

CITATION: Stranges v. Allstate Insurance Company of Canada, 2010 ONCA 457

DATE: 20100621

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COURT OF APPEAL FOR ONTARIO

Goudge, MacFarland and LaForme JJ.A.

BETWEEN:

Daniela Stranges

Plaintiff (Respondent/Appellant by way of cross-appeal)

And

Allstate Insurance Company of Canada

Defendant (Appellant/Respondent by way of cross-appeal)

Sheldon A. Gilbert, Q.C., and Shawn Stringer, for the appellant/respondent by way of cross-appeal

Michael J. Winward and James P. Cavanagh, for the respondent/appellant by way of cross-appeal

Heard: March 31, 2010

On appeal from the judgment of Justice Nick Borkovich of the Superior Court of Justice dated March 2, 2009, with reasons reported at (2007), 47 C.C.L.I. (4th) 244.

MacFarland J.A.:

[1] The appellant appeals from the judgment of Borkovich J. wherein he ordered that the respondent was to have judgment against the appellant in the sum of \$107,732.79 in damages for Income Replacement Benefits (“IRBs”), plus \$438,268.65 in prejudgment interest in accordance with s. 68 of the *Statutory Accident Benefits Schedule – Accidents After December 31, 1993 and Before November 1, 1996*, O. Reg. 776/93 (the “SABS”). Further, although not discussed in the reasons, the trial judge also found that the appellant was required to continue to pay ongoing weekly benefits until such time as the appellant provided a proper notice of termination of benefits and a proper disability Designated Assessment Centre (“DAC”) assessment was conducted.

[2] The respondent cross-appeals and seeks to overturn the trial judge's finding that as of the fall of 1998, the respondent no longer continued to suffer a substantial inability to perform the essential tasks of her employment.

BACKGROUND

[3] The respondent suffered injuries in a motor vehicle accident on May 18, 1996. The record discloses that her injuries were of a physical and psychological nature. The appellant paid the respondent IRBs until September 1997, when it terminated her benefits. The notice of termination sent to the plaintiff was a standard form prescribed by the Commissioner of Insurance [now the "Superintendent"] and was identical in form to the one considered in the decision of the Supreme Court of Canada in *Smith v. Co-operators General Insurance Co.*, [2002] 2 S.C.R. 129. In *Smith*, the majority of the Supreme Court held that the notice of termination form did not comply with s. 71 of the *SABS* because it did not inform the claimant of the entire dispute resolution process set out in the *Insurance Act*, R.S.O. 1990, c. I.8.

[4] In his reasons, the trial judge, after referring to *Smith*, concluded at paras. 12 to 14:

Likewise, in this lawsuit, the notices to terminate weekly benefits are invalid and therefore Allstate has improperly terminated the plaintiff's weekly benefit.

Section 64(13) SABS as it applies to the circumstances of this law suit sets out as follows:

..., and, if it is finally determined that the benefits should not have been stopped, the insurer shall,

- (a) resume payment of the benefits; and
- (b) pay the benefits that were not paid.

I therefore conclude that the plaintiff is entitled to the payment of weekly benefits to the date hereof and the continuation of weekly benefits in the amount of

\$356.00 hereafter.

ANALYSIS

[5] In my view, the trial judge's reliance on *Smith* was misplaced. *Smith* was concerned with the applicability of the two-year limitation period in the *Insurance Act*. The legislation required that a claimant bring an action against an insurer "within two years after the insurer's refusal to pay the benefit claimed or within such longer period as may be provided in the [SABS]." The *SABS* provided that where an insurer refused to pay a benefit, the insurer had to inform the claimant in writing of the procedure in the *Insurance Act* for resolving disputes relating to benefits.

[6] In *Smith*, the insured had been in a motor vehicle accident on April 14, 1994. She claimed and received statutory benefits from her insurer who ceased paying those benefits on May 8, 1996, by letter of that same date. The insured was unable to persuade the insurer to reinstate her benefits and proceeded to the required mediation on August 11, 1997, which failed. The insured issued a statement of claim for ongoing statutory benefits on September 8, 1998. The insurer moved for summary judgment to dismiss her claim on the basis that her claim had been issued more than two years after the insurer's refusal to pay the benefit claimed.

[7] The majority of the court found that the form sent by the insurer to notify the insured of the refusal to pay her IRBs was inadequate as it did not satisfy the requirement in the *SABS*. It did not inform the insured of the dispute resolution process in the *Insurance Act*, which provided how an insured who disagreed with the decision to terminate benefits could challenge that decision. The court determined that without certain basic information on the dispute resolution process, it could not be said that a valid refusal had been given. Since the limitation period only begins to run upon a refusal, the limitation period was not triggered and the insured's action could continue.

[8] Importantly, however, at para. 1 of the reasons Gonthier J. noted:

[T]here was no proper refusal made and the limitation period did not begin to run. The appellant is not barred from bringing her action. *However, I make no conclusion about the merits of her claim, which a trial judge must assess.* [Emphasis added.]

[9] The inadequate notice did not automatically entitle the insured to payment of benefits. She was still required, as the court acknowledged, to prove her claim.

[10] That same reasoning applies to the facts of this case. The inadequacy of the refusal notice did not entitle the respondent to payment of benefits in perpetuity until proper notice was given or a proper DAC assessment was carried out. The respondent was still required to prove that she was entitled to the continued payment of IRBs because of her continued substantial inability to perform the essential tasks of her employment. Moreover in this case no question of an expired limitation period arises.

[11] On the evidence before him the trial judge found that at the time the appellant gave the respondent notice of termination of her IRBs, her physical injuries had resolved to the point where she could resume a graduated return to her full-time employment. Her inability to perform her employment at that time was largely due to her psychological injuries. He further found that by August 1998 she was no longer depressed so that as of the fall of 1998 she no longer continued to suffer a substantial inability to perform the essential tasks of her employment at the restaurant, and had recovered from all her injuries related to the motor vehicle accident.

[12] The trial judge's findings are amply supported on the evidence before him.

[13] The respondent also argued that because the doctor who performed the DAC assessment was only authorized to assess musculoskeletal, brain and spinal cord impairments and not psychological or psychiatric impairments, the DAC assessment was invalid. The trial judge agreed and found that the

process was flawed and the respondent was entitled to continue to receive weekly benefits until a proper DAC assessment was conducted.

[14] While the doctor who performed the DAC assessment had the necessary academic and professional qualifications to conduct both physical and psychological assessments, he was only authorized under the DAC process to perform assessments of musculoskeletal, brain and spinal cord impairments. ^[1] While the DAC process was flawed as the result of this lack of authorization, this procedural flaw did not entitle the respondent to ongoing disability benefits unless she was entitled to those benefits under the statute – i.e., unable to substantially perform the essential tasks of her employment.

QUANTUM OF BENEFITS

[15] There is nothing in the reasons of the trial judge that demonstrate how he came to the conclusion that the amount of weekly benefit payable to the respondent was \$356.00.

[16] The appellant's position is that the amount of weekly benefit payable is \$234.23, which is based on the respondent's actual employment earnings during the four-week period preceding the accident.

[17] The relevant section of the *SABS* in force at the time reads:

GROSS ANNUAL INCOME

9. (1) For the purpose of determining the amount of a person's weekly income replacement benefit under paragraph 1 or 2 of subsection 7(1), the person's gross annual income from employment shall be deemed to be the following amount:

1. In the case of a person who designated the four weeks before the accident under paragraph 1 of subsection 7(2), the person's gross income from employment for the four weeks before the accident,

multiplied by thirteen.

...

(2) For the purpose of subsection (1), a person who,

(a) is entitled to weekly income replacement benefits under paragraph 1 of subsection 7(1);

(b) designated the four weeks before the accident under paragraph 1 of subsection 7(2); and

(c) started the employment in which he or she was engaged at the time of the accident during the four weeks before the accident,

may elect that the person's gross income from employment for the four weeks before the accident be deemed to be the amount determined by taking the person's gross income from employment for the part of the four-week period for which the person earned income from the employment in which he or she was engaged at the time of the accident and extrapolating it over the rest of the four-week period.

[18] The appellant's position is that having been continuously employed at the Village Inn Steak House & Dining Lounge (the "Village Inn") in the four-week period prior to the accident, and having chosen such four-week period for the calculation of the weekly benefit, it is s. 9(1)1 of the *SABS* that ought to apply. Using her actual employment income for the four-week period yields a benefit of \$234.23 per week.

[19] If one applies s. 9(2) of the *SABS*, it is argued, the benefit would be \$356.00 per week; however, the appellant submits that s. 9(2) is only available where the respondent had changed jobs during the four-week period prior to the accident.

[20] The record discloses that the respondent began to work at the Village Inn in December 1995 on a part-time basis. She worked about 15 hours per week and was paid \$10 per hour less deductions. She mostly did the books, although when required she would help out the owner in the kitchen or with other aspects of the business including the day-to-day administration of the office.

[21] About two and one-half weeks before the accident, the respondent became a full-time employee of the restaurant. She was doing all the things she did before but now on a full-time basis, working Monday through Friday from 8:30 a.m. to 4:30 p.m. or 9:00 a.m. to 5:00 p.m. This change resulted in an obvious increase in her income that, if she were permitted to take into account in the calculation of her IRBs, would result in a greater weekly benefit payment to her.

[22] The appellant argues that the respondent did not “[start] the employment in which she was engaged at the time of the accident during the four weeks before the accident”. Rather, she started that employment in December 1995. Her job remained unchanged and her employer remained unchanged. All that changed was the number of hours worked and her status as a part-time or full-time employee.

[23] Clearly, the respondent started full-time employment in the two and one-half weeks prior to the accident. The question remains whether that change alone is sufficient to bring the respondent within the language of s. 9(2)(c) – “started the employment in which he or she was engaged at the time of the accident during the four weeks before the accident”.

[24] In my view, the change is sufficient. The appellant has not pointed to anything elsewhere in the legislation that suggests the legislature intended by this section to reference only changes in the actual nature of the employment or employer. Indeed, common sense would suggest the contrary. If, for example, the respondent had left the Village Inn and started a new job with a different employer doing the same kind of work she had at the Village Inn, there is no doubt she would have been covered and able to qualify for IRBs using s. 9(2). Similarly, if she had gone from an entry-level employee at a hotel earning \$10 per hour to the manager at the same hotel earning \$150,000 per year, she would qualify under s. 9(2).

[25] The obvious purpose of s. 9(2) is to afford to persons who have started new employment with higher wages immediately before being injured in an accident, access to IRBs at a higher rate.

[26] It will be recalled that at the time this particular regime was in place in Ontario, injured claimants were unable to bring claims in tort for economic loss. To make up for this loss, accident benefits were more generous than they had been under prior regimes.

[27] Had the legislature intended a more restrictive interpretation, it could and would have chosen clear language to signal that intention. It did not do so. In my view, the language is sufficiently broad to cover the respondent's situation and she should be paid benefits during the period of her entitlement accordingly.

THE CROSS-APPEAL

[28] The respondent cross-appeals against the trial judge's finding that by the fall of 1998 she no longer continued to suffer a substantial inability to perform the essential tasks of her employment.

[29] The medical evidence before the trial judge was conflicting and it was for him to decide what evidence he accepted and what evidence he rejected.

[30] There was evidence before the trial judge which supported his finding. For example, there was evidence that the respondent had begun a course of treatment with a psychiatric outreach program in November 1997 and that the respondent was discharged from that program in July 1998. The discharge note stated: "... she is coping well despite some ongoing family/business stressors."

[31] I see no basis on which to interfere with the trial judge's conclusions in this regard.

CONCLUSION

[32] In result, the appeal is allowed, and the judgment is set aside. In its place, judgment shall issue in accordance with these reasons. The cross-appeal is dismissed.

[33] Costs of the appeal and cross-appeal are to the appellant, fixed in the sum of \$30,000.00 inclusive of disbursements and G.S.T.

[34] In view of the result on appeal, in the event counsel are unable to agree on the costs of trial, they may make brief written submissions to the court within 30 days of the release of these reasons.

[35] The result of this decision is that the respondent is entitled to payment weekly of benefits at the rate of \$356.00 to September 24, 1998, and interest on any unpaid amount in accordance with the *SABS*.

RELEASED: June 21, 2010 “STG”

“J. MacFarland J.A.”

“I agree S. T. Goudge J.A.”

“I agree H. S. LaForme J.A.”

[\[1\]](#) The doctor was certified individually onto the DAC roster. As such, at his office only musculoskeletal, brain, and spinal cord impairments were authorized to be assessed under the DAC process.