule provides, in short, that both versions of the statute are expressions of the same legislative intent and that courts interpreting statutes should, as far as possible, attempt to ascertain that intent through a determination of the shared or common meaning of the two versions.

I find that one cannot simply read down the English version based on the French version. Instead, one must search for the shared or common meaning of the two versions, which I find the Arbitrator failed to do. I find the Arbitrator therefore had no basis for finding "that the only way to reconcile the English and French versions of the *Guideline* with regard to the provision of 'compelling evidence' would be to interpret both provisions as an exhortation to medical

practitioners and other *stakeholders* to provide credible, or convincing evidence if they wish to ensure that an insured is to be treated as being outside of the *MIG*."

Finally on this point, I find that the Arbitrator mixed up the ultimate burden of proof and the sufficiency of the evidence. To go back to the *El-Saikali* citation from above, the sufficiency of the proof depends on what is reasonable in the circumstances and involves consideration of the evidence presented by both parties. The legislature has mandated in the *SABS* itself that the evidence has to be "compelling" or "probant," which I find goes beyond being merely credible. Whether the evidence meets that test in any given case is a matter of fact, but I find that the evidence must be considered in the light mandated in the *SABS*.

Ironically, the Arbitrator found Mr. Scarlett did *not* have a pre-existing condition that would have taken him out of the MIG if the MIG had applied to him:

> As for the *Waddell's signs* as a pre-existing condition that would also take Mr. Scarlett out of the *MIG*, on the limited evidentiary record I am not prepared to accept that they are more than just some corroboratory evidence of propensity or vulnerability, albeit evidence that would bolster the findings of chronic pain and other unfavourable independent outcomes.

After discussing the meaning of "compelling evidence," the Arbitrator also considered whether the MIG is binding and found it was not, based on s. 268.3 of the *Act*.

– Binding Nature of the MIG

Section 268.3 of the *Insurance Act* contains several provisions regarding guidelines. Subsection 268.3(1) is the general power given to the Superintendent to issue guidelines, last amended in 1997:

> The Superintendent may issue guidelines on the interpretation and operation of the *Statutory Accident Benefits Schedule* or any provision of that *Schedule*.

The specific provision dealing with guidelines regarding medical and rehabilitation benefits, enacted in 2002, is s. 268.3(1.1):

> The Superintendent may issue guidelines setting out the treatment, services, measures or goods applicable in respect of types of impairments for the purposes of payment of a medical or rehabilitation benefit provided under the *Statutory Accident Benefits Schedule*, and such guidelines may include conditions, restrictions and limits with respect to such treatment, services, measures or goods.

Moreover, as noted above, the definition of Minor Injury Guideline in the *SABS* itself refers to s. 268.3(1.1), as it means a guideline that is issued by the Superintendent under s. 268.3 (1.1) of the Act and published in *The Ontario Gazette*, and that establishes a treatment framework in respect of one or more minor injuries. I find that is exactly what the MIG does.

However, the Arbitrator only considered s. 268.3(2), enacted in 1993, which provides that "a guideline shall be considered in any determination involving the interpretation of the *Statutory Accident Benefits Schedule*." The Arbitrator found that s. 268.3(2) renders the MIG non-binding, citing *Ligocki v. Allianz Insurance Co. of Canada,* 2010 ONSC 1166, again without giving the parties an opportunity to make submissions. However, the issue in *Ligocki* was a Guideline related to employment status and not a guideline like the MIG that is incorporated into the *SABS*. I find that *Ligocki* is not relevant to the discussion of the MIG.

While the Arbitrator did not refer to s. 268.3(1.1) in his decision, he did acknowledge that the MIG is incorporated by reference into the *SABS*. He also acknowledged that the effect of incorporation by reference is that the material incorporated becomes part of the *SABS*. Nonetheless, the Arbitrator found that "although the *Guideline* is incorporated by reference into the *Schedule,* it remains a non-binding interpretative aid in deciding specifically whether Mr. Scarlett comes within the *MIG*." I find the logic of this conclusion puzzling.

The following statements from *R. v. Sims*, 2000 BCCA 437, were adopted by the Ontario Court of Appeal in *R. v. St. Lawrence Cement Inc*. (2002), 60 O.R. (3d) 712, and the Ontario Superior Court of Justice in *Desbiens v. Mordini*, 2004 CarswellOnt 4804:

- The legislature has the ability to incorporate any material by reference in regulations as well as in statutes.

- When material is incorporated by reference into a statute or regulation it becomes an integral part of the incorporating instrument as if reproduced therein.

- The effect of such legislation is as though the extrinsic law referred to was written right into the Act.

In *Desbiens*, Spiegel J. was considering how the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, had been incorporated into the *SABS*. What is more, the Arbitrator himself in *Augello and Economical Mutual Insurance Company*, (FSCO A07-001204, December 18, 2008) adopted the reasoning from *Desbiens* that the AMA Guides are "part and parcel of the legislation which incorporated them."

I find that, similarly, the MIG is issued pursuant to s. 268.3(1.1), defined in s. 3(1) of the *SABS*, and applied in Part III of the *SABS*, thereby being incorporated into it. For that reason, I find that the MIG is a different type of guideline from that considered in *Ligocki* and is as binding as the *SABS*.

Mr. Scarlett notes that, subsequent to the arbitration decision under appeal, the Legislature has enacted the following amendment to s. 283:

> (2.1) Despite subsection (2), a guideline that is incorporated by reference into the *Statutory Accident Benefits Schedule* is binding. 2013, c. 2, Sched. 8, s. 13.

Mr. Scarlett submits that the law must have been different before the amendment, as otherwise the amendment was not necessary, so the MIG was not binding until now. However, the *Legislation Act, 2006*, S.O. 2006, c. 21, Sched. F, in s. 56(1) specifically provides that "The repeal, revocation or amendment of an Act or regulation does not imply anything about the previous state of the law or that the Act or regulation was previously in force," and in s. 56(2) provides that "The amendment of an Act or regulation does not imply that the previous state of the law was different."

Accordingly, I find that the MIG was binding even before the recent amendment.

I also do not accept Mr. Scarlett's submission that only the portions in the MIG referenced by the *SABS* should be considered binding. I find that is not what s. 268.3(1.1) says.

I also disagree with his submission that the MIG invalidly redefines the meaning of minor injury where it states "This term is to be interpreted to apply where a person sustains any one or more of these injuries." To go back to the definition in the *SABS*, "'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." I find that all the Superintendent did was set out the *SABS* definition in plainer language.

I will turn to the final point I mentioned above, procedural fairness.

Procedural Fairness

I have noted above several instances where the Arbitrator raised his own arguments like the effect of the French version, conducted his own research and reached his own conclusions without providing counsel the opportunity to provide submissions.

As yet another example of this, the Arbitrator raised s. 233 of the *Insurance Act* regarding statements allegedly made by Mr. Scarlett during an insurer's examination of his own accord. The Arbitrator wrote that

> the Insurer's conclusions raise questions as to whether section 233 of the *Insurance Act* was taken into account by the Insurer when it relied on Mr. Scarlett's alleged statements in refusing benefits. Section 233, of course, is the provision that forbids an insurer from relying on any statement by an insured in defence of a claim for benefits unless that statement is contained or embodied in the written and signed application for benefits.

The parties agree that s. 233 is not applicable, as it deals with the initial application for insurance and not the application for benefits, so I find that the Arbitrator erred in finding that s. 233 prevents the insurer from taking into account statements made by an insured to an assessing doctor. I find that this error also had an effect on his assessment of the expert evidence of the Insurer.

The Arbitrator failed to invite counsel to provide submissions on *Calverley*, *Ligocki*, *R. v. St. Lawrence Cement Inc.*, the French version of the MIG, the Federal *Interpretation Act*, and s. 233 of the *Act*. He did the same regarding

- *Bater v. Bater*, [1950] 2 All E.R. 458
- *Hanes v. Wawanesa*, [1963] S.C.R. 154
- *MacIntosh v. Manulife Financial*, [2012] O.J. No. 386
- *Florence Mining Co. v. Cobalt Lake Mining Co*., [1909] O.J. No. 196
- *R. v. Summers*, 2013 ONCA 147
- *Sullivan on the Construction of Statutes*, 5th Ed., LexisNexis Canada, 2008

Furthermore, I agree with Belair's submission that the decisions made in this tribunal resemble judicial decision making, so as set out in *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817, procedural protections closer to the trial model will be required by the duty of fairness.

In that regard, Belair submits that

> By taking it upon himself to raise these arguments, consider these arguments, review law not provided to him or commented on by the parties and then to accept his own arguments, it is submitted that the Arbitrator failed to properly hear the case and that the Appellant was deprived of its right to make full submissions on this significant and novel area of law.

Aside from the issues of fairness and due process raised by Belair, an arbitrator raising his or her own issues and doing his or her own research without seeking submissions from counsel runs the risk of referring to irrelevant law or cases, as happened with s. 233.

This is an expert tribunal, so one of the advantages for the parties to come here is that they do not have to educate the adjudicators about the system, and arbitrators may be more sensitive to issues and be prepared to raise them than a judge.

There is also pressure to provide decisions on a timely basis, so occasionally an arbitrator or delegate may refer to some materials without going back to the parties for further submissions. Indeed, constantly seeking further submissions could be taken as a delaying tactic.

However, I find that it is another matter if an adjudicator makes key findings based on materials or research that the parties had no opportunity to make submissions on, as happened here, and especially considering the issues in this case.

Accordingly, I find that a new hearing is required to ensure that the proceeding is fair.

Conclusion

I find that the matter should proceed to a new hearing, but the conclusions above show the difficulty with this kind of preliminary issue hearing.

That is, although Belair submits that the matter should be heard again as a preliminary issue before another arbitrator, Mr. Scarlett has other issues that are not subject to the MIG in any event. I adverted above to his other claims for non-earner benefits, attendant care benefits, and payments for housekeeping and home maintenance services. I find it would not be efficient to send this issue alone to another arbitrator. Rather, I find that the matter should proceed to a full hearing where all the issues should be dealt with.

In fact, I have my doubts about this kind of preliminary issue hearing in general. The determination of whether or not an insured is subject to the MIG will often involve determinations of credibility, disputed facts or conflicting medical reports, that is, the same kinds of issues that would come up at the main hearing. I find it is duplicative to hear those matters twice. (I contrast the situation here with a preliminary issue hearing on whether an insured has suffered a catastrophic impairment, where considering the amounts involved and the additional benefits that could be available, such a hearing may be warranted.) For that reason, I find that this matter should proceed to a full hearing, and I would discourage similar preliminary issue hearings in the future.

The appeal is allowed, the arbitrator's decision is rescinded, and the matter is remitted to a full hearing before a different arbitrator, not just on the preliminary issue of whether Mr. Scarlett is subject to the MIG, but on all the issues.

IV. EXPENSES

If the parties are unable to agree on the legal expenses of this appeal, an expense hearing shall be requested within sixty days of this decision. The request shall be accompanied by a Bill of Costs describing the expenses claimed, the services received and the costs, as well as written submissions regarding entitlement to or the quantum of these expenses, or both, as are in dispute.

David Evans Director's Delegate	November 28, 2013 Date