Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A06-000399

BETWEEN:

T.N.

Applicant

and

PERSONAL INSURANCE COMPANY OF CANADA

Insurer

REASONS FOR DECISION

Before: Eban Bayefsky

Heard: April 6-8, 12-15, October 12, 13, 19-21, 26, 28, December 7-9, 13, 15-17, 2010, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: Kevin Doan for Ms. T.N.
Philippa Samworth for Personal Insurance Company of Canada

Issues:

The Applicant was catastrophically injured in a motor vehicle accident on October 29, 2000, when she was 21 years old. She applied for and received certain statutory accident benefits from Personal Insurance Company of Canada ("Personal"), payable under the *Schedule*. [1] Personal denied the Applicant's claim for various other benefits. The parties were unable to resolve their disputes through mediation, and the Applicant applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

---

[1] *The Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996, Ontario Regulation 403/96, as amended.*

The Applicant requested that her identity be anonymized in this decision. The Insurer consented to this request. Given the highly sensitive nature of the personal, family and medical information in this case, I find the Applicant's request to be reasonable.

The issues in this hearing are:

1. Is the Applicant precluded from receiving income replacement benefits on the basis that she failed to apply for mediation and arbitration within two years of Personal's refusal to pay those benefits, pursuant to section 51(1) of the *Schedule*?

2. Was the Applicant employed or self-employed at the time of the accident?

3. If the Applicant was self-employed, is the rent of the family-owned barn to be added as losses from self-employment, pursuant to sections 6(5) and 6(6) of the *Schedule*?

4. Did the Applicant fail to submit an application for attendant care benefits to Personal within 30 days after receiving the application forms, contrary to section 32(3) of the *Schedule*, and, if so, what are the consequences of that failure?

5. Did the Applicant fail to submit an application for housekeeping benefits to Personal within 30 days after receiving the application forms, contrary to section 32(3) of the *Schedule*, and, if so, what are the consequences of that failure?

6. If the answer to Issue 4 is "no", is the Applicant entitled to attendant care benefits, from the date of the accident and ongoing, at the rate of $5,904.76 per month, pursuant to section 16(2) of the *Schedule*?

7. If the answer to Issue 5 is "no", is the Applicant entitled to housekeeping benefits from October 29, 2000 and ongoing, at a rate of $100 per week, pursuant to section 22(1) of the *Schedule*?

8. Is the Applicant entitled to nutritional counselling services, in the amount of $720, pursuant to sections 14(2)(h) and/or 15(5)(l) of the *Schedule*?

9. Is the Applicant entitled to medical and/or rehabilitation benefits for the purchase of medical marijuana, from December 14, 2005 and ongoing, at the rate of $1,200 per month, pursuant to sections 14(2)(h) and/or 15(5)(l) of the *Schedule*?

10. Is Personal liable to pay the Applicant a special award on the basis that it unreasonably withheld or delayed payments, pursuant to section 282(10) of the *Insurance Act*?

11. Is the Applicant entitled to interest on overdue benefits, pursuant to section 46 of the *Schedule*?

12. Is either party entitled to its expenses of the arbitration, pursuant to section 282(11) of the *Insurance Act*?

Result:

1. The Applicant is not precluded from receiving income replacement benefits.

2. The Applicant was employed at the time of the accident.

3. Given that the Applicant was employed at the time of the accident, it is unnecessary to determine Issue 3.

4. The Applicant did not fail to submit an application for attendant care benefits as required, and is entitled to arbitrate her entitlement to those benefits.

5. The Applicant did not fail to submit an application for housekeeping benefits as required, and is entitled to arbitrate her entitlement to those benefits.

6. The Applicant is entitled to attendant care benefits from October 29, 2000 and ongoing, at the rate of $5,056.80 per month, less any amounts already paid by the Insurer.

7. The Applicant is entitled to two hours of housekeeping services per week, from May 1, 2008 and ongoing.

8. The Applicant is entitled to nutritional counselling services, in the amount of $720.

9. The Applicant is entitled to medical benefits for the purchase of medical marijuana, from March 27, 2007 and ongoing, at the rate of $567.60 per month.

10. At the request of the parties, the issue of a special award will be addressed at a resumption of the hearing, if required.

11. At the request of the parties, the issue of interest will be addressed at a resumption of the hearing, if required.

12. The issue of expenses will be addressed at a resumption of the hearing, if required.

EVIDENCE AND ANALYSIS:

Limitation Period

The Applicant claimed income replacement benefits ("IRBs") from May 2, 2003, the date of the Insurer's most recent denial of IRBs. In the course of the hearing, the Insurer conceded the Applicant's substantive entitlement to these benefits. However, the Insurer maintained that the Applicant was precluded from receiving the claimed benefits on the basis that she had failed to apply for mediation or arbitration within two years of the Insurer's refusal to pay the benefits. Pursuant to sections 281.1 of the *Insurance Act* and 51(1) of the *Schedule* an insured person must commence a mediation or arbitration "within two years after the insurer's refusal to pay the benefit claimed." The Insurer denied IRBs on three separate occasions. The Insurer submits that the Applicant had until May 2, 2005 (two years from its most recent denial of IRBs) to apply for mediation or arbitration. The Applicant applied for mediation on November 4, 2005 and for arbitration on February 20, 2006.

The Applicant made several arguments in respect of the limitation period:

- the limitation period never began to run because the Insurer had never clearly accepted the Applicant's entitlement to IRBs;

- the limitation period never began to run because the Applicant had not been advised of her ability to make a claim for certain IRBs, and therefore she had not "discovered" her loss to make such a claim;

- the Insurer failed to issue a clear and unequivocal refusal of benefits;

- the Insurer failed to set out the reasons for the denial, contrary to section 45 of the *Schedule*;

- the Insurer failed to properly advise her of her rights to dispute the denial, contrary to the Supreme Court of Canada's decision in *Smith v. Co-Operators General Insurance Company*;[2]

- the Applicant lacked the capacity to dispute the Insurer's refusal of IRBs in a timely manner;

- the Insurer's termination of IRBs was unconscionable, and therefore null and void, since the Insurer knew the medical and personal difficulties the Applicant was experiencing at the relevant times.

I find that I need only consider the question of whether the Insurer issued a clear and unequivocal refusal of benefits in accordance with *Smith v. Co-operators* in order to determine whether the Applicant was entitled to proceed to mediation and arbitration on her claim for IRBs. I find that the Insurer failed to issue a proper termination of benefits, that the limitation period never began to run and that the Applicant was, therefore, not barred from proceeding to mediation and arbitration on her entitlement to IRBs.

The two-year limitation period begins to run from the date the applicant receives a clear and unequivocal refusal of benefits.[3] Further, section 49 of the *Schedule* states that if an insurer

[2] [2002] 2 S.C.R. 129

[3] See, for example, *Zeppieri and Royal Insurance Company of Canada* (FSCO A-005237, February 17, 1994), appeal dismissed (FSCO Appeal P-005237, December 22, 1994), *Adami and Wawanesa Mutual Insurance Company* (FSCO A08-000172, October 8, 2008) and *Monks and Dominion of Canada General Insurance Company* (FSCO A08-001237, May 1, 2009), appeal dismissed (FSCO Appeal P09-00018, December 10, 2009).

refuses to pay a benefit, it shall provide the insured person with a written notice concerning the person's right to dispute the refusal. In *Smith v. Co-Operators*, Gonthier, J., for the Court, stated:

> In my opinion, the insurer is required under s. 71 [the predecessor to s. 49] to inform the person of the dispute resolution process contained in ss. 279 to 283 of the *Insurance Act* in straightforward and clear language, directed towards an unsophisticated person. At a minimum, this should include a description of the most important points of the process, such as the right to seek mediation, the right to arbitrate or litigate if mediation fails, the mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process. Without this basic information, it cannot be said that a valid refusal has been given.

As noted, the Insurer denied the Applicant IRBs on three separate occasions. The first was on April 10, 2001 in an OCF-9 (an Explanation of Benefits Payable by Insurance Company form) issued to the Applicant, in which the Insurer noted the IRBs payable as "0.00" and stated:

> Based on Section 30(2)(b) you are excluded from receiving Income Replacement Benefits under this policy as you are not a named insured according to Section (3). We are therefore denying payment of Income replacement benefits…

The OCF-9 leaves the "Eligible" and "Ineligible" boxes in the Weekly Benefits section blank. Neither the OCF-9 nor a letter of the same date sent to the Applicant's lawyer at the time, Mr. Allan Dick, and copied to the Applicant, set out the process by which the Applicant could dispute the Insurer's denial of benefits. The issue of the exclusion was subsequently resolved and the Insurer began to pay the Applicant IRBs. However, the Insurer then had the Applicant medically assessed and determined that she was no longer entitled to these benefits. The Insurer, therefore, issued its second denial in an OCF-9, dated November 15, 2002, in which the "Not Eligible" box in the IRB section was checked off, and the following stated:

> Based on the Neuropsychological, Orthopaedic and Functional Abilities Examination reports as well as all other medical documentation on file, you are no longer eligible for this benefit as you do not suffer a substantial inability to perform the essential tasks of your employment or a complete inability to perform any employment for which you are suited by education, experience and training. Please see attached correspondence dated November 15, 2002 for further documentation.

The accompanying letter set out the process by which the Applicant could dispute the denial of IRBs, as follows:

> You have the right to dispute our decision pursuant to the dispute resolution provisions of Sections 279 to 283 of the Insurance Act. The dispute resolution process includes the following:
>
> - The first step is for you to apply for mediation at the Financial Services Commission of Ontario (FSCO) within two years of our refusal to pay the amount claimed
> - If mediation fails to resolve the dispute, you have the right to arbitrate the dispute at FSCO or initiate legal proceedings in court against us
> - Before the claim proceeds to arbitration or litigation it must proceed through the mediation process at FSCO
> - Any arbitration or court action must be commenced within two years of our refusal to pay the benefit claimed
> - The release of the mediator's report will extend the limitation period by 90 days, if the mediation was commenced in time

The Applicant subsequently accepted the Insurer's offer to be assessed by a Designated Assessment Centre (a "DAC") and, once the DAC had delivered its report, the Insurer issued its final denial. In an OCF-9 dated May 2, 2003, the "Not Eligible" box in the IRB section was checked off and the Insurer stated as follows:

> Based on the Post-104 Disability DAC, you do not suffer a complete inability to engage in any employment for which you are reasonably suited by education, training or experience. You are no longer eligible for the Income Replacement Benefit. We have received your self employment documentation submitted by Goodman Carr and are currently having it reviewed by an accountant. We shall contact you should further information be required.
>
> A copy of the Disability DAC has been forwarded to Allan Dick of Goodman Carr.

The OCF-9 also set out the Applicant's right to dispute the denial, as follows:

> You have the right to dispute our decision pursuant to the dispute resolution provisions of Sections 279 to 283 of the Insurance Act. The dispute resolution process includes the following:

- The first step is for you to apply for mediation at the Financial Services Commission of Ontario (FSCO) within two years of our refusal to pay the amount claimed

- You cannot commence a mediation proceeding unless:
    - you have notified us of the circumstances giving rise to a claim for an accident benefit and submitted an application within the prescribed times,
    - you have made yourself reasonably available for any insurer examination required by the insurer, and
    - you have made yourself available for any designated assessment centre assessment and you have cooperated with the centre and submitted to any examinations requested by it.

- Any arbitration or court action must be commenced within two years of our refusal to pay the benefit claimed

- The release of the mediator's report will extend the limitation period by 90 days, if the mediation was commenced in time

I need not consider the adequacy of the first denial given that the Insurer subsequently began to pay the Applicant IRBs and, therefore, negated any refusal that had previously been issued.[4] I find that the second denial was clear and unequivocal and contained the elements set out by the Supreme Court in *Smith v. Co-operators*. However, the Applicant subsequently underwent a DAC assessment and, consequently, the Insurer continued to pay the Applicant IRBs. Once the DAC delivered its report, the Insurer issued its third denial. While the second denial appeared to be a valid refusal, the limitation period was not triggered until the Insurer notified the Applicant that it was relying on the DAC report to stop paying benefits.[5] The Insurer's third denial was problematic in two respects. First, it did not contain a clear and unequivocal refusal of IRBs, in that it stated both that the Applicant was no longer eligible for such benefits, and that the Insurer had received the Applicant's self-employment information and was having it reviewed by an accountant. The Insurer also raised the possibility of obtaining further information from the Applicant. I find that, at the same time it was attempting to deny benefits, the Insurer was also signalling to the Applicant that it was considering information relevant to the payment of IRBs and, therefore, that the payment of IRBs was still a possibility.

---

[4] See, for example, *Rudnicki and Certas Direct Insurance Company* (FSCO A00-000930, April 19, 2001), appeal dismissed (FSCO P01-00024, December 12, 2001).

[5] See, for example, *Murugappa and Aviva Canada Inc.* (FSCO P06-00036, May 1, 2008), application for judicial review dismissed (2009) 251 O.A.C. 193 (Ont. S.C.J., Div. Ct.) and *Trewin and Wawanesa Mutual Insurance Company* (FSCO A07-001852, November 10, 2008).

Secondly, the third denial contained a much more convoluted statement than the second denial of the Applicant's rights to engage the dispute resolution process. In her submissions, the Applicant noted that a denial in language identical to that contained in the third denial was recently found to be inadequate to trigger the limitation period.[6] The Insurer submitted that *Yifru* was wrongly decided because it overextended the meaning and scope of *Smith v. Co-operators*, that it was distinguishable since, unlike the present case, it dealt with a situation in which the only communication of the insured's rights was the noted language in the OCF-9, and that, in any event, the second and third denials were valid refusals (taken either separately or together).

In *Smith v. Co-operators*, the Supreme Court stated that an insurer must inform the insured person of the dispute resolution process in "straightforward and clear language, directed towards an unsophisticated person." As already noted, the second OCF-9 was overtaken by the subsequent payment of benefits pursuant to the DAC process. However, even if the second OCF-9 were still relevant to the running of the limitation period, it cannot be viewed in isolation from the third OCF-9. In my view, in order for the dispute resolution process to be described in a clear and straightforward manner, it must be done clearly and *consistently*.[7] In this case, the description provided in the second denial was significantly obfuscated by the explanation provided in the third denial. The third denial omits two of the key elements contained in the second denial (and required by *Smith v. Co-operators*), namely, the right to arbitrate or litigate if mediation fails and the need to seek mediation before resorting to arbitration or litigation. The third denial substitutes a sizeable list of what the Applicant must do prior to commencing a mediation, and then returns to basic statements as to the time lines for arbitration and litigation. I find (as was found in *Yifru*) that the third denial failed to set out the sequence of steps in the dispute resolution process in a clear and straightforward manner, and in a way that would make sense to an unsophisticated person. I find that the alterations and deficiencies in the third notice were fatal in themselves and rendered the overall denial process confused and ineffective.

---

[6] *Yifru v. Certas Direct Insurance Company*, [2010] 83 C.C.L.I. (4th) 299 (Ont. S.C.J.)

[7] I note, as well, the observation that "requiring an applicant to piece together information from scattered documents opposes the principle in *Smith* that the insurer is required to inform the applicant of the dispute resolution process 'in straightforward and clear language directed to an unsophisticated person.'" *Yee and Lambton Mutual Insurance Company* (FSCO A02-001550, September 16, 2003) and *Trewin*, *supra*, note 5.

The Insurer attempted to suggest that the Applicant understood her rights under the *Schedule* and that her delay in pursuing IRBs was done on the advice of counsel. While the Applicant testified that she understood the place of the DAC in the process of claiming IRBs, I do not see any evidence to the effect that the Applicant understood the various steps in the dispute resolution process (as articulated in *Smith v. Co-operators*). In any event, in order to assert the limitation period, the Insurer bears the onus of establishing that it has issued a clear and unequivocal refusal of benefits, which sets out the Applicant's right to engage the dispute resolution process in a clear and straightforward manner. This is an objective test to be applied without regard to what an insured might or might not have known following a termination of benefits.[8] I find that the Insurer has failed to meet the onus of establishing, on an objective basis, that it issued a clear and unequivocal refusal of benefits in accordance with the decision in *Smith v. Co-operators*. It is, in part, on this basis that I find it unnecessary to consider the issue of whether the Applicant lacked the capacity to dispute the Insurer's refusal of IRBs in a timely manner and whether the Insurer's termination of IRBs was unconscionable, and therefore null and void.

I, therefore, conclude that the manner in which the Insurer terminated IRBs was inadequate to trigger the limitation period and that the Applicant was not precluded from mediating or arbitrating the issue of income replacement benefits.

Employment Status and IRB Calculation

The parties disagree as to whether the Applicant was employed or self-employed at the time of the accident for the purposes of calculating the quantum of IRBs. The Insurer maintained that the Applicant was a manager-employee of her parents' business, whereas the Applicant maintained that she ran her own business. If the Applicant was self-employed, the issue is whether the rent of the family-owned barn should be treated as a loss from self-employment within the meaning of section 6(5) of the *Schedule*.

[8] See *Turner and State Farm Mutual Automobile Insurance Company* (FSCO P00-00046, February 1, 2002), application for judicial review granted (2004), 18 Admin. L.R. (4th) 306 (Ont. S.C.J., Div. Ct.), appeal allowed (2005), 26 Admin. L.R. (4th) 275 (Ont. C.A.), and *Monks and Dominion of Canada General Insurance Company* (FSCO Appeal P09-00018, December 10, 2009), application for judicial review dismissed, [2011] O.J. No. 3292 (Ont. S.C.J., Div. Ct.).

At the time of the accident, the Applicant lived with her family on a farm where, in April 2000, she started a facility for the boarding and training of horses. Her mother testified that they had built stables for the horses, that the Applicant set up the stalls for the horses, and that at the time of the accident, the business was good, with 18-20 boarders, and 7-8 students. Her mother stated that the Applicant would be at the barn from 7:00 a.m. to 7:00 p.m., seven days a week, taking care of the horses and giving lessons. She also did marketing for the training programme and to get boarders for the business. Her mother stated that this enterprise was set up because the Applicant's father wanted to give her a business and an opportunity. Her mother said that the Applicant did not get a salary for taking care of the barn, that the lessons the Applicant taught were separate from the business account and that she was allowed to keep the money she generated from the lessons. Only the Applicant's father and mother had signing authority for the business. The Applicant's mother stated that she and her husband provided all of the capital for the business and that the Applicant's father bought the equipment for the business. She said that the Applicant was not going to pay rent for the leasing of the barn for her teaching during the first year of the business and that she was not paid wages out of the business's account. The mother stated that the Applicant was self-employed in the teaching lessons, and that she was deemed to be a barn manager/coach.

The Applicant's younger brother testified that the Applicant was in charge of the whole operation at the barn.

The Applicant testified that the enterprise was one business and that her mother was the bookkeeper. She said that her parents bought the equipment for the business and that she would not be responsible for paying rent for the first year of the business. On November 27, 2002, the Applicant filed a Declaration of Post-Accident Income and Benefits, in which she stated that she had received income from self-employment at the business from May 2000 to the present, and that her job title was "manager-trainer."

The Applicant's father owned the property on which the barn was situated, as well as the barn itself. The business was legally registered in June 2000, and the Applicant's father was identified as the sole proprietor of that business. The Applicant's father stated that he wanted his daughter

to start a business and that he expected to receive rent from her as soon as the business began to make money. He also stated that if the business did not make money, he would either not charge his daughter any rent or he would close down the business.

The Applicant received free room and board, and lived in an apartment above the barn where the horses were kept. The Applicant did not file income tax returns for the business.

Section 2(5) of the *Schedule* states that, for the purposes of the Regulation, a person is employed if "for salary, wages, other remuneration or profit, the person is engaged in employment, including self-employment, or is the holder of an office…." The *Schedule* does not define "self-employment." The Commissioner's Guideline 4/96, entitled *Guideline for Identifying Self-employed Individuals*, sets out some of the criteria for determining self-employment under the *Schedule*. Pursuant to section 268.3 of the *Insurance Act*, such a guideline "shall be considered" in any determination involving the interpretation of the *Schedule*. The Guideline states, in part, as follows:

> For the purposes of the *SABS*, an individual is considered self-employed if the business he or she derives his or her remuneration from is not incorporated under any law. For example, sole proprietorships and partnerships are considered to be self-employment situations. If the individual derives his or her remuneration from an incorporated business, then he or she is considered to be an employee of the corporation.
>
> **DEFINITIONS**
>
> …
>
> Employee — An individual who is hired to perform pre-determined tasks/work in a business in exchange for remuneration.
>
> Employer — An entity, such as a corporation, group of individuals or a single individual, who hires another individual(s) to perform pre-determined tasks/work in a business in exchange for remuneration.
>
> …

1. TRADITIONAL SELF-EMPLOYMENT SITUATION

THE INDIVIDUAL:

…

- has an established location where business transactions take place.
  …
- determines own method and schedule for accomplishing tasks.
- determines own hours and may not necessarily work a set number of hours per period (i.e. 40 hour week).
- negotiates the price(s) of product(s) or fee(s) for service(s) with the customer or client with the exception of regulated fields (i.e. physicians).
- determines the annual income as his or her profit from the business according to the Income Tax Act (Canada) and Income Tax Act (Ontario).
- is ineligible for regular Employment Insurance benefits.
- contributes the employer and employee contributions to Canada Pension Plan (CPP) for his or her own pension plan.
- collects and remits all taxes to different levels of government according to each respective tax legislation (i.e. GST, PST, source deductions from employee(s)).

IN THE CASE OF A SOLE PROPRIETORSHIP:

- has control over:

  (1) the hiring and dismissal of employee(s),
  (2) the wage level and hours of work of employee(s),
  (3) the method by which employee(s) accomplish work, and
  (4) executive decisions surrounding the business.

The proper use of the Guideline was discussed in the case of *Johnston and AXA Insurance (Canada)* (FSCO A04-002670, February 8, 2008), the following comments from which I find instructive:

> …as noted by Director's Delegate Makepeace in *Iankilevitch and CGU Insurance Co. of Canada* [FSCO P03-00013, August 31, 2004], the Guideline sets out the indicators of a "traditional self-employment situation" and "does not purport to be an exhaustive statement of the law [as] that would be unrealistic, because deciding whether a claimant is self-employed or a corporate employee requires a consideration of many factors."

> …
>
> The Guideline therefore is to be considered but, while it may be persuasive, it is not determinative. It is trite to say that each case must be decided on its own facts. The substance as well as the form of an applicant's business and financial arrangements within the overall pre-accident context must be considered in order to decide whether "self-employment" or "employment" best reflects the applicant's fiscal reality and keeps with the objective of neither over [n]or under compensating.

In the judicial decision of *Ligocki v. Allianz Insurance Company of Canada*, [2010] 100 O.R. (3d) 624 (Ont. S.C.J.), the Court considered the issue of whether the plaintiff was working as an employee or an independent contractor for the purposes of determining how to calculate income replacement benefits under the *Schedule*. The Court stated the following:

> The determination that a worker is an employee or an independent contractor is largely a finding of fact. There is no one conclusive test which can be universally applied to determine whether a person is an employee or an independent contractor….The court must take into account the total relationship of the parties: *671122 Ontario Ltd. v. Sagaz Industries Canada Inc.*, [2001] 2 S.C.R. 983 (S.C.C.) [*Sagaz*], at para. 46. In saying this, the Supreme Court of Canada rejected the traditional control test as the sole test of employment status. Among other tests, the Supreme Court considered the entrepreneur test articulated in *Wiebe Door Services Ltd. v. Minister of National Revenue*, [1986] 3 F.C. 553 (Fed. C.A.) [*Wiebe Door*], to be determined by examining the following non-exhaustive list of factors (*Sagaz*, at paras. 40, 46-48):
>
> - Level of control over the worker's activities;
> - Whether the worker provides his own equipment;
> - Whether the worker hires his own helpers;
> - The degree of financial risk taken by the worker;
> - The degree of responsibility for investment and management held by the worker; and
> - The worker's opportunity for profit in the performance of his or her tasks.
>
> The key question is whether the individual has been engaged to provide services as a person in business on his or her own account, weighing each of these factors against the particular facts and circumstances of the case (*Sagaz*, at para. 47).
> …
> In addition to what may be called objective factors which can determine the status of the relationship, some courts at the federal level have begun to consider the intention of the parties, or what might be called subjective factors.

This is a somewhat unique business situation. The working relationship between the Applicant and her parents contained elements of both employment and self-employment. On balance, however, I find that the Applicant's status was more in the nature of an employee than a self-employed person. While the Applicant had basic control of the operations of the equestrian facility, the key financial aspects of the business remained with her parents. The Applicant's father established the business as an opportunity for the Applicant, but she bore none of the business's financial risk. The Applicant retained the money generated by the lessons she taught, but this was due to her parents allowing this to occur, and she did not stand to suffer financially as a result of the lessons not generating income. The Applicant's father purchased and owned all of the equity in the facility. While the Applicant identified herself after the accident as being self-employed, the Applicant's father registered as the sole proprietor of the business when it was established. The Applicant's mother was the bookkeeper for the business, only the parents had signing authority and the Applicant did not file income tax returns for what she earned from the business. The business was essentially in its infancy at the time of the accident, and the Applicant had not yet begun to pay rent for use of the premises. This was contingent on the business becoming profitable, and if it did not, the Applicant's father had the option of shutting the business down entirely. I, therefore, find that while the day-to-day operations of the facility were in the Applicant's hands, in form, substance and intention the Applicant's parents retained control of the business, with the Applicant operating the facility more as an employee on behalf and at the discretion of her parents, than as a self-employed individual running her own business.

In light of this conclusion, I find it unnecessary to determine the issue of whether the rent of the family barn was a loss from self-employment for the purpose of calculating the Applicant's income replacement benefits.

The Application for Attendant Care Benefits

Pursuant to section 32(1.1) of the *Schedule*, a person is required to notify the insurer, within 30 days of the accident, or as soon as practicable thereafter, of their intention to apply for a benefit. An insurer must then promptly provide the person with the appropriate application forms and

information to assist the person with applying for benefits. Pursuant to section 32(3), the person must submit an application for benefits within 30 days of receiving the application form.

The Insurer maintains, in part, that the Applicant did not apply for attendant care benefits within 30 days of receiving the application forms, as required by section 32(3) of the *Schedule*, and that it should not be required to pay attendant care benefits prior to December 18, 2006, when the Applicant submitted an application for attendant care benefits. I find that the Applicant's delay in submitting a formal Application for Benefits does not, in itself, relieve the Insurer of paying the Applicant any attendant care benefits to which she may have been entitled.

On November 15, 2000, roughly two weeks after the accident, the Insurer sent the Applicant an Application for Benefits by registered mail. The Applicant's lawyer at the time, Mr. Dick, advised the Insurer that the Applicant did not receive the Application, and the Insurer sent out another Application on December 13, 2000. The parties exchanged a number of letters over the next few months, concerning both the nature of the Applicant's claim, as well as the Insurer's concern that the claim should, in fact, be advanced to another insurer. On at least two occasions during this time, the Insurer reminded the Applicant of the need to submit a completed Application for Benefits. The Applicant ultimately submitted an Application on or about April 4, 2001.

The only specific consequence under the *Schedule* for failing to submit an Application for Benefits in a timely fashion is that set out in section 50(a), namely, being precluded from proceeding to mediation. The Insurer did not argue that the Applicant was precluded from mediating or arbitrating the issue of attendant care benefits because of her failure to submit the Application within 30 days of receiving the forms. However, the Insurer did, in part, suggest that the Applicant's delay relieved it from paying attendant care benefits until at least December 2006, when it received the specific application for attendant care benefits. I find that the fact that the Applicant did not submit an Application for Benefits until April 2001 has no bearing on the Insurer's obligation to pay the Applicant benefits to which she may have been entitled. In my view, the delay in submitting an Application for Benefits is only relevant to an insured person's ability to mediate or arbitrate a claim. This determination turns on whether the person provides

the insurer with sufficient information to permit the insurer to commence the process of adjusting the claim.[9]

I find that the Insurer in this case had ample information to commence the process of adjusting the claim, if not for all of the available benefits, then certainly for the matter of attendant care benefits. This arises from two principal sources, the first being Mr. Dick's correspondence of November 30, 2000 and the Insurer's Claims Advisor's meeting with the Applicant and Mr. Dick on December 19, 2000. In the noted correspondence, Mr. Dick stated, in part, as follows:

> [The Applicant] apparently scored an 8 on the Glasgow Coma Scale ["GCS"] at the time of the accident and, as such, suffered a catastrophic impairment within the meaning of the Statutory Accident Benefits Schedule.
>
> She was initially seen at Mississauga Hospital and was transferred to Sunnybrook Hospital where she remained until last week. She had a number of surgeries at Sunnybrook Hospital including two to her head. She was admitted last week to West Park Hospital. It is currently contemplated that [the Applicant] will be allowed to remain at home relatively soon and arrangements will be made for her to receive the ongoing care and treatment she requires.
>
> We are recommending the use of the case management and rehabilitation services provided by Kent Bowman & Associates Ltd. As you are aware, Mr. Bowman has extensive experience in managing the care of individuals who have suffered head injuries.

The parties then arranged a meeting and the Claims Advisor attended the Applicant's residence to discuss the case with the Applicant and Mr. Dick. The Claims Advisor subsequently wrote to Mr. Dick, in part, as follows:

> Thank you for taking the time out of your busy schedule to meet with me on December 19,20 [sic] with your client. I truly appreciate your time and courtesy and I am very happy to see the progress that [the Applicant] has made to date.

---

[9] See, for example, *McIntosh and Allstate Insurance Company of Canada* (FSCO A02-001277, April 23, 2004), appeal dismissed (FSCO Appeal P04-00019, March 15, 2005).

In her log notes, the Claims Advisor noted that she had spoken to the Applicant in the presence of her mother and lawyer. The Claims Advisor notes certain details of the accident, the Applicant's pre-accident employment, income and living circumstances, her insurance coverage, the initial hospital report (noting a GCS score of 7 upon arrival at the hospital) and the Applicant's visible head injuries. The Claims Advisor also notes that there had been "some A/C [attendant care] needs and [Mr. Dick] has arranged for her to attend Brampton Rehab Centre which is a DAC [Designated Assessment Centre]." The Claims Advisor also noted that she had "advised [Mr. Dick that she] will arrange for a Form 1 to be completed."

Over the next few months, the parties continued to be in contact on various aspects of the claim, including her treatment and progress, associated expenses and the proper insurer to respond to the claim.

In these circumstances, I find that, although there was some delay in the Applicant forwarding a formal Application for Benefits, the Insurer had more than sufficient information to begin the process of adjusting the claim for attendant care benefits, and had, in fact, indicated that it would commence the assessment of the Applicant's attendant care needs. I, therefore, find that the Applicant's failure to comply with section 32(3) of the *Schedule* does not, in itself, relieve the Insurer of paying the Applicant any attendant care benefits to which she may have been entitled.

The Insurer maintained that it should not be required to pay attendant care benefits prior to December 2006, when it received a formal application for those benefits. Pursuant to sections 16(1) and (2) of the *Schedule*, an insurer must pay all reasonable and necessary attendant care expenses incurred as a result of an accident. Under section 16(4), the monthly amount of the attendant care benefit must be determined in accordance with Form 1. As of 2005, section 39(1) of the *Schedule* provided that an application for attendant care benefits must be in the form of an assessment of attendant care needs prepared and submitted by a legally authorized health professional. Similarly, section 39(3) stated that an insurer "may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with subsection (1) is submitted to the insurer." I find that the fact that the Applicant did not submit a Form 1 to the

Insurer until December 2006, does not relieve the Insurer of its obligation to pay the Applicant any attendant care benefits to which she might have been entitled.

In my view, section 39(3) of the *Schedule* does not displace an insurer's basic obligation to pay reasonable and necessary attendant care benefits determined in accordance with a duly prepared Form 1. Section 39(3) establishes an insured's obligation to claim attendant care benefits in accordance with a Form 1, and an insurer's right to await a Form 1 before assessing an insured's entitlement to attendant care benefits. Section 39(3) allows an insurer to pay attendant care benefits without a Form 1. It states that an insurer is not required to pay attendant care benefits before a Form 1 is submitted. This does not, in my view, mean that an insured forfeits their right to attendant care benefits, or that an insurer is released of any obligation to pay attendant care benefits, prior to the Form 1 being submitted. In my view, significantly stronger statutory language would be required to effect this purpose. The section as it now reads simply ensures the orderly determination of a person's need for attendant care (in accordance with a proper attendant care needs assessment), and protects an insurer from having to determine what it should pay in the absence of a specific and legitimate attendant care needs assessment. This, however, leaves open the question of whether a person is entitled to attendant care benefits prior to the submission of a Form 1, and this can only be answered in light of the evidence at the relevant times. The question at that point will be whether the evidence prior to the receipt of the Form 1 reflects the assessment contained in the Form 1.

The Insurer in this case maintained that it would be prejudicial for it to be required to pay attendant care benefits retroactively, and in particular, from the time of the accident. However, as with the previous determination under section 32(3), I find that the Insurer had ample information in the early stages of the claim to begin to address the issue of attendant care benefits, especially in light of the fact that the Applicant had likely been catastrophically impaired in the accident. Significantly, the Insurer's log notes of August 3, 2001 note that a Form 1 was to be completed "to ensure that clients attnd [attendant] care needs are $0" and that this was "to be documented, should client attempt to submit a backdated attdnt care claim." Subsequently, at the Insurer's request, Aneez Virani, an occupational therapist, prepared a Form 1 on September 17, 2001, concluding that no attendant care was required. According to a

December 19, 2001 internal Corporate Office Reporting Status Report (Narrative), the Insurer concluded that, based on the Form 1, there were "no attendant care issues." The Applicant did not challenge Ms. Virani's report at the time. The Insurer also did not issue an Explanation of Benefits denying the Applicant's entitlement to attendant care benefits. The Applicant was recovering well from her injuries, and the focus of the parties shifted primarily to the Applicant's ability to return to productive employment.

The Applicant changed lawyers in mid-2005. She subsequently applied for mediation on various issues, including her entitlement to attendant care benefits in accordance with her having been catastrophically impaired. At the Insurer's request, the Applicant submitted an Application for Determination of Catastrophic Impairment on June 15, 2006. The parties proceeded to a pre-hearing conference, at which time the Insurer acknowledged that the Applicant had sustained a catastrophic impairment as of the date of the accident. The Insurer confirmed this in a letter dated December 14, 2006. On December 18, 2006, the Applicant submitted a Form 1 and formal application for attendant care benefits. The Insurer adjusted the claim in the normal course, initially denying these benefits on March 1, 2007, but then paying them in accordance with a Form 1 they had prepared in July 2008. At the hearing, Andrea Kool, the Insurer's senior accident benefits claims advisor who handled the Applicant's file from 2002 forward, testified that the Insurer had not been disadvantaged at all by the late submission of the claim for attendant care benefits, and that the Insurer was not maintaining that the Applicant was disentitled to anything on this basis.

In my view, while the Applicant did not formally and specifically apply for attendant care benefits until December 2006, the Insurer was well aware of the issue of attendant care benefits from early on in the process, and in fact anticipated the possibility that the Applicant might seek to claim such benefits retroactively. It would, of course, have been preferable for the Applicant to have responded to Ms. Virani's report at the time it was issued, but I see no evidence that the Insurer was incapable of properly responding to the claim once it was made, and the Insurer's senior claims advisor, in fact, testified that there was no prejudice to the Insurer from having received the formal application for attendant care benefits much later in the claim. I note, as well, that the Insurer never clearly denied these benefits until 2007, and did not attempt to suggest that

the Applicant was precluded from claiming them by operation of any limitation period. The Applicant was free to claim these benefits at a later stage, particularly in light of the fact that the Insurer only formally acknowledged in December 2006 that the Applicant had been catastrophically impaired since the date of the accident.

I, therefore, find that, while delayed, the Applicant properly raised the issue of attendant care benefits, that the Insurer was fully capable of responding to the claim, and that the real question is whether the Applicant has established her entitlement to the quantum and duration of benefits claimed.

The Application for Housekeeping Benefits

The Applicant claims housekeeping benefits from the date of the accident, ongoing, at the rate of $100 per week. In a manner similar to its argument on attendant care benefits, the Insurer maintains that the Applicant failed to apply for housekeeping benefits within 30 days of the expenses being incurred, contrary to sections 32(3) of the *Schedule*. While the Insurer raised these concerns, it did not specifically argue that the Applicant is disentitled to housekeeping benefits as a result. I note, as well, the evidence of Ms. Kool (discussed above in connection with attendant care benefits) that the Insurer was not prejudiced by the Applicant's delay in applying for benefits, and was not attempting to suggest that the Applicant was disentitled to any benefits on this basis. In any event, I find that the Applicant is not precluded from receiving housekeeping benefits on the basis of delay.

As with the Applicant's claim for attendant care benefits, the Insurer either was or ought to have been aware of the Applicant's claim for and/or potential entitlement to housekeeping benefits from early on in the claim. The Insurer's Claims Advisor met with the Applicant, along with her mother and lawyer, approximately two months after the accident, and reviewed the Applicant's living circumstances, as well as the Applicant's need for attendant care assistance. The Applicant submitted a formal Application for Benefits in April 2001, along with a Disability Certificate from the Applicant's family doctor, which indicated that the Applicant suffered from an impairment that substantially prevented her from performing her pre-accident housekeeping

and/or home maintenance activities. The Insurer's log notes of April 10, 2001, indicate that the Applicant is able to "shop and partially prepare meals…to wash dishes [and] with respect to housekeeping she is partially able to complete these chores." The Insurer did not issue an Explanation of Benefits either denying housekeeping benefits or requesting additional information about the extent of the Applicant's household limitations. In my view, the Insurer had ample information to commence the process of adjusting the Applicant's entitlement to housekeeping benefits.

Following her change of solicitors in mid-2005, the Applicant filed for mediation on a variety of issues, including her entitlement to housekeeping benefits. The Applicant subsequently applied for arbitration and, pursuant to a request by counsel for the Insurer on August 24, 2006 (and following the pre-hearing conference on September 5, 2006, at which time housekeeping benefits were confirmed as an issue for the arbitration), the Applicant formally applied on December 18, 2006 for housekeeping benefits, from November 24, 2000 to July 31, 2006 at an average rate of $100 per week, and from August 1, 2006, onward, at $50 per week. The Applicant subsequently made several specific claims for housekeeping benefits commencing in January 2009, and the Insurer responded with several OCF-9s denying these claims on the basis that the Applicant did not suffer a substantial inability to perform her pre-accident housekeeping duties.

While the issue of housekeeping benefits developed in a somewhat haphazard way, I find that the Insurer was more than capable of addressing the matter, and particularly in early 2001. The issue was confirmed at the mediation in late 2005, and subsequently in late 2006. While the Applicant only submitted specific claims for housekeeping expenses commencing in 2009, I do not find that the Applicant is precluded from receiving such benefits, as long as she is able to establish her substantive entitlement to them. Again, during the hearing, the Insurer's evidence was that it was not prejudiced by the Applicant's delay in applying for benefits, and it was not suggesting that the Applicant was disentitled to any benefits on this basis. The essential question is whether the evidence as a whole indicates that, as a result of the accident, the Applicant was substantially disabled from performing her pre-accident housekeeping duties.

Entitlement to Attendant Care Benefits

The Applicant sought attendant care benefits 24 hours per day from the date of the accident, due to the severity of her impairments and the risks she faces if left without round-the-clock assistance and monitoring. The Insurer maintained that the Applicant was not entitled to any attendant care benefits, on the basis that she had not provided sufficient evidence of the nature and extent of the services allegedly provided. In the alternative, the Insurer maintained the Applicant would be entitled to attendant care from the date of the accident, in accordance with the Form 1s prepared by Ms. Irene Vrckovnik, an occupational therapist, at rates ranging from $1,246.20 per month to $1,685.60 per month. The Insurer has been paying attendant care benefits at the rate of $1,685.60 per month as of July 18, 2008.

As a preliminary matter, the Applicant maintained that the Insurer did not properly advise her of her rights to attendant care benefits, did not properly assess her entitlement to those benefits (when it was both clear attendant care was required, and when there was sufficient information to constitute an application for attendant care benefits), and did not offer the Applicant an attendant care DAC in a timely way. However, the Applicant did not go to the point of arguing that these breaches (assuming them to have taken place) entitled her to attendant care benefits regardless of her substantive entitlement to those benefits. In any event, even if the alleged breaches occurred, they would not, in my view, entitle the Applicant to the attendant care benefits claimed. I rely on the case of *Stranges v. Allstate Insurance Company of Canada*, [2010] 103 O.R. (3d) 73 (Ont. C.A.) (leave to appeal to the Supreme Court of Canada dismissed, without reasons, [2010] S.C.C.A. No. 334), where the Court of Appeal found, in part, that the failure of an insurer to provide adequate notice of the denial of income replacement benefits did not "automatically entitle the insured to payment of benefits. She was still required…to prove her claim." I find that, even if the procedural breaches occurred as alleged, the Applicant must still establish her substantive entitlement to attendant care benefits.

Pursuant to section 16(2) of the *Schedule*, an insurer is required to pay, in part, for "all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant." Pursuant to section 16(4) of the

Schedule, the monthly amount of attendant care benefits "shall be determined in accordance with Form 1."

What constitutes reasonable and necessary attendant care expenses is, of course, something to be determined on the particular facts of the case. As indicated above, the fact that an applicant has delayed in submitting a Form 1 is not necessarily fatal to their entitlement to attendant care benefits, as long as they can establish that they have incurred such expenses as a result of the accident, and that the expenses are at least those set out in the Form 1 ultimately provided. While entitlement to attendant care benefits can be determined in the absence, or prior to the date, of the Form 1, arbitral decisions have established that there must be "fairly detailed evidence of what services were provided, by whom and for what period of time" and that the "*Schedule* does not allow [an arbitrator] to speculate about the nature of the services provided, the length of time they were provided, as well as their cost in order to make an award based on what seems reasonable."[10] I note, however, that it is not essential that an applicant provide proof that services were, in fact, obtained and/or paid for, as long as they have provided sufficient evidence of their need for such services.[11]

I find that, as a result of the significant physical and psycho-emotional injuries she suffered in the accident, the Applicant experienced various personal, social and functional difficulties which required her to be supervised, assisted and monitored throughout the day and night, for her own safety and that of the people around her. The Insurer submitted that various assistive devices were available to the Applicant to protect her in the event of an emergency. I find that, given the nature of the Applicant's impairments, these devices would not be adequate to ensure her personal safety or the people with whom she was involved. I further find that the Applicant provided sufficient evidence of the nature of attendant care services provided, the identity of the individuals providing the care, and the times this assistance was either required or provided.

---

[10] *The Estate of Salvatore Buccellato and Allstate Insurance Company of Canada* (FSCO A03-000609, April 14, 2004). See, also, *McKnight and Guarantee Company of North America* (FSCO A02-000299, October 28, 2003) and *A.K.P. and ING Insurance Company of Canada* (FSCO A04-000219, May 3, 2006).

[11] *Belair Insurance Company v. McMichael* (2007), 86 O.R. (3d) 68 (Ont. S.C.J., Div.Ct.)

As noted earlier, at the time of the accident, the Applicant was in the process of establishing an equestrian facility for the boarding and training of horses, as well as providing riding lessons. The Applicant had also been involved in competitive riding, at which she excelled. Her mother described her as being in a "good place" and a "happy place" in her life, and as having a normal temper. The Applicant's mother testified that her daughter was fully involved with her equestrian business, and that it would have been very successful if the accident had not happened. Her older brother also described the Applicant this way, although he acknowledged that after high school and before the accident, his sister had become involved with the "rave" scene at dance clubs, taking "magic mushrooms" and "Ecstacy." The Applicant testified that she was heavily involved in the rave scene, but that this was only until she was 19, roughly two years before the accident.

(i) The Applicant's Injuries

The Applicant suffered significant physical, psychological and emotional injuries as a result of the accident. The Insurer has accepted that the Applicant is catastrophically impaired as a result of the accident. A Medical and Rehabilitation DAC on October 29, 2002 noted the following as some of the accident related injuries:

- significant head injury – Glasgow Coma Scale 7/15
- depressed compound skull fracture of temporal bone
- left pulmonary contusion
- right facial nerve damage
- right cranial nerve damage
- TM joint pain
- neck and back strain
- depression
- substance abuse
- post-traumatic stress disorder

On August 2, 2002, Dr. Lawrence Freedman, a neuropsychologist, reported as follows:

> Cognitively [the Applicant] is presenting with mild to at times moderate neurocognitive impairment….In addition, [the Applicant] also presents with behavioural features of mild disinhibition, which likely secondary to traumatic damage to the right orbitofrontal or ventromedial cortex.…[The Applicant] also acknowledged that she suffers from significant posttraumatic fatigue, and in my opinion, this is not unexpected given the nature and severity of the sustained

> injuries….she appears to present with difficulties adjusting to the multiple cognitive, behavioural and sensorimotor sequelae from the craniocerebral and facial trauma….

In late 2002, Ms. Johanna Gabel, a registered nurse and psychotherapist who has been working with the Applicant since May 2001, reported that "behaviorally there have [been] some significant changes [in the Applicant] such as: a hearing impairment, slurred speech, facial disfigurement, and anger outbursts" and that she has "difficulty with organization, memory, and concentration", with "frequent mood swings related to triggering events and concurrent depressive symptoms." On June 30, 2005, Ms. Gabel reported that the Applicant suffered from adjustment disorder, post-traumatic stress disorder and chronic pain.

On April 6, 2006, Ms. M. Pinchefsky, a speech language pathologist, reported the Applicant and her mother stating that the Applicant suffered from the following difficulties as a result of the accident:

- lack of mental energy to do activities
- being slow to respond
- having the feeling that her mind is blank
- easily distracted by surrounding noise
- difficulty keeping track of activities and thoughts as her mind wanders
- being able to concentrate for only very short periods of time
- misses details and makes mistakes
- easily gets off track if people are milling about nearby
- difficulty paying attention to a conversation if more than one person participates
- easily loses her place if the task or her thinking is interrupted
- easily overwhelmed if a task has several components
- difficulty paying attention to more than one thing at a time

(ii) The Applicant's Impairments

A number of individuals testified that, as a result of the injuries she suffered in the accident, the Applicant experienced various personal, social and functional difficulties.

The Applicant said that she has lost control of her emotions following the accident. She testified that, while she had used drugs prior to the accident, she has begun to use alcohol and marijuana on a regular basis to cope with the pain, anxiety and insomnia resulting from the accident.

She said that she often stumbles in the morning if she gets up too fast, because she has lost equilibrium in one ear. She stated that she does not know how many times she has almost burnt her parents' house down by leaving things on the stove. The Applicant testified that, for the first five years after the accident, her mother provided all of her attendant care, noting that she drove her to all of her surgeries (of which there have been approximately seventeen) and medical appointments. The Applicant acknowledged that her mother was reimbursed for her driving expenses. The Applicant said that she will call her husband (whom she married in 2008) three to four times a day.

The Applicant recounted a number of incidents involving her safety and security following the accident, and provided a written chart of some of these situations. She recorded that in February 2002, she "impulsively drove against [her] parents' advice…during a winter storm…, lost control and caused [a] collision." The Applicant recounted an incident in 2004 where she was sexually assaulted by a friend and co-worker after some drinking, and that if she had had better balance, she could have fought him off. This incident does not appear to have been reported to the police, although it was mentioned to Ms. Gabel, the Applicant's psychotherapist. Various other incidents began in 2006, after the Applicant stopped seeing Dr. Chanth Seyone, a psychiatrist, due to the issue of using traditional pain and anxiety medication versus marijuana. She drove her car while her licence was suspended. She was charged with driving while under the influence of alcohol. Her use of drugs and alcohol increased significantly. She was involved in various disputes with her family, sometimes resulting in the police being called, and one involving a serious physical altercation with her older brother, where she suffered broken ribs.

The Applicant testified that in the summer of 2009, she drank three large beers while sitting in a car in a parking lot, after which she drove the car, hitting another car in the parking lot, and was charged with impaired driving. She stated that she has mentioned suicide a few times since the accident, and that once, in the summer of 2009, she cut her wrist with the dull side of a knife in front of her brother after an argument with him, stating that "I've been through so much, maybe I'll just kill herself."

The Applicant's mother testified that the Applicant was unable to fully return to her work at the barn, became depressed and was rendered a "walking zombie" as a result of anti-depressant medication she had been prescribed by Dr. Seyone. She said that her daughter did not think she had any limitations, and tried to return to her horse training business and competitive riding. The Applicant's mother stated that she was her daughter's caregiver for the first five years after the accident, and, in particular, drove her daughter to almost all of her medical appointments during this time. However, she did say that her daughter was able to take her to the hospital in 2003 when she, herself, suffered a heart attack. She stated that her daughter's short-term memory diminished after the accident and that she had to remind her to take her medications. The Applicant's mother testified that the Applicant would sometimes lose her way to medical and other appointments, and called for directions (and on at least one occasion in 2002, she had to "talk her down" because her daughter was lost and frustrated). She stated that her daughter would "go with anyone, since she was so thankful they went out with her." She said that she only heard about the alleged sexual assault much later, in approximately 2005. She reported in 2006 that she would call her daughter each day to see if she had had anything to eat for lunch. She testified that this was the case from the time of the accident. She said that her daughter once set a grease fire in her kitchen in 2006. She stated that her daughter stopped taking all of the prescribed medication in the spring of 2006, began to self-medicate and became very argumentative and abusive at that time. The Applicant's mother testified that in late 2007, she was forced to take out a restraining order against her daughter because her daughter would come to her house with her boyfriend at the time and damage her property. She has had very little contact with her daughter since then.

The Applicant's mother-in-law testified that the Applicant was quite forgetful, and that she was worried about the Applicant's health since she was so thin. However, she stated that the Applicant was able to work to a certain extent with her horses, doing some heavy chores, such as lifting feed bags, and that the Applicant was "emotionally intact" when around animals.

The Applicant's younger brother testified that the Applicant became very abusive to him after the accident, and that their relationship has become very strained as a result. He stated that she

was very forgetful after the accident, sometimes burning toast and leaving the water running. He was concerned that his sister is by herself and that she might start a fire in her house.

The Applicant's older brother testified to the same effect, noting that the Applicant had left a pot of water on the stove even after the water had fully boiled off. He stated that the Applicant has become very abusive after the accident, probably without realizing that she's hurting people's feelings. He testified that the Applicant once threatened suicide, that the police were called and she was taken to a place and kept under observation for a day or two.

Ms. Gabel, who has been treating the Applicant since approximately six months after the accident, testified that from the very beginning of their sessions together, the Applicant was very impulsive, angry and emotional. A year after beginning therapy, Ms. Gabel noted the Applicant as being in "perpetual crisis" and as needing "reassurance and support." Ms. Gabel testified that, despite the Applicant being very depressed and anxious, she had no general concerns with the Applicant's safety because she was with her mother all of the time. She stated that, in the first two years of therapy, the Applicant's mother came into the sessions with her. Ms. Gabel testified that the Applicant forgot multiple appointments with her, that she forgot to take things with her when she left Ms. Gabel's office, and that she would forget to look at the lists of things Ms. Gabel set out for the Applicant to do. Ms. Gabel recorded that, in January 2008, the Applicant mentioned the alleged sexual assault.

Ms. Michele Himelstein, an occupational therapist and, since 2007, the Applicant's case manager, testified that she responds to the Applicant's calls approximately two to three times per week, to help her cope with financial and marital problems, as well as to remind her to prepare meals, and to attend medical appointments. Ms. Himelstein stated that, in two team meetings at the Applicant's home, she had to remind the Applicant to eat breakfast, that the Applicant could not hear people knocking at the door, and that she had to remind the Applicant to turn off the kettle on the stove. Ms. Himelstein testified that she was very concerned for the Applicant's safety living alone and that she needed constant supervision, which she, and the Applicant's friend and mother-in-law were providing. Ms. Himelstein stated that the Applicant's husband provided support when he was there in the evenings and weekends. In cross-examination,

Ms. Himelstein acknowledged that the Applicant was on her own during various times of the day and sometimes on the weekend, when her husband was away, and that an automatic shut-off kettle had been provided to the Applicant in 2009 and is working.

The Applicant's friend testified that she was with her in the summer of 2010, when the Applicant's husband was away, and that she helped to remind her to have meals, and to take her to her medical appointments, because the Applicant would often forget to eat and would get lost.

The Applicant's husband testified that the Applicant has significant problems with anger and anxiety, that in anger she has mentioned killing herself, that on three separate occasions, he has had to restrain her from jumping out of the car, and that on one occasion, she cleaned ashes out of the fireplace and placed them in a container on the carpet, which then burned through the carpet. The Applicant's husband testified that his home "may not be there the next time." He stated that the Applicant got into an altercation with her brother in January 2008, that her brother assaulted her and broke three of her ribs. The Applicant's husband testified that he talks to his wife on the phone morning, noon and night, when he is at work, to make sure everything is all right. He stated that he is out of the house four to five times a week in the evening, for roughly six months a year, as a referee in a hockey league.

Given the significant emotional and psychological difficulties the Applicant suffered following the accident, I accept that she would be entitled to a certain degree of attendant care assistance. The issue is what level of care she would be entitled to and at what times. A number of reports were prepared on this matter.

(iii) Assessments of Attendant Care Needs

The first assessment of the Applicant's attendant care needs was prepared by Ms. Aneez Virani, an occupational therapist, at the request of the Insurer. Ms. Virani reported the Applicant as saying that she had made a "substantial recovery", and had "resumed tasks related to self-care and homemaking." Ms. Virani prepared a Form 1, dated September 17, 2001, in which she did not recommend any attendant care services.

The Applicant first submitted an attendant care Form 1 on December 18, 2006, prepared by Ms. Nancy Katsouras, an occupational therapist, and dated May 8, 2006. Ms. Katsouras recommended 24-hour attendant care, almost exclusively under the Level 2 Attendant Care category for Severe Brain Injuries where the "the client lacks ability to respond to an emergency or needs custodial care due to changes in behaviour." Ms. Katsouras indicated that the Applicant was not safe to be left alone and would not be able to live independently. Ms. Katsouras testified that the Applicant was unpredictable and, therefore, needed 24 hour support and assistance, which she had had through her family since the accident.

At the request of the Insurer, a further Form 1 was prepared on January 29, 2007 by Ms. Vrckovnik, an occupational therapist, who indicated that, "while…in the past [the Applicant] might have required some level of attendant care, this [was] not supported at the present time." Based to a significant degree on interviews with the Applicant and her boyfriend at the time (with whom she had been living for approximately six months), Ms. Vrckovnik felt that the Applicant was safe to be left alone. Ms. Vrckovnik noted that the Applicant had various people she could call for assistance.

Ms. Vrckovnik conducted a further assessment on July 18, 2008, at which time the Applicant's personal and living circumstances had changed, and Ms. Vrckovnik now recommended four hours of attendant care per day, five days a week, essentially to assist at "meal preparation times…and help break up the monotony and loneliness during the day when [the Applicant] is home alone" (the latter being as a result of being "isolated in her current home, with no public transportation or ability to drive"). Ms. Vrckovnik noted that "without attendant supervision, …[the Applicant] is at risk of experiencing an incident and has a lower functional level due to her cognitive limitations such as poor memory." However, Ms. Vrckovnik did not provide for attendant care while the Applicant's husband was otherwise present in the house. Ms. Vrckovnik stated that, when the Applicant was home alone, she would benefit from the "Linkage with Life Line Support" programme, which allows an individual 24 hour access to emergency support. Ms. Vrckovnik testified that such a "lifeline" could be used to call 911, a friend or relative in the event of an emergency.

Ms. Vrckovnik prepared one final Form 1 on October 16, 2009, with an increase to eight hours per day, seven days a week, in "attendant care supervision…due to [the Applicant's] increased stress level and poor coping skills" and the "husband's working evenings." As indicated, the Insurer is now paying attendant care on this basis. Ms. Vrckovnik continued to feel that 24-hour supervision was not necessary, in part, for the following reasons:

- the Applicant specifically said she did not want someone with her at all times, telling her what she could and could not do

- even with the assistance and presence of her family and friends, the Applicant continued to demonstrate maladaptive and risky behaviour, including excessive alcohol and drug consumption

- the Applicant's general psychological and functional competence is inconsistent with round-the-clock supervision

- the Applicant is quite manipulative and would continue to act out due to increased pain and stress levels, even with a professional attendant

On April 10, 2008, Dr. Robert Gates, a psychologist retained by the Applicant, reported that he did not "know for certain if [the Applicant] would be unsafe living alone, but…it [was] reasonable to assume that she <u>would</u> be unsafe due to her cognitive impairments in the domains of perceptual cognitive function and executive function" (emphasis in original). Dr. Gates stated that the Applicant did not need "continuous, one-to-one supervision, but she needs support, which could include, on a long-term basis, assistance with housekeeping and homemaking." Dr. Gates also stated that, in respect of the Applicant's ability to function within the community, "without any support I fear that her functioning could deteriorate, particularly from the psycho-emotional or behavioural point of view, and if that were to happen, she would certainly encounter any number of substantial risks to her safety…." Again, Dr. Gates did not feel one-to-one supervision was required. In a supplemental report, Dr. Gates clarified that the Applicant required 24-hour supervision, in the sense that "someone in a position of responsibility <u>always</u> needs to be aware of [the Applicant's] location and her activity" (emphasis in original). He stated that "this has been the case ever since her injury, and will hold true for the rest of her life." Dr. Gates testified that he had some doubt if the Applicant could respond appropriately to an emergency at night, without someone available to assist her. He noted, for example, that individuals, such as the Applicant, with frontal lobe injuries, would decide to stay and fight a

fire, instead of trying to flee it. He said that specific arrangements needed to be worked out for someone she could call for assistance, and someone who would know where and when she was planning on going out. In cross-examination, he acknowledged that the Applicant had assisted her mother when she suffered a heart attack (by, in part, calling 911), stating that, on that day, she had the ability to respond.

On June 16, 2008, Ms. Tharshi Sivapalan, an occupational therapist retained by the Insurer, conducted a further attendant care assessment and prepared a Form 1, indicating that due to the Applicant's decreased memory and processing speed, as well as her poor executive functional skills, limited judgment, poor insight and low mood, which, in part, "affects her ability…to use good judgment in an unforeseen event/emergency", she required "24 hours per day of attendant care or supervision."

On September 9, 2009, Ms. Susanne Evanitski, an occupational therapist, prepared an updated Form 1 at the request of the adjuster, and reported that, "due to her cognitive-behavioural impairments…[the Applicant] requires 24 hour supervision or access to support to maintain her safety, security and emotional comfort." Ms. Evanitski testified that the Applicant was unpredictable and impulsive. She stated that the Applicant was not reliable in an emergency, and, for example, that she would be more inclined to stay and fight a fire to protect her pets and horses, than to escape the fire. On February 5, 2010, Ms. Evanitski prepared a Retrospective Assessment of Attendant Care Needs Report and Form 1, covering the period October 29, 2000 (the date of the accident) to September 9, 2009 (the day Ms. Evanitski assessed the Applicant's attendant care needs), and stated that due to the Applicant's cognitive-behavioural impairments, the Applicant required "24 hour supervision or access to support to maintain her safety, security and emotional comfort." In cross-examination, Ms. Evanitski testified that, "access" could refer to access to a "phone attendant."

On March 5, 2010, at the request of counsel for the Applicant, Ms. Katsouras, an occupational therapist, prepared a Retrospective Assessment of Attendant Care Needs Report and Form 1, covering the period October 29, 2000 (the date of the accident) to May 7, 2006 (the day before Ms. Katsouras became involved in the Applicant's case). Ms. Katsouras based her assessment on

a review of the file materials, as well as interviews with the Applicant, the Applicant's mother and Ms. Himelstein, the Applicant's case manager. Ms. Katsouras noted that, in the relevant time period, the Applicant was either in the hospital (the initial few weeks) or resided in the family home (in the country on a farm) with her mother as her primary support, with a two-year period (2005-2006) spent living with a boyfriend at a nearby apartment and an apartment over the barn on the family's farm. Ms. Katsouras noted that, within approximately two months of returning home from the hospital, the Applicant became independent in almost all of the Level 1, 2 and 3 Attendant Care activities noted in the Form 1. Ms. Katsouras noted that the Applicant underwent approximately seventeen surgeries and procedures following the accident, and that the Applicant's mother attended to her daughter on a one-to-one basis during those times, being roughly seventeen to thirty-four days in total. Ms. Katsouras stated that, despite the Applicant's significant overall recovery following the accident, as a result of her behavioural and cognitive changes and unpredictability the Applicant's safety had been severely compromised and that she required constant, twenty-four hour attendant care. Ms. Katsouras reported that between shortly after the accident and 2006, this care was provided by the Applicant's mother who was "either in the house, or called frequently and had the ability and flexibility with her job to leave as needed" and that this care continued "when the Applicant's boyfriend was at work and not available." Ms. Katsouras prepared the Retrospective Form 1 for $5,073.85 per month assistance, almost exclusively on the basis of Level 2 Attendant Care for Severe Brain Injuries where "the client lacks ability to respond to an emergency or needs custodial care due to changes in behaviour."

In cross-examination, Ms. Katsouras testified that the Applicant was able to dial 911 and leave the house in the event of an emergency. She also stated that a smoke alarm could be used in relation to the Applicant's hearing impairment, that a life-line button could help and that a vibrating device could be used to remind the Applicant to take her medications. Ms. Katsouras, nevertheless, maintained that the Applicant required 24-hour attendant care since her condition was unpredictable, that she needed someone to call, and that she needed a "safety net."

Finally, on March 10, 2010, Ms. Vrckovnik prepared a response to Ms. Evanitski's Retrospective Assessment of Attendant Care Needs Report, and concluded that the Applicant would have required six hours per day of attendant care from the time of the accident until

December 2005, no attendant care for 2006 and 2007 in accordance with her January 2007 report, and attendant care from 2008 onward at the rates set out in her 2008 and 2009 reports. The following is the most salient passage from her report on the need for attendant care from the time of the accident to 2005:

> It is also important to note, that at no point was there any mention (in any of the numerous reports reviewed), of [the Applicant's] cognitive challenges escalating to the point that she would have required 24 hour supervisory care. It is significant to remember that from the time of her auto accident, [the Applicant] was assessed by a coterie of medical/rehabilitation professionals (experienced, well trained individuals/specialists who likely possessed a good understanding of, and knowledge of accident benefits) who could have advocated for her in the event that she truly required 24 hour attendant care, for her safety. Thus, it appears that the assessors at the time felt that [the Applicant's] clinical presentation was not 'alarming' to warrant an assessment of her attendant care needs. The writer believes that although [the Applicant] likely required some attendant care after her accident, this was not at the level of 24 hour supervision. Based on the subjective reports of the client's mother, it is understood that she provided [the Applicant] with some assistance with transportation, preparing meals and supervising her behaviour (to keep track of her schedule of appointments), however, [the Applicant's mother] did not indicate that night time supervision was necessary nor 24 hour care.

(iv) The Applicant's Entitlement to Attendant Care

I find that the Applicant is entitled to 24-hour attendant care from October 29, 2000. I am cognizant of the caution against speculating about past attendant care needs. I am also aware of the fact that, despite the serious accident in which the Applicant was involved, and the very significant injuries she suffered, she was able to make an impressive recovery, even to the point of making a legitimate attempt to run her horse boarding and training business, as well as returning to a certain amount of competitive riding. Nevertheless, I find that there is more than sufficient evidence to establish that the Applicant had impairments as a result of the accident requiring round-the-clock supervision, and that this degree of care has been provided by a number of individuals since the time of the accident.

I find the most recent report of Ms. Vrckovnik to be a useful framework within which to consider the Applicant's entitlement to 24-hour attendant care in the first years following the accident.

I agree that none of the assessing or treating physicians, or other health care practitioners, in the initial stages of the Applicant's case identified a need for 24-hour supervision. However, the issue is not whether these individuals were ***qualified to*** assess such a need, or ***could have*** identified such a need, but whether they squarely addressed that question and determined that there ***was no*** such need. Other than Ms. Virani (which I will discuss in a moment), this is simply not the case. The closest that the physicians came to dealing with this issue is as follows:

1) Dr. Michael Devlin's response in 2001 to the question of whether the Applicant should participate in cognitive/behavioural therapy implemented by a psychologist familiar with acquired brain injury;

2) Dr. Freedman's consideration in 2002 of whether the Applicant suffered from any neurocognitive impairment that affected her ability to work or perform her activities of daily living, and whether she required any additional supportive counselling;

3) Dr. C. Goodfield's consideration in 2002 (as part of the Medical and Rehabilitation DAC assessment) of whether the Applicant should receive any additional treatment or services;

4) Dr. Shulamit Mor's response in 2003 (as part of the Post-104 Week Disability DAC assessment) to the question of whether the Applicant suffered a complete inability to engage in any employment for which she was reasonably suited.

First, none of these assessors was asked directly about the Applicant's need for attendant care, whether during part of the day or for the entire day. Dr. Devlin indicated that the Applicant did not need any special cognitive/behavioural therapy, but this was on the basis of the Applicant's self-reporting that, although she had poor short-term memory, she was using a daybook to remind herself of appointments, and was improving. However, this flies in the face of Ms. Gabel's and the Applicant's mother's more detailed and extensive evidence of the Applicant's significant need to be reminded of medical appointments and the limited usefulness of tools to help her in this regard. Various practitioners also observed that, because of her admirable motivation to get better and to return to her previous life, the Applicant tended to downplay her limitations.

Dr. Freedman concluded that the Applicant did not need any specific neurocognitive therapy, but in doing so, noted Ms. Gabel's observation that the Applicant had difficulty in controlling emotional outbursts, and required ongoing, supportive counselling. He also indicated that the Applicant would benefit from "brief psychological intervention to help her abort episodes of inappropriate social behaviour secondary to mild disinhibition."

Dr. Goodfield agreed that a disputed treatment plan for psychotherapy and counselling was reasonable and necessary, and in so doing, noted that objective psychological testing indicated that the Applicant suffered from significant depressive symptoms (including increased irritability, fatigue and cognitive disturbance) and that the Applicant may be "repressing the extent of her unhappiness." Dr. Goodfield also noted the Applicant as saying that she had a "wonderful boyfriend" at the time, who "keeps me cool."

Finally, while Dr. Mor found that the Applicant was not completely incapable of engaging in reasonably suitable employment, this was on the basis that she had returned to part-time work, and that, "given the fragility of [the Applicant's] emotional state, although she is able to manage some work within her self constructed environment,…there remains some psychological concern."

Thus, while none of these practitioners indicated a need for attendant care, they were not asked to comment on the question, and, in any event, supported the view that the Applicant suffered from significant psycho-emotional problems in the initial years following the accident that required support, counselling and intervention.

The only person to directly address the issue of attendant care was Ms. Virani (roughly a year after the accident). While Ms. Virani concluded that no attendant care was needed, there are two significant problems with this result. First, Ms. Virani's analysis is extremely limited, essentially revolving around the Applicant's self-report of substantial ***physical*** recovery and having resumed her self-care and homemaking tasks, as well as some of her vocational duties. This fails to take into account the significant psycho-emotional upheaval in the Applicant's life, and the counselling and support she needed and was receiving from the people around her. It is also contradicted by Ms. Vrckovnik's most recent report, which, on the basis of a more complete

understanding of the Applicant's situation, concluded that the Applicant would have required six hours per day of attendant care from the time of the accident until December 2005. I find that Ms. Virani's conclusion that the Applicant required no attendant care at all, to be unsupportable.

The question, now, is whether the Applicant required round-the-clock supervision. This involves a consideration of the professional and lay evidence of such a need, the evidence of whether such assistance was actually provided, and whether reasonable alternative strategies existed which obviated the need for 24-hour care.

I find that the available evidence supported the need for 24-hour care in the years following the accident and continues to do so. While none of the early health care practitioners specifically identified a need for constant supervision, I find that the evidence established such a need. As discussed above, the views of the physicians consulted by the Insurer indicated serious problems on the part of the Applicant, requiring significant support and intervention. I found Ms. Gabel's evidence to be the most instructive in this regard. Ms. Gabel has intimate knowledge of the Applicant's challenges. She has treated the Applicant consistently from shortly after the accident to the present. Ms. Gabel aptly put it when, a year and a half after the accident, she stated that Applicant was in a state of "perpetual crisis" and needed "reassurance and support." I find significant her testimony that she had no particular concerns with the Applicant's safety because her mother was with her all of the time.

Ms. Vrckovnik felt that, while 24-hour care was not required (either initially or currently), six hours per day and eventually eight hours per day were required. In my view, however, this conclusion does not give sufficient weight either to the extensive problems the Applicant was experiencing or the care she was, in fact, receiving. Ms. Vrckovnik reported that the Applicant's mother only assisted with transportation, preparing meals and helping the Applicant to keep track of her appointments. But, as noted by Ms. Gabel and Ms. Katsouras, the Applicant's mother provided round-the-clock supervision and care, either by being available during the day to assist the Applicant and respond to her needs (including transporting her to her surgeries and medical appointments, and in fact participating in the psychotherapy sessions with her in the initial two years) or by being in the house during the day and night to respond to any problems that might

arise. Ms. Vrckovnik noted that the Applicant's mother did not identify a need for night time supervision or 24-hour care. But I see no evidence to the effect that the Applicant's mother was ever asked if this was required. In any event, the Applicant's mother (and the Applicant herself) testified, and I accept, that she was her daughter's caregiver in the first five years of the accident, providing various forms of assistance and being available to her daughter whether she was in or out of the house. I also find that the Applicant's mother's evidence must be viewed in light of Dr. Gates' evidence, namely, that while one-to-one supervision was not required, for the sake of the Applicant's safety someone in a position of responsibility always needed to be aware of the Applicant's whereabouts and activity. I find that the Applicant's mother provided just this type of role, by being, for all intents and purposes, on-call for the Applicant during the day, and available to and aware of the Applicant while in the house at night. I, therefore, agree with Ms. Evanitski that, due to the Applicant's cognitive-behavioural impairments, she required 24-hour supervision or access to support to maintain her safety, security and emotional comfort.

I acknowledge that the Applicant was not physically with someone at all times and that the people around her have attempted to go about their daily lives, leaving the Applicant alone during the day and evenings. In my view, however, this does not mean that the Applicant was not in need of care and supervision. Several people expressed concern for the possibility of the Applicant setting fire to the house. And the Applicant's family and companions remained in touch with her, despite their absence. As noted by Ms. Katsouras, this was even the case from 2005-2006, when the Applicant lived with her boyfriend at an apartment near her family's house and then over the barn at the family farm. Ms. Vrckovnik noted that the Applicant's boyfriend at the time did not feel there were any safety concerns in leaving the Applicant unaccompanied. However, this individual did not testify at the hearing, and appears to have been the same person the Applicant's mother complained was coming over to her house and damaging her property. This was also at the time that the Applicant's mother reported that she had to call her daughter every day to make sure she was eating lunch, that her daughter set a grease fire in her house and became very argumentative and abusive. I, therefore, put little weight in this evidence. I also note that, in a manner consistent with the evidence of Dr. Gates, Ms. Evanitski and Ms. Katsouras, Ms. Vrckovnik noted at the time that the Applicant had various people she could call

for assistance. I find that this is essentially the type of continuous care envisioned by the other three practitioners.

I acknowledge that the chart submitted by the Applicant (of incidents relating to her safety and well-being) only contains two incidents in the first five years of the accident, followed by a string of incidents to 2009. However, one of those incidents involved an alleged sexual assault. Even if it could be said that there were only two incidents in five years, and (without making any finding in this respect), even if it could be said that the assault did not take place, I do not find that this displaces the evidence discussed above to the effect that the Applicant faced significant challenges in her life as a result of the accident and required constant supervision and assistance.

The Applicant's situation deteriorated further in 2006, apparently related to the fact that she had begun to self-medicate. While this may or may not have been advisable, I find this to be consistent with the Applicant's mother's testimony that the conventional medications the Applicant was using rendered her a "walking zombie" and the Applicant's desperation to deal with the pain, anxiety, insomnia and lack of appetite she experienced following the accident. While the Applicant had used various types of drugs prior to the accident, I find that her drug use following the accident became much more frequent and serious, and was directly related to the injuries and impairments she suffered in the accident. The Applicant experienced stress and anxiety, as well, from her parents' divorce in the first few years after the accident. However, I do not find that this at all rendered insignificant the enormous effects of the accident on the Applicant's life and her attempts (whether successful or not) to alleviate the suffering she was experiencing. As several of the people around her testified, the Applicant has become abusive, unpredictable, volatile and potentially a danger to herself and others, particularly since 2006. I find that this supports the type of continuous care and monitoring suggested by Dr. Gates.

Based on Ms. Vrckovnik's evidence, the Insurer attempted to suggest that it would not make a difference to the Applicant's safety whether someone was with the Applicant or not, since she has been known to engage in dangerous and self-destructive behaviour in the presence of others (for example, abusing drugs and alcohol, becoming involved with individuals potentially dangerous to her, cutting herself and attempting to jump out of moving cars). In my view,

however, this does not mean that the Applicant should be left to her own devices. On the contrary, this reaffirms the Applicant's need for continuous support, assistance, monitoring and supervision. I note, in this regard, that Ms. Vrckovnik stated that, without attendant supervision, the Applicant was at risk of experiencing an incident due to her cognitive limitations. This is consistent with Ms. Sivapalan's conclusion that, due, in part, to her cognitive limitations, the Applicant had diminished ability to use good judgment in the event of an emergency and required twenty-four hour a day attendant care or supervision.

I also see no relevance to the fact (as noted by Ms. Vrckovnik) that the Applicant, herself, did not want someone to be with her twenty-four hours a day. As noted by a number of practitioners, the Applicant tended to minimize her needs for assistance. And Ms. Vrckovnik nevertheless suggested personal attendant care while the Applicant's husband was not present in the house.

Ms. Vrckovnik indicated that attendant care was not necessary while the Applicant's husband was in the house, specifically at night. In my view, however, just as the Applicant's mother was there to assist and monitor the Applicant when she lived at her house in the initial years following the accident, so too does the husband now provide that assistance. In this regard, I find the case of *Morrison v. Greig*, [2007] O.J. No. 225 (Ont. S.C.J.) instructive. *Morrison* involved a young man who also suffered a frontal lobe injury in an automobile accident, and as a result, was "confused, disoriented, agitated, experience[d] physical aggression, poor memory, lack of insight and poor balance, and concrete thinking." The Court stated that the plaintiff would require a great deal of assistance, even "when out socially." I find the following comments instructive:

> Because of his limitations, he will require attendant care for the rest of his life. There is some disagreement about the quality of attendant care that should be allowed for Derek. He has some reluctance to accept assistance from caregivers. The defence suggests that a much lower level of damages be considered because of a lack of likelihood that the Plaintiff will accept the help. In effect, such funds might be wasted.
>
> I do not agree with the defence position regarding attendant care. Today, Derek receives attendant care assistance. The care is not a luxurious form of care. It is necessary. There is no likelihood that Derek will recover and have no need for this form of care. Acquired brain injury is permanent. It affects his frontal lobe. To suggest that the recommended attendant care be reduced significantly or

> abandoned completely simply passes the task over to the family in the sense of dumping such responsibility on them. There is simply no justification for doing so.

I note that the plaintiff in that case also lived with his family after the accident. While, in certain ways, the plaintiff in *Morrison* functioned at a lower level than the Applicant, I find significant similarities between the two cases. I also consider it unreasonable to conclude that the Applicant's reluctance to accept constant personal attendant care or the fact the Applicant's husband resides with the Applicant at certain times of the day in any event, suggests that 24-hour care would not otherwise be required.[12]

I find the present case distinguishable from that of *Ryan and ING Insurance Company of Canada* (FSCO A07-000989, February 17, 2009) where the Arbitrator dismissed a claim for 24-hour attendant care, in part, on the basis that there was insufficient evidence to establish both that occasional incidents of forgetfulness and poor social judgment (such as leaving the stove or lit candles unattended, and breaking into a locked room while her parents were away) were related to the accident and that the applicant required "supervision while she sleeps because she is unable to

---

[12] I note the recent decision in *Henry v. Gore Mutual Insurance Company*, [2012] O.J. No. 2928 (Ont. S.C.J.), where the court considered entitlement to attendant care benefits under the amended *Statutory Accident Benefits Schedule*, which now defines the term "incurred." Section 3(7)(e) of the *Schedule* now provides:

> …an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,
>
> (i) the insured person has received the goods or services to which the expense relates,
>
> (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
>
> (iii) the person who provided the goods or services,
>
> (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
> (B) sustained an economic loss as a result of providing the goods or services to the insured person

The Court in *Henry* stated that this amendment "was apparently to prevent a member of an insured's family who was not ordinarily an income earner or working outside the home, from profiting from an attendant care benefit, when they would likely be at home anyway - and would have looked after the injured insured without compensation," thus addressing the finding in *L.F. and State Farm Mutual Automobile Insurance Company* (FSCO P02-00026, June 3, 2004) that payment by the insured to a family member for attendant care was not a precondition to the insured receiving attendant care benefits for the assistance of that family member.

Given that the current accident occurred in the year 2000, the amended *Schedule* does not apply in the present case.

rouse herself in response to an emergency." The Arbitrator found that, unlike in *Morrison*, the "residual cognitive and emotional impairments experienced by Mrs. Ryan that can be attributed to the 1998 accident are relatively mild." As discussed earlier, I find that there is considerable medical and lay evidence of the significant injuries the Applicant suffered as a result of the accident and that these have significantly impaired the Applicant's day-to-day functioning. I also find that the evidence establishes that, as a result of the accident, the Applicant faces significant danger in the event of an emergency, whether awake or asleep at the time.

The Insurer alluded to the fact, without actually arguing, that the Applicant had a checkered pre-accident history, involving drug use and a run-in with the police, and that her conduct following the accident was not considerably different from before the accident. As discussed, the Applicant did use drugs and alcohol prior to the accident, as she has done since the accident. However, I find that the Applicant's pre-accident use was in the context of socializing during "raves", whereas following the accident, her use has been on a much more frequent, and in fact daily basis to cope with her accident-related pain, anxiety, insomnia and lack of appetite. The Applicant did have an incident with the police approximately two years before the accident while on a family vacation in Mexico, where she was incarcerated overnight after being accused of possessing marijuana and being disorderly while dealing with the police. While, as Dr. Gates noted, this evinced poor judgment by the Applicant, I find that her behaviour has become much more abusive to the people around her, including her closest family members, and on a much more frequent and dangerous basis following the accident (for example, when a physical altercation with her older brother resulted in her ribs being broken). I, therefore, find that the Applicant's drug and alcohol abuse, as well as her inappropriate social behaviour, has significantly worsened following and as a result of the accident.

The Applicant claimed attendant care almost exclusively under Form 1, Level 2 Attendant Care for Severe Brain Injuries, where "the client lacks ability to respond to an emergency or needs custodial care due to changes in behaviour."

In respect of the Applicant's need for assistance to respond to an emergency, the Insurer argued that 24-hour attendant care was not necessary because there were various assistive devices

available to the Applicant to protect her in the event of an emergency, such as smoke detectors, a lifeline button and the Applicant's own cell phone. The Insurer also noted that the Applicant could be provided with a kettle and stove with an automatic shut-off feature. In my view, however, these devices do not address the fundamental problem of the Applicant's unpredictability, impulsivity and impaired judgment. As Dr. Gates, Ms. Katsouras and others testified, the Applicant may be capable of responding to certain situations (as she did when her mother suffered a heart attack), but due to her frontal lobe injury, she is also just as capable of responding inappropriately and dangerously to a crisis (for example, even if aware of a fire, staying to battle the blaze instead of leaving the premises). The availability of assistive devices also does not address the Applicant's need, not only to have access to assistance for the personal crises that she faces in the course of the day, but to have her whereabouts known throughout the day and to be accompanied when going out socially. The key here is that the Applicant requires constant monitoring and assistance to ensure that she neither harms herself nor is harmed by others.

Finally, the Insurer argued that the reference in Form 1 to "custodial care" does not include the type of access to support or monitoring sought by the Applicant. The Insurer referred me to definitions of "custodial care" which indicate that such care generally refers to assistance in performing activities of daily living (for example, assistance walking, preparing meals, dressing and so on).[13] Custodial care is not defined in the *Schedule*. The definitions provided are by no means exhaustive, and of course are not binding on me. Similarly, the Form 1 reference to custodial care could well include the type of access to support and monitoring sought by the Applicant, given that it is in relation to changes in behaviour due to severe brain injury. There is nothing to suggest custodial care ought to be given the narrow meaning suggested by the Insurer. I note, as well, that in determining the Applicant's potential entitlement to this (broader) form of attendant care, Ms. Vrckovnik (on whose evidence the Insurer so heavily relied) did not suggest that such assistance was not available under either Form 1 or the *Schedule*. On the contrary, Ms. Vrckovnik has already recommended assistance in light of the Applicant's legitimate need for access to support and monitoring.

[13] *My Patient Guide* (http://www.mypatientguide.com), *KIA Insurance Glossary of Terms* (http://www.kiains.com) and *Presbyterian Glossary* (http://www.phs.org)

I, therefore, find that the Applicant is entitled to 24-hour attendant care from the time of the accident. In final submissions, counsel for the Applicant stated that the Applicant sought attendant care benefits at the rate of $5,904.76 per month, without articulating the basis on which this amount was being claimed. The Form 1s the Applicant submitted range in value from $5,056.80 per month to $5,103.85 per month. I find the Form 1s prepared by Ms. Evanitski and Ms. Sivapalan (recommending attendant care at the rate of $5,056.80 per month) reasonably reflects the attendant care required by the Applicant. I find the Applicant is entitled to attendant care benefits at this rate from October 29, 2000, less the amounts already paid by the Insurer.

Entitlement to Housekeeping Benefits

The Applicant sought housekeeping benefits from the date of the accident, onwards, at a rate of $100 per week, on the basis that, as a result of the accident, she was substantially unable to do her normal pre-accident housekeeping activities, within the meaning of section 22 of the *Schedule*. The Insurer maintained that the Applicant provided little, if any, functional or medical evidence of the assistance she required following the accident, or of the expenses she incurred, and had, therefore, not established her entitlement to ongoing housekeeping benefits.

Pursuant to section 22 of the *Schedule*, three elements must be satisfied to establish entitlement to housekeeping benefits:

1. The insured must have performed housekeeping and home maintenance services before the accident;

2. The insured must suffer a substantial inability to perform those housekeeping and home maintenance services, as a result of an accident-related impairment, and;

3. Additional expenses must be incurred for someone else to perform those services.[14]

[14] See *Waheed and RBC General Insurance Company* (FSCO A06-000761 and A06-000856, October 26, 2007) and *McQueen v. Echelon General Insurance Company*, [2009] I.L.R. I-4890 (Ont. S.C.J.), appeal dismissed (2011), 107 O.R. (3d) 780 (Ont. C.A.).

Section 22 states that an insurer shall pay for housekeeping and attendant care expenses "incurred by or on behalf of an insured person." Arbitration decisions have held that an insured person "incurs" housekeeping expenses if he or she has promised to pay or is otherwise legally obligated to pay the expense.[15] However, in a manner similar to attendant care benefits, the meaning of "incurred" is broad enough to include situations where an insured has established their need for such services, without in fact receiving or becoming financially liable for them.[16]

The substantive test of entitlement for housekeeping benefits is set out in *Konstantakos and Aviva Canada Inc.* (FSCO A05-000546, May 17, 2006):

> …the test under section 22 involves a consideration of the housekeeping and home maintenance services the insured normally performed before the accident and then a consideration of whether the insured suffered a substantial inability to perform those services as a result of an impairment suffered in the motor vehicle accident. This involves a comparison of what the insured did before the accident and what he could do after the accident and whether the difference amounts to a substantial inability. If it does amount to a substantial inability, the next question is whether the expenses the insured incurred as a result of that inability are reasonable and necessary.

On December 19, 2000, roughly six weeks following the accident, the Applicant gave a statement to the Insurer, in which she said the following about her pre-accident household activities:

> I do not pay rent for living here nor do I buy food. I do however buy most of my own clothes. I buy 90% of my clothes. I am responsible for my own laundry. I do not have any designated household chores. I am responsible for my own room and bathroom and cleaning up after myself. I am responsible for preparing my own lunches and from time to time my own dinners.

---

[15] See, for example, *Morelli and Zurich Insurance Company* (FSCO A97-001997, January 14, 2000) and *Jelisic and Guarantee Company of North America* (FSCO A98-000029, April 8, 1999).

[16] See, for example, *Watson and TTC Insurance Company Limited* (FSCO A04-000346, July 18, 2006), appeal dismissed (FSCO Appeal P06-00027, September 24, 2007), and *Stargratt and Zurich North America Canada* (FSCO Appeal P01-00045, March 31, 2003).

The Applicant's mother testified that, before the accident, the Applicant would do everyone's laundry, clean the kitchen, cook meals, wash the floors and vacuum, and that, after the accident, the Applicant could prepare simple meals and do small shopping at the store. However, on cross-examination, the Applicant's mother testified that, before the accident, she (the Applicant's mother) did meal preparation and shopping, and that the Applicant helped with the laundry and light cleaning.

One of the Applicant's friends testified that the Applicant lived with her at her apartment in the month preceding the accident. She testified that they fell out of touch after the accident until 2008, at which time they reconnected, and that during the summer of 2010, when the Applicant's husband was away, she helped the Applicant doing meals, housekeeping and gardening.

The Applicant's mother-in-law testified that she helps the Applicant with her housekeeping approximately once a month, since it is not one of the Applicant's skills and she is very messy.

The Applicant testified that she has returned to some of her pre-accident housekeeping activities, and that her husband helps to make her lunches, and to carry the laundry upstairs.

On September 12, 2001, the Applicant underwent an occupational therapy in-home assessment by Ms. Virani. Ms. Virani reported as follows:

> Overall, [the Applicant's] Cognitive status and Physical abilities were found to be in keeping with that required to manage self care tasks as well as her share of duties related to homemaking. Whereas she complained of residual areas of discomfort and decreased endurance, this did not result in any substantial functional limitations providing she paced herself and used good body mechanics (i.e. crouching instead of stooping for prolonged low level work etc).

Dr. Devlin, who assessed the Applicant on December 4, 2001 at the request of the Insurer, notes that the Applicant "is able to do the cooking, the laundry and the housework" and that, "from a functional perspective, she has resumed almost all of her pre-accident activities, though not to the same degree or intensity she had been performing prior to the accident."

On October 15, 2002, Dr. Robert Galway, an orthopaedic surgeon who examined the Applicant at the request of the Insurer, reported that "the claimant is able to perform her normal pre-accident housekeeping and home maintenance activities." As part of the same assessment, Mr. Peter Ramos, a kinesiologist, reported that the Applicant "possesses sufficient strength, muscular endurance, flexibility, postural tolerance, and motor dexterity to perform her…pre-accident housekeeping responsibilities."

On October 24, 2002, as part of a multi-disciplinary DAC assessment, Dr. Howard Platnick, a general practitioner and the primary DAC evaluator, reported the Applicant as saying that she "is able to assist with light groceries and prepare simple meals…assists washing a few dishes and wiping the kitchen counters…does her own laundry…light cleaning, including sweeping, dusting, and tidying up…[and] attempts mopping, vacuuming, and scrubbing although it worsens her neck and back pain."

In the context of a Post-104 Week Disability DAC Assessment, dated April 29, 2003, Dr. Bruce Paitich, an orthopaedic surgeon, reported the Applicant as saying that she was able to perform "most domestic tasks about her home such as vacuuming, cleaning out a bathroom, washing laundry, washing dishes, making a bed, and making meals."

The Applicant underwent a Housekeeping Assessment on May 23 and 30, 2008 by Ms. Sivapalan at the request of the Insurer. The Applicant had moved into a two-storey home with her new boyfriend in December 2007, and subsequently married in March 2008. Ms. Sivapalan reported that:

> Due to her physical, perceptual and cognitive deficits, [the Applicant] needs 6.3 hours of housekeeping assistance per week to complete the following activities:
>
> - Meal preparation and clean up: 2 hours/week
> - Heavy Cleaning (tub/vacuum/mopping wash windows/ garbage): 2 hours/week
> - Laundry: 10 minutes/week
> - Home Repairs: 10 minutes/week
> - Outdoor maintenance (Garden/Lawn care/Shovelling): 1 hour/week
> - Grocery Shopping/Carrying grocery bags: 1 hour/week

In the context of her attendant care assessment on July 18, 2008, Ms. Vrckovnik reported on July 30, 2008, as follows:

> [The Applicant] stated that she performs some housekeeping tasks such as sweeping the floor, doing the laundry (after it is carried down by her husband), feeding the pets and horses, and preparing some simple meals. [The Applicant] stated that she depends on her husband to carry down the laundry as she feels the need to hold onto the wall to support herself on these steep stairs….[The Applicant] stated that she does not perform any outdoor work, when home alone. She described an incident of cutting the lawnmower electrical cord when she attempted to cut the grass independently.
>
> [The Applicant] stated that she makes herself simple lunches such as "Pizza Pockets, tuna sandwich, salad and peanut butter and banana sandwich."… [The Applicant] stated that for dinner, she makes simple meals such as "soup, chicken or tacos."

In the context of a reassessment of her attendant care needs on August 18 and September 8, 2009, Ms. Evanitski reported that the Applicant needed "8.25 hours of housekeeping and yard maintenance support per week" for the same activities noted by Ms. Sivapalan, as follows:

- Meal preparation and clean-up: 2 hours per week
- Heavy cleaning: 2 hours per week
- Laundry: 15 minutes per week
- Home repairs: 1 hour per week
- Outdoor maintenance: 2 hours per week
- Grocery shopping/carrying grocery bags: 1 hour per week

In her Retrospective Assessment of Attendant Care Needs, dated February 5, 2010, Ms. Evanitski concluded that the Applicant required housekeeping support from the time of the accident, at the rate of $100 per week, although she "was able to manage resuming the light housekeeping roles required of her in the home of her parents and in [her boyfriend's] home", since "it has become more evident that she lacks the physical endurance/stamina and the attention and organizational skills to carry out her own housekeeping tasks on a consistent basis."

On October 16, 2009, Ms. Vrckovnik reported the Applicant as saying that she "engages in light housekeeping such as mopping floors, sweeping, organizing the home environment and doing laundry (after the unwashed laundry has been carried down to the basement by her husband or the RSW [Rehabilitation Support Worker])." The Applicant stated that "when home alone, she

sometimes lacks the ability to effectively organize her day and engage in tasks in a manner that would minimize pain flare-ups." The Applicant reported that she was "able to engage in light housekeeping with assistance from her husband", that her husband is "responsible for the outdoor seasonal work including grass cutting and snow removal" and that he "usually…prepares the dinner meal…."

I find that the Applicant is not entitled to housekeeping benefits prior to May 2008, and thereafter only at the rate of two hours per week.

While the evidence indicates that the Applicant had not lived with her family for approximately a month before the accident, the Insurer did not attempt to suggest that this should be used as the reference point for her pre-accident housekeeping responsibilities. Given that section 22 of the *Schedule* refers to the "housekeeping and home maintenance services [the insured] normally performed before the accident", I find that the proper reference is the Applicant's housekeeping duties while she lived at her parents' house.

In final argument, the Applicant submitted that the written statement she provided in December 2000 was not an accurate description of her pre-accident housekeeping activities because it was given shortly after the accident and neither she nor her mother were properly focussed on the matter of housekeeping benefits. However, I find that both the Applicant's and her mother's testimony at the hearing support what is contained in the written statement, namely, that the Applicant had limited housekeeping responsibilities prior to the accident.

The Applicant testified that she did some pre-accident housekeeping, and her written statement suggests that she was only responsible for doing her own laundry, cleaning her own room and bathroom, and making her own lunches and some dinners. While the Applicant's mother attempted to suggest that the Applicant was responsible for significant laundry, cleaning and cooking responsibilities, I find that her testimony on cross-examination is more consistent with the Applicant's written statement and oral evidence, namely, that she had more limited cooking, cleaning and laundry responsibilities.

Despite the severity of the accident, the Applicant recovered to a significant degree shortly afterwards, to the point of being able to resume a considerable number of her pre-accident activities. The Applicant offered very little evidence at the hearing of how or to what extent her family or friends assisted her with housekeeping after the accident. The evidence was that her mother cared for her in the five years following the accident (but this referred primarily to attendant care assistance), that her friend assisted her in the summer of 2010 with meals, housekeeping and gardening, that her mother-in-law assists once a month because the Applicant is messy, and that her husband helps with lunches and to carry the laundry. This evidence is very limited and vague, as to both the timing and extent of the assistance provided. I find that it is insufficient to establish that the Applicant was substantially incapable of doing the modest cooking, cleaning and laundry tasks she did prior to the accident.

While not determinative, I note, as well, that the Applicant did not introduce any evidence to the effect that she had promised to pay or reimburse anyone for the housekeeping assistance they provided or that she had become legally obligated to compensate anyone for these services.

Until 2008, the medical evidence also establishes that the Applicant was not substantially disabled from her pre-accident housekeeping tasks. The evidence indicates that she experienced pain and restrictions, but was otherwise capable of doing her tasks. This is evident in the reports of Ms. Virani, Dr. Devlin, Dr. Galway, Mr. Ramos and Dr. Paitich. It is particularly evident in Dr. Platnick's report where the Applicant is noted as saying that she does essentially the same tasks as she did prior to the accident.

The picture changes somewhat in 2008 and 2009, with the assessments of Ms. Sivapalan, Ms. Vrckovnik and Ms. Evanitski. The Applicant also testified that she is now in more pain than at the beginning of the accident. However, the reports continue to establish considerable ability on the part of the Applicant (in relation to her pre-accident housekeeping responsibilities), and the assessments are conducted at the Applicant's new residence, which was larger than her pre-accident accommodations with her parents. The Applicant was also not responsible for home repairs, outdoor maintenance or grocery shopping prior to the accident. Nevertheless, I find that the reports more clearly establish a need for housekeeping assistance at that time.

Therefore, while the estimates must be modified, I find that, as of May 1, 2008, the Applicant would reasonably be entitled to two hours of housekeeping assistance per week, for meal preparation, heavy cleaning and laundry.

Entitlement to Nutritional Counselling

The Applicant claimed the cost of an eight-session nutritional counselling programme, in the amount of $720, recommended in a treatment plan dated February 1, 2001, from Nancy Polsinelli, a registered dietitian at Springdale Physiotherapy. The treatment plan indicated that counselling was needed to address the weight and muscle mass loss the Applicant had experienced as a result of the accident, and to "enhance wound healing." The Insurer initially denied this claim on February 19, 2001, on the basis that the Applicant had not yet provided a completed Application for Benefits. Following receipt of the Application for Benefits on April 4, 2001, the Insurer denied the nutritional counselling treatment plan on April 10, 2001, on the basis that it needed clarification whether the programme was covered under OHIP, indicating that it would seek the required clarification from Springdale Physiotherapy. The Insurer's covering letter for the denial states that it was denying the treatment plan "until we receive an explanation why this service is not covered under OHIP…." Pursuant to section 60(2) of the *Schedule*, payment of a medical or rehabilitation benefit is not required if the expense is reasonably available to the insured person under any insurance plan or law.

At the hearing, the Insurer acknowledged that the Applicant probably needed nutritional counselling. Log notes of a January 17, 2002 meeting between Anne Cleary (a nurse and case manager at Functional Rehabilitation Inc.) and the Applicant and her mother, indicate that the Applicant was having problems with a proper diet and needed the assistance of a nutritionist. Grace Drummond, the Insurer's claims professional and team leader dealing with the Applicant's file in the early stages of the claim, testified that while she supported Springdale's recommendation for physiotherapy, she denied the request for nutritional counselling given that it was likely covered by OHIP, and stated that the Insurer never received an explanation as to why the service was not covered by OHIP.

I find that the Applicant is entitled to the cost of the nutritional counselling programme. The evidence establishes that she suffered significant weight loss following the accident, had poor eating habits, and was in need of assistance with proper nutrition and diet to deal with the weight loss and injuries she had experienced. The Insurer did not provide any evidence that it sought the clarification it wanted as to whether the programme was covered under OHIP, nor is there any evidence that the programme was, in fact, covered under OHIP. While the Insurer's Explanation of Benefits and covering letter denying the Applicant's request for nutritional counselling could be interpreted as requiring the Applicant to provide clarification as to whether the programme was covered by OHIP, this is not at all clear, I see no reason that the Applicant was obligated to provide this information, and the Insurer, in fact, stated that **it** would seek the necessary clarification from Springdale Physiotherapy. I note, as well, that counsel for the Insurer indicated that it was not taking the position that the Applicant was disentitled to benefits as a result of any failure to provide information, pursuant to section 33 of the *Schedule*. In all of the circumstances, I find that the Applicant provided sufficient evidence to support her claim for nutritional counselling and that the Insurer has not disproved her entitlement to those services.

Entitlement to the Purchase of Medical Marijuana

The Applicant claims $1,200 per month for the purchase of marijuana, from December 14, 2005, to alleviate the pain, anxiety, insomnia and poor appetite she has experienced as a result of the motor vehicle accident, pursuant to sections 14 and 15 of the *Schedule*. In support of this claim, the Applicant submitted treatment plans from Dr. Mortimer Mamelak, a neuropsychiatrist, dated March 27, 2007 and December 21, 2009, for the purchase of indica marijuana (a cannabis derivative) from the Toronto Compassion Centre (a clinic authorized by the federal government to sell marijuana for medicinal purposes). With Dr. Mamelak's assistance, the Applicant's application to the Marihuana Medical Access Division of Health Canada for the medical use of marijuana was approved on January 27 and 28, 2010. Section 14(2) of the *Schedule* entitles an insured person to medical benefits for "reasonable and necessary expenses" for, among other things, medication and other goods and services "of a medical nature" that the person requires. Sections 15(2) and (5) entitle an insured person to rehabilitation benefits for "reasonable and necessary expenses" for "goods and services" that the person requires for "measures undertaken

…to reduce or eliminate the effects" of a disability or to "facilitate the insured person's reintegration" into his or her family, the rest of society or the labour market. The Insurer submitted that, in the circumstances of this case, the purchase of marijuana is not a reasonable and necessary expense, is not a good or service of a medical nature, and is a good or service of an "experimental nature," which, pursuant to section 14(3) of the *Schedule*, the Insurer is not liable to pay.

The Applicant testified that, as a result of the accident, she had used prescribed opiates (such as morphine and codeine), anti-depressants, tranquilizers and hypnotic medications, but that the only substance that alleviated her pain, anxiety, insomnia and poor appetite, without significant side-effects, was marijuana. Dr. Mamelak testified that the Applicant suffered from "frontal disinhibition syndrome." Dr. Mamelak stated that opioids, such as Tylenol 3, are inadequate for lessening pain, that he "would like to use marijuana more" for addressing his patients' pain, and that the Applicant's use of alcohol to reduce pain would simply aggravate the syndrome from which she suffers. In a March 1, 2010 report, in which he summarizes some of the studies that have been done on the therapeutic use of marijuana, Dr. Mamelak states that "[a]fter reviewing this literature, and given how commonly medical cannabis and its components and derivatives are being used today, not to mention its extraordinary use for thousands of years to control pain, it is difficult to understand why the use of marijuana for medicinal practice is still considered experimental." Dr. Mamelak further stated that "everyone who works with patients in chronic pain following motor vehicle accidents recognizes how…inadequate the current treatments are…[and that the Applicant's] poor pain control despite the use of opiates and other conventional methods is a case in point."

On cross-examination, Dr. Mamelak testified that while he had done studies on the use of marijuana by brain injured patients (such as the Applicant), he had not attached those studies to his report, that he did not have a "systematic knowledge" of marijuana use, that he was not familiar with the effects of marijuana on the disinhibition syndrome from which the Applicant suffered, and that the use of marijuana could, in certain circumstances, increase her symptoms of disinhibition. Dr. Mamelak also acknowledged that the use of marijuana is still considered experimental by governments and insurance companies.

Dr. Anthony Feinstein, a neuropsychiatrist with specialization in brain injuries, reported on June 5, 2007 that marijuana is "not a medication that is conventionally used with Neuropsychiatry" and that its use "should be considered experimental." He stated that the use of marijuana "as a treatment for sleep and pain difficulties remain[s] a controversial point given the relative absence of sound empirical data", that the "jury is still out on its efficacy" and that the "lack of thorough empirical data precludes any definite opinions at this point in time."

However, Dr. Feinstein also suggested a pragmatic approach to the use of marijuana in this case. He stated that "one has to judge the merits of the case on an individual patient by patient basis" and that since the Applicant had stopped using prescribed pain medications, and given the side-effects of those medications (including "sedation, dependency, and a deleterious effect on cognition"), the use of marijuana "would have some merit." Dr. Feinstein also reported that given the potentially serious side-effects of conventional pain relief medication and anti-depressant and mood stabilizing drugs for people like the Applicant with "Personality Change Secondary to a significant traumatic brain injury" and given the Applicant's refusal to take medications prescribed to her, if she "believes the medication is beneficial to her and if it is given under close supervision, an ongoing therapeutic trial, at least in the short term, (namely three months) would seem reasonable." Dr. Feinstein stated that, at the end of the three-month trial, "the situation could be reassessed and if still considered therapeutic, and in the absence of troubling side effects, the treatment could continue." Dr. Feinstein concluded by stating, "Thus, what I am suggesting here is some flexibility when it comes to managing a complicated clinical situation."

At the hearing, Dr. Feinstein was somewhat more reserved in his approach. For example, he testified that he would not have prescribed marijuana in this case, given the Applicant's brain injury and disinhibition. He stated that he had "major concerns" regarding the use of cannibas for treatment and that he does not prescribe marijuana for brain injured patients because it is "unhelpful." He said that he was "less inclined" to suggest a trial of marijuana given that he was now aware of the Applicant's long-standing use of the drug, and that he was "very concerned" about keeping the Applicant on marijuana in the long term. He also said that he would be "very concerned" about prescribing marijuana if, as the Applicant indicated, she drinks a significant

amount of beer each night. Nevertheless, Dr. Feinstein acknowledged that marijuana can help with insomnia, and that the Applicant did not appear to be suffering from some of the more serious side-effects of marijuana use on brain injured patients, such as psychosis. He reiterated his view that a three-month trial, with objective monitoring by someone like Dr. Mamelak, would be acceptable, despite being in "experimental waters" and despite the Applicant's history of marijuana use, since it was better to "do something" rather than to "lose the patient entirely."

On June 15, 2006, Dr. Chanth Seyone, a neuropsychiatrist and one of the Applicant's treating physicians, indicated that he would only continue to treat the Applicant "on the condition that she consider medication as a primary method of treatment, excluding marijuana" and that he would "not prescribe marijuana until it is determined by the Canadian Guidelines as an approved treatment for traumatic brain-injured patients." The Applicant left Dr. Seyone because he would not prescribe marijuana for her.

As a preliminary matter, I find that the Applicant's claim for the purchase of marijuana to treat her symptoms is more appropriately addressed as a medical benefit under section 14 of the *Schedule*, as opposed to a rehabilitation benefit under section 15 of the *Schedule*. As suggested by the appeal decision of *Driver and Traders General Insurance Company* (FSCO Appeal P03-00006, November 18, 2003), the purchase and use of marijuana for the treatment of a specific medical condition is more in the nature of a medical benefit as set out in section 14, particularly section 14(2)(h), "other goods and services of a medical nature that the insured person requires", than a general rehabilitation programme, as set out in section 15. As further suggested in *Driver*, the only provision in section 15 under which the purchase and use of marijuana could be considered is section 15(5)(l), "other goods and services that the insured person requires, except services provided by a case manager", but rehabilitation benefits under that provision must, as a matter of statutory interpretation, resemble the rehabilitation programmes enunciated more specifically in the body of that section (for example, life skills training and social rehabilitation counselling), which I find it does not. Finally, *Driver* indicates that section 15(5)(l) is not designed to address benefits properly considered, but found not to be covered, under section 14 of the *Schedule*. I, therefore, will only consider the Applicant's claim for marijuana under section 14, not section 15, of the *Schedule*.

In considering the Applicant's claim on its merits, I find the following passage from *Pacquette and Certas Direct Insurance Company* (FSCO A05-000934, July 24, 2006) on the meaning of "experimental in nature" instructive:

> I agree that scientific principles must underlay the interpretation of these terms, but I return to the comments of the arbitrator in the [*Caruso and General Accident Assurance Co. of Canada* (OIC A96-000644, March 27, 1997)]. The *Schedule* was intended to be a remedial regime. We are specifically concerned here with the rapid provision of therapeutic medical service. There is no requirement that an applicant prove to a medical certainty that a treatment will be therapeutic. Equally, to my mind, the test is not whether or not it is certain, as a matter of scientific certainty, that a given therapy is proven effective and therefore no longer experimental in nature.

Further, in *Driver and Traders General Insurance Company* (FSCO A01-000841, January 8, 2003), the Arbitrator stated:

> I concluded from the evidence before me that Vistasp therapy is a form of hands-on body therapy similar to massage, unique to Victor Guard; that it is a passive modality of treatment; that it is not very well understood by the three, or possibly four, health practitioners who have even heard of it; and that it is not a form of treatment known or accepted by any recognised body in the health field. As no objective, reliable evidence was presented at the hearing to establish an accepted scientific or medical basis for the therapy, or to substantiate the claims made for it that it is an effective, safe treatment for whiplash, chronic pain, migraine or fibromyalgia, I am not persuaded that it even meets the first, or threshold criterion, under section 14 of the *Schedule*, that it is a "good or service of a medical nature."
>
> The criteria are clear. Vistasp must be either a good or a service of a medical nature; it must not be experimental in nature; it must be necessary as a result of the accident; and it must be reasonable. Insurers are not required to pay for therapy or treatments that do not meet these criteria. Ms. Driver bears the onus of establishing, on a balance of probabilities, that the first, third and fourth criteria are met. For the reasons set out below, I did not find that Ms. Driver met this onus. With respect to whether or not a particular therapy is experimental in nature, I agree with Ms. Driver that, as this claim is asserted by Traders, it has the onus to establish that proposition. This is an evidentiary onus, however. Once the Insurer has presented sufficient evidence to establish that the treatment is *prima facie* experimental, the onus shifts to Ms. Driver to show that it is not. Although I found that Ms. Driver failed to establish that Vistasp was a service of a medical nature for the purposes of section 14, in the event my finding is in error, I find that Traders presented sufficient *prima facie* evidence that Vistasp was experimental in nature, which Ms. Driver's evidence did not rebut.

> For the purpose of determining whether a particular therapy is a good or service of a medical nature within the meaning of section 14, I find that the minimum requirements are: credible evidence of independent research in the form of case studies or clinical trials to verify claims, conducted by health practitioners with recognised qualifications in the relevant field, published results, and peer review. I do agree, however, that the use of the qualifier "nature," as in the phrases "goods or services of a medical nature" and "experimental in nature," does allow for a somewhat broader and more flexible interpretation of the terms "medical" and "experimental."

This case is a difficult one. I am satisfied that the Applicant's use of marijuana arises as a result of the accident and that, based in part on Health Canada's approval of her application, it is a good or service of a medical nature. The real question is whether it is experimental in nature and, if not, whether it is reasonable and necessary. The Insurer has established a *prima facie* case that, in general, the use of marijuana in neuropsychiatry is experimental in nature. However, the Insurer has not shown that the use of marijuana for the Applicant's specific symptoms, namely, pain, anxiety, insomnia and poor appetite, is experimental in nature. While Dr. Feinstein indicated at the hearing that we are in "experimental waters", the most the Insurer has shown is that the available evidence does not definitively prove that marijuana is a safe and effective treatment for these problems. However, the fact that the use of marijuana for these symptoms remains controversial does not, in itself, relieve the Insurer of its obligation to cover the costs of such treatment, provided that the Applicant can establish that these are reasonably required as a result of the accident.

However, even if it could be said that the Insurer has established a *prima facie* case that the use of marijuana is experimental in nature for the Applicant's symptoms, I find that the evidence as a whole rebuts this presumption. I accept Dr. Mamelak's evidence that marijuana is now understood as a legitimate option in the treatment of pain. Dr. Feinstein only stated that marijuana is not "conventionally used" within neuropsychiatry and that it "should be considered" experimental. In my view, the fact that something is not conventionally used within the general field of neuropsychiatry (or, as Dr. Seyone put it, that it has not been approved by the relevant governing bodies) is not synonymous with it being experimental in respect of all of a person's symptoms in a particular case. This, to a certain extent, is borne out by the fact that, despite his concerns about the Applicant using marijuana, Dr. Feinstein supported a supervised therapeutic trial. Dr. Feinstein was not ruling out marijuana as a legitimate treatment option; he was simply

suggesting that there are risks in taking such a course of action in this particular situation, and that the Applicant's progress had to be closely monitored. In my view, however, the fact that there are risks in a particular treatment modality does not mean that it is experimental. As noted by Dr. Feinstein, the Applicant does not appear to be suffering from the more serious side-effects of marijuana use. I, therefore, find that prescribing the Applicant marijuana was a viable treatment option and, in her particular circumstances, not experimental.

The issue now is whether the Applicant's continued use of marijuana is reasonable and necessary. I accept the Applicant's uncontroverted evidence that marijuana, as opposed to the other prescribed medications, is helpful to her. I also accept Dr. Mamelak's and Dr. Feinstein's evidence that the more conventionally prescribed medications carry significant risks, and that the Applicant's use of marijuana may, in fact, be beneficial. I find that the Applicant's use of marijuana is reasonably required in the circumstances. Dr. Feinstein supports a three-month trial of marijuana. However, the Applicant has already been using it for a much longer time. What the Applicant is really seeking is entitlement to the costs of ongoing marijuana use. Based on Dr. Feinstein's evidence, there continue to be significant risks for the Applicant using marijuana. However, I see no basis upon which to limit the Applicant's entitlement. The key, as noted by Dr. Feinstein, is that her progress be closely monitored by Dr. Mamelak. He is qualified to assess whether the Applicant's use of marijuana is no longer beneficial, or has become harmful, to her. I, therefore, find that the Applicant is entitled to the reasonable costs of her marijuana use from the date of the first treatment plan, namely, March 27, 2007.

The Applicant sought entitlement to $1,200 per month for marijuana. This was based on an estimate of the cost of purchasing marijuana from the street. However, I agree with the Insurer that the Applicant's entitlement should be based on the amount set out in the treatment plan, namely, $567.60 per month, which, in turn, is based on purchasing marijuana through the regulated system of the Toronto Compassion Centre.

Special Award and Interest

In the course of the hearing, the parties indicated that, subject to my rulings on the above issues, they would discuss the Applicant's claims for a special award and interest between themselves, and, if required, address these matters at a resumption of the hearing.

EXPENSES:

The parties have not yet addressed the issue of expenses. This will be done at a resumption of the hearing, if required.

______________________________	July 26, 2012
Eban Bayefsky Arbitrator	Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A06-000399

BETWEEN:

T.N.

Applicant

and

PERSONAL INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered and adjudged that:

1. T.N. is not precluded from receiving income replacement benefits.

2. T.N. was employed at the time of the accident.

3. T.N. did not fail to submit an application for attendant care benefits as required, and is entitled to arbitrate her entitlement to those benefits.

4. T.N. did not fail to submit an application for housekeeping benefits as required, and is entitled to arbitrate her entitlement to those benefits.

5. Personal Insurance Company of Canada shall pay T.N. attendant care benefits from October 29, 2000 and ongoing, at the rate of $5,056.80 per month, less any amounts already paid.

6. Personal Insurance Company of Canada shall pay T.N. two hours of housekeeping benefits per week, from May 1, 2008 and ongoing.

7. Personal Insurance Company of Canada shall pay T.N. $720 for nutritional counselling services.

8. Personal Insurance Company of Canada shall pay T.N medical benefits for the purchase of medical marijuana, from March 27, 2007 and ongoing, at the rate of $567.60 per month.

_________________________	July 26, 2012
Eban Bayefsky Arbitrator	Date