Appeal P11-00032

OFFICE OF THE DIRECTOR OF ARBITRATIONS

ALLSTATE INSURANCE COMPANY OF CANADA

Appellant

and

T. S.

Respondent

BEFORE:	David Evans
REPRESENTATIVES:	Jennifer Griffiths for Allstate Insurance Company of Canada T.S. representing herself
HEARING DATE:	By written submissions received by April 30, 2014

APPEAL ORDER

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

1. The Appeal of the Arbitrator's order dated November 15, 2011 is allowed. Paragraphs 1, 2 and 3 of the Arbitrator's order are revoked, and the following substituted:

    1. T.S. does not meet the criteria for catastrophic impairment.
    2. T.S. is not entitled to Attendant Care Benefits more than 104 weeks after the accident of November 21, 2001.
    3. T.S. is not entitled to Housekeeping and Home Maintenance Expenses more than 104 weeks after the accident of November 21, 2001.

3. A further paragraph is added to the Arbitrator's order dated November 15, 2011.

    7. T.S. shall repay to Allstate Insurance Company of Canada all interim benefits paid pursuant to the Arbitrator's orders of October 14, 2008 and May 29, 2009.

4. If the parties are unable to agree on the legal expenses of this appeal, an expense hearing shall be requested pursuant to the *Dispute Resolution Practice Code* (Fourth Edition, Updated – January 2014), but as set out below.

David Evans
Director's Delegate

September 25, 2014
Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

Allstate Insurance Company of Canada appeals the order of Arbitrator Wilson dated November 15, 2011, as well as several preceding interim decisions. I will occasionally refer to the November 15, 2011 decision as the "final" decision. The Arbitrator found that T.S. suffers a catastrophic impairment under the *SABS–1996*[1] as a result of an accident on November 21, 2001. He also found she is entitled to ongoing housekeeping and home maintenance expenses at $100 per week and attendant care benefits at the rate of $77.40 per month.

T.S. in her responding materials seeks an increase in her benefits. However, she never filed her own appeal in this matter. She also filed a great deal of additional documents, without seeking leave or providing reasons why they should be admitted. Some predate the hearing, so if relevant they could have been put before the Arbitrator; others postdate the hearing and are irrelevant. In any event, the Arbitrator ruled on July 12, 2010, that evidence relating to periods after the commencement of the Arbitration hearing would not be admissible. I have not taken those materials into account in this decision, nor T.S.'s submissions on them.

II. BACKGROUND

As a result of the injuries sustained by T.S. in the accident on November 21, 2001, Allstate paid certain accident benefits, including income replacement benefits, medical and rehabilitation benefits, as well as the benefits that were the subject of the arbitration hearing, namely housekeeping and attendant care benefits (ACBs). These were terminated at the 104-week mark, as Allstate took the position that T.S.'s impairments did not meet the catastrophic threshold.[2] T.S. eventually took steps to seek a finding that she was catastrophically impaired.

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

[2] Attendant care and housekeeping benefits are not payable for expenses incurred more than 104 weeks after the accident unless the impairment is catastrophic: ss. 18(2) and (3) and 22(3) and (4).

On December 9, 2005, T.S.'s treating psychologist, Dr. Tory Hoff, prepared an Application for Determination of Catastrophic Impairment (OCF-19), asserting that T.S.'s condition met the threshold for catastrophic impairment under s. 2(1.1)(g) – which I will generally refer to as "category (g)" – for accidents that occurred before October 1, 2003, namely "an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder."

Dr. Hoff did not tick the box for category (f), the whole person impairment (WPI) designation: "an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person." Nonetheless, the Arbitrator criticized the CAT DAC (discussed next) for failing to rate T.S.'s WPI or to consider the combined effect of categories (f) and (g).

Allstate referred T.S. for a catastrophic DAC evaluation at the North Toronto Assessment Centre. The executive summary of the CAT DAC report dated November 6, 2006 notes that the DAC considered all the categories of catastrophic impairment. Dr. Alborz Oshidari, physiatrist, concluded that, "due to numerous inconsistencies and non-organic findings" during T.S.'s examination, her category (f) impairment was not ratable. As for category (g), which was the object of the referral, the summary notes that Dr. William Gnam, psychiatrist, with the assessment of Ms. My-Linh Nguyen, occupational therapist, concluded that T.S. did not meet the definition of catastrophic impairment under the criteria for category (g), with an "overall Class 3: Moderate Impairment under the mental behavioural disorders classification."

T.S. sought mediation and then arbitration, claiming catastrophic impairment under both categories (f) and (g). She claimed entitlement to ongoing ACBs of $400 per week. However, the most recent Form 1, Assessment of Attendant Care Needs, prepared for T.S. prior to the termination of the ACBs and dealt with physical disability and not mental or behavioural disorders, was by Ashok Jain, OT, for $77.40 per month. The Arbitrator eventually ordered ACBs in that amount based on this Form 1. T.S. also claimed ongoing housekeeping at $400 per week: the Arbitrator in the final decision awarded the maximum of $100 per week.

As noted above, Allstate appeals several interim decisions as well as the final decision.

Interim Decisions

The arbitration hearing commenced on April 21, 2008, adjourned, and resumed June 9, 2008. It was immediately contentious. Over Allstate's objection, the Arbitrator admitted all the documents in its briefs, even though they included material upon which it had not intended to rely. The Arbitrator then refused to allow Allstate to file a report relating to catastrophic impairment (decision dated June 18, 2008: leave to appeal refused by letter decision dated July 18, 2008).

On June 12, 2008, T.S. disclosed to the Arbitrator alleged (and inaccurate, says Allstate) settlement figures. On July 28, 2008, Allstate brought a motion for recusal due to the disclosure. The Arbitrator communicated his denial of the recusal motion on August 6, 2008, ultimately releasing a decision with reasons on September 26, 2008. Meanwhile, Allstate tried to appeal the recusal refusal, was denied, and moved for judicial review.

Thus, on September 28, 2008, when the matter was scheduled to resume, Allstate attended before the Arbitrator, but indicated it was not prepared to proceed pending the judicial review. The Arbitrator treated that as an adjournment request, and ordered interim benefits as a condition for the adjournment payable "until February 9, 2009 or until the arbitration hearing in this matter recommences, whichever comes first": decision dated October 14, 2008. The Arbitrator set the interim benefit for ACBs at $400 per week without mentioning the Form 1 of $77.40 per month. Allstate appeals this decision.

In a further decision dated May 29, 2009, the Arbitrator extended his interim benefit order until the hearing resumed, but subject to repayment based on success. Allstate appeals this decision.

While the Divisional Court on July 8, 2009 granted leave for the judicial review application and stayed the arbitration pending disposition, the judicial review was ultimately dismissed in a decision dated December 17, 2009: 2009 CanLII 71001. The court found that the disclosure of settlement information in this case did not raise a reasonable apprehension of bias.

After the Court of Appeal refused a further leave application, the hearing resumed on July 12, 13, and 30, and October 4, 6, 7 and 12, 2010 before the same Arbitrator.

After the completion of the hearing, on November 12, 2010, the Arbitrator wrote to the parties that, as part of "examining the documents on the record as part of the entirety of the evidence before" him, he noticed that the CAT DAC report did not indicate a psychologist was part of the team, "Although just before the DAC report in the Insurer's document brief there is a report by a psychologist, Dr. Michael Gadon, which appears to have been created in the context of an earlier Medical Rehabilitation DAC report, not in the context of a CAT DAC report."

In its response in a letter dated November 26, 2010, Allstate advised that there was no psychological assessment as part of the CAT DAC, but submitted that this should make no difference, considering that T.S. had not raised the issue before the hearing concluded, at the appeal level it had been held that the guidelines for the DAC process are not absolute, and had this been flagged as an issue, then Dr. Gnam, the DAC psychiatrist, could have been asked about the DAC's panel.

Regardless, in an interim decision dated December 3, 2010, the Arbitrator found that a new CAT DAC should take place pursuant to the Commission's 2002 CAT DAC assessment guidelines, which required a psychologist to be on the assessment team, unless T.S. advised that she did not wish to proceed with a further DAC assessment. Allstate appeals that order, but since T.S. in fact declined a further assessment, the issue is now moot.

In a letter dated March 17, 2011, the Arbitrator found that the catastrophic threshold had been met and rejected Allstate's request to make submissions on recent court cases. In a letter decision dated May 10, 2011, he provided his decision regarding the amounts payable. The reasons for the final decision were released November 15, 2011.

Final Decision of November 15, 2011

In the reasons of this decision, the Arbitrator noted that "for this arbitration the crucial documents on the issue of catastrophic impairment are Dr. Hoff's initial report assessing T.S.'s status in the context of catastrophic impairment, and the reports issued by the Designated Assessment Centre…

Both Dr. Hoff, T.S.'s treating psychologist, and two of the DAC assessors, Ms. Nguyen, the Occupational Therapist, and Dr. Gnam, the psychiatrist, also testified at the hearing."

Over 10 pages, the Arbitrator criticized the process undertaken by the DAC. He referred to Dr. Hoff's finding in his OCF-19 of December 9, 2005 that T.S. met the Class 4 criteria in several areas. He found support for this in the medical/rehabilitation DAC report of Dr. Michael Gadon, psychologist, from April 13, 2006 (a report that was part of a medical/rehabilitation DAC, not a CAT DAC). He contrasted that with Dr. Gnam's ratings of moderate or class 3 in the four domains of activities of daily living (ADL), social functioning, concentration, persistence and pace, and work adaptation ("deterioration or decompensation in work or worklike settings").

The Arbitrator then criticized the CAT DAC for failing to set out a combined figure for category (f), the whole person impairment, and category (g), the mental or behavioural disorder, stating that "it would have been more useful had the assessors not taken a dogmatic position on combined ratings. Clearly this was not done, leaving us only to guess as to what an open-minded assessment team would have found for a combined score."

As mentioned above, Dr. Hoff had only ticked category (g) on the OCF-19 referral.

The Arbitrator stated that "The DAC assessment's shortcomings were not, however, limited to its blinkered view of the assessment approach to be taken." He then reiterated his criticisms about the lack of a psychologist on the DAC team, set out in his December 2010 decision. He found that while "elements of the reports contained in the DAC, together with the background medical reports, can give us a fairer appreciation of T.S.'s status at the time the DAC examinations were completed… I am convinced that an appropriate CAT DAC would have been of assistance in making a fair 'adjudicative assessment' on the issue of catastrophic impairment."

After noting that T.S. had declined a further CAT DAC, the Arbitrator turned to the medical evidence of impairment, which in addition to that mentioned above included the records of Dr. Manohar, T.S.'s treating psychiatrist, as well as those of Dr. McIntosh, her family physician.

The Arbitrator then set out the test regarding the *Guides*:

> In assessing the severity of mental and behavioural impairments under the *Guides,* four aspects of functional abilities are considered: (1) activities of daily living; (2) social functioning; (3) concentration, persistence and pace; and (4) deterioration or decompensation in work or work-like settings). Also, independence, appropriateness, and effectiveness of activities must be considered.
>
> The *Guides* provide a guide for rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment.

After reiterating the opinions of Dr. Hoff that T.S. met the criteria under category (g) and Dr. Manohar that T.S. suffered from a Major Depression and Chronic Pain Disorder, he first turned to the O.T. report of Ms. Nguyen. He found that "While Ms. Nguyen paid lip service to the four domains for assessment in catastrophic cases involving psychological issues, in T.S.'s case her examination of both workplace and social functioning was perfunctory at best."

As for Dr. Gnam, while the Arbitrator found him an "attractive witness" who had clearly "read and considered the *AMA Guides* in depth," he commented:

> Even the cleverest expert, however, may have his Achilles heel. In Dr. Gnam's case, it was his willingness to provide a psychiatric assessment without the opportunity to review the testing that would form part of the mandatory psychological assessment. Indeed, in his testimony Dr. Gnam minimized the role of psychologists.

The Arbitrator noted that Dr. Gnam's finding of moderate impairment was done without "the benefit of a full psychological report or an O.T. assessment that fairly addressed T.S.'s activities of daily living challenges." He found that "Dr. Gnam deprecated the usefulness of Dr. Hoff"s and Dr. Manohar's opinions since, in his opinion, they spoke to diagnosis rather than directly to impairment."

The Arbitrator concluded that "although there were opinions to the contrary, the balance of the psychological and psychiatric evidence suggests that is more likely than not that T.S. met these criteria."

As for T.S.'s evidence, the Arbitrator stated that, considering "the four functional domains of *ADL; social functioning; concentration, persistence and pace; and work adaptation,* T.S.'s evidence, which I accept, is sufficient to establish at the very least a marked impairment in these areas." In four paragraphs over less than a page the Arbitrator then set out T.S.'s evidence supporting this finding.

The Arbitrator concluded the discussion about the criteria under category (g) by agreeing with Dr. Hoff that "T.S. met the criteria for catastrophic impairment based on a marked impairment due to mental or behavioural disorder." He declined to make an order regarding category (f), the whole body impairment, since "With the failure of the DAC to provide any useful, numerical ratings and the limited medical evidence as to the appropriate ratings, any number rating I could give would be purely speculative."

The Arbitrator then considered the quantum of the ACBs. He noted that while "a single reason for the presence of an attendant was never provided, the evidence touched on several possible scenarios to justify the expenditure." He noted that, in light of T.S.'s pain disorder, "Presumably an attendant would assist her in eating and food preparation and getting up to attend to her physical needs," and "Another possible scenario that was only briefly touched upon by the direct evidence would be the prevention of harm to T.S." However, while "both of the above scenarios could well be both reasonable and indeed necessary," there was "no specific recommendation in the evidence, in either the written materials submitted or in the oral evidence specifically endorsing the provision of attendant care services for any of the above reasons."

"Even more problematic," as the Arbitrator noted, was "the lack of a Form 1 filed by T.S., prepared by a qualified professional, outlining the nature or extent of the attendant care services required." As the Arbitrator recognized, s. 16(4) of the *SABS* provides that "the monthly amount payable by the attendant care benefit shall be determined in accordance with Form 1." Nonetheless, the Arbitrator noted the Form 1 issued by Ashok Jain on July 24, 2002 that recommended T.S. receive $77.40 per month by way of attendant care,[3] and stated that "Although the assessment addressed the physical aspects of T.S.'s disability and did not deal directly with any needs arising from her at times acute depression, I am satisfied that at least the amount of attendant care specified remains appropriate."

[3] It does not appear that the Arbitrator considered the attendant care DAC of November 12, 2002, that identified attendant care needs in the amount of $103.19 per month.

Accordingly, he awarded ACBs of $77.40 a month. He reiterated that he had "considered no evidence and made no findings as to evidence of quantum for the period following the commencement of this hearing."

As for the housekeeping claim, the Arbitrator noted that "T.S. has submitted expenses that, even with deductions for dubious claims, far exceed the statutory ceiling" of $100 per week set out in s. 22(2). However, he stated, "Even though many elements of T.S.'s claim remain non-compensable, given total amounts incurred", he had "no trouble accepting that at least $100 per week of housekeeping and home maintenance expenses has been incurred."

The Arbitrator refused to grant a special award. He noted that "the lack of any Form 1 analysis would have justified non-payment of the attendant care claim." Furthermore, "It was only after considering the documentary evidence, painstakingly assembled and filed by Allstate, in the light of the *viva voce* testimony" that he began to reconsider his initial impression that he "would have been loath to accept the possibility of T.S. meeting the criteria for catastrophic assessment."

As to repayment, the Arbitrator noted that "the second interim benefit order was specifically made to be repayable at the request of the Insurer. While T.S. has been successful in obtaining benefits, the amounts in question do not necessarily accord with the amount of the interim benefit order. I remain seised of this issue should it remain in dispute."

As part of its appeal, Allstate is seeking repayment of the interim benefits paid.

Finally, a note on the appeal process. While Allstate filed a timely appeal, it requested a long period to prepare written submissions, in part due to the complexity of the case as well as other reasons of counsel. T.S. also required a long time to prepare her submissions. A hearing was scheduled for October 30, 2013. However, after the hearing started, I accepted the recommendation of counsel for Allstate that she provide to T.S. and myself what she termed a "transcript" of the oral submissions that she would have made at the appeal hearing. T.S. then was given several months to prepare her response to the transcript of the oral submissions, and counsel provided her reply to that response.

III. ANALYSIS

Allstate submits that the Arbitrator committed numerous errors throughout the hearing process, starting with his decision over Allstate's objections to accept as evidence all the documents in the binders it had prepared and then to review them on his own to determine the issues. Allstate submits that "the difficulty with this approach is that the insurer then did not know the case it had to meet. It did not know which documents the Arbitrator might find to be persuasive or important."

Allstate submits that this approach became problematic when the Arbitrator raised and decided issues on his own initiative and after the completion of the hearing, namely whether a further CAT DAC should be held due to a psychologist not being on the DAC team (decision of December 3, 2010). Allstate submits that this "resulted in a cascade of errors in that the Arbitrator appeared to rely heavily upon his analysis respecting the 'interim issue' (i.e. the sufficiency of the roster of DAC assessors) in rejecting the conclusions of the CAT DAC."

Allstate submits that the interim benefits decisions of October 2008 and May 2009 were in error, starting with the Arbitrator granting interim benefits without prior notice to Allstate and in the absence of a formal request or motion advanced by T.S. Further, Allstate submits that the Arbitrator did not address whether there was a *prima facie* case for a determination of catastrophic impairment, and awarded $400 per week of ACBs, notwithstanding that the only Form 1 on file was for $77.40 per month.

Allstate submits that the Arbitrator was far more critical of its expert evidence than that of T.S.'s. For instance, over six pages of his decision, the Arbitrator criticized the process followed by the CAT DAC assessment team, beginning with its analysis of the category (f) 55% whole person impairment rating. Allstate submits "This is notwithstanding the fact that there was no OCF-19 seeking consideration under this criterion and that no evidence was led by [T.S.] speaking to a whole person impairment rating at any level… No submissions were made by either party on this topic during the hearing…" Furthermore, Allstate submits, there was no evidence to suggest that the CAT DAC assessors were not "open-minded" or were "blinkered" in their approach or in any respect "dogmatic."

Allstate submits that the Arbitrator erred in not applying the same level of scrutiny to the evidence of Dr. Hoff and Dr. Manohar that he applied in considering the evidence of the CAT DAC assessors and that the "critique of the expert testimony and reports relied upon by the insurer should have been balanced by a similar critical approach to the reports and evidence relied upon by [T.S.]."

Allstate submits that the Arbitrator erred in simply accepting T.S.'s testimony with no qualifications, stating that her evidence was "sufficient" to establish at the least a marked impairment in the four areas identified in Chapter 14 of the *AMA Guides*. Allstate submits that the Arbitrator's analysis of impairment relative to the four areas was entirely inadequate.

As for the amount of the ACBs, Allstate submits that when the Arbitrator noted that "the evidence touched on several possible scenarios to justify the expenditure" for the attendant care, he was reversing the onus of proof, and that "scenarios to justify the expenditure" are not sufficient to lead to a finding of entitlement.

Regarding the housekeeping claim, Allstate submits that the Arbitrator made no particular findings regarding any amounts that had been incurred or whether these amounts were reasonable, and he made no reference to the evidence upon which he was relying in finding any amount of housekeeping was incurred by T.S.

Allstate requests that the orders in question be reversed on appeal: "It is Allstate's submission that [T.S.] was given every opportunity to present her case and that she was simply not able to discharge her burden of proof through the evidence she led."

I find that the evidence presented by T.S. could not support a finding of catastrophic impairment because the medical evidence she led did not address the criteria, and her uncorroborated evidence standing alone is insufficient to prove catastrophic impairment.

The decision of Arbitrator Sapin in *Ms. M.G. and The Economical Mutual Insurance Company*, (FSCO A09-002443, November 23, 2012), serves as a model for the approach to the issue of catastrophic impairment and category (g). As she set out in that decision, under s. 2(1.2)(g) of the

SABS, a catastrophic impairment is an impairment that, in accordance with the *AMA Guides*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to a mental or behavioural disorder. "Impairment" in turn is defined in s. 2(1) as a loss or abnormality of a psychological, physiological or anatomical structure or function. Further, as outlined in *Ms. M.G.* regarding the *SABS*:

> mandates that medical and legal professionals rate impairment under category (g) using the criteria and methods set out in Chapter 14 of the *AMA Guides,* entitled *Mental and Behavioural Disorders.* Under this edition of the *Guides,* mental or behavioural disorders are diagnosed using the *DSM III-R*.
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> After diagnosis, assessors must rate any resulting impairment according to how it impacts four broad and overlapping areas of function. The four areas of function are:
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> 1. Activities of daily living ("ADLs");
>
> 2. Social functioning;
>
> 3. Concentration, persistence and pace;
>
> 4. Adaptation – "deterioration or decompensation in work or worklike settings."
>
> There are five levels of severity described in Chapter 14, ranging from no impairment (Class 1) to extreme impairment (Class 5).
> …
> Under the *Guides*, impairment levels are rated according to how they compare to "useful functioning." In any of the four functional categories, for example, as indicated in the chart from pg. 301 of the *Guides* and entitled *Table: Classification of Impairments Due to Mental and Behavioral Disorders*, a Class 3, or moderate impairment rating applies where "impairment levels are compatible with some, but not all, useful functioning." … A Class 4, or marked impairment, refers to impairment levels that "significantly impede useful functioning." A severe or Class 5 rating would preclude useful functioning.
>
> The term "useful functioning" is not defined anywhere in the *Guides,* as such. Instead, it is left to assessors to exercise their clinical judgment and interpret their findings with reference to the qualitative descriptions of each functional area, and examples of impaired functioning, that the *Guides* do provide. The exercise is rendered even more difficult, and allows for variation in ratings, because of the considerable overlap in the four functional categories.

After an overview of the medical opinions, Arbitrator Sapin then considered in detail over 5 pages each of the four areas of function, comparing and contrasting the medical evidence as well as the evidence of Ms. M.G. and her family with respect to those areas. Her finding of catastrophic

impairment was so well-founded that Economical appealed the special award and the granting of expenses to Ms. M.G., but not the finding of catastrophic impairment.[4]

I have gone into this amount of detail to illustrate just how deficient the medical evidence was in this case. I find this deficiency goes beyond a mere insufficiency of evidence to an outright lack of evidence.

To reiterate, medical professionals rate impairment under category (g) using the criteria and methods set out in Chapter 14 of the *AMA Guides,* entitled *Mental and Behavioural Disorders.* The report of Dr. Michael Gadon does not even attempt to do this, as it related to a disputed treatment plan and did not speak at all to the criteria for impairment under category (g).

The report of Dr. P. Manohar, psychiatrist, is no better. It does not address the *Guides* at all, as Dr. Manohar simply states, regarding T.S., "Her illness can be termed catastrophic because of significant anxiety, depression, deterioration in adjustment socially, diminished noise tolerance and frustration tolerance and poor stress tolerance. Her everyday activities are markedly restricted."

As for Dr. Hoff, the entirety of his discussion on the application of the *Guides* appears at p.8 of the Arbitrator's decision:

> Dr. Hoff's report (Form OCF19), which essentially set the catastrophic assessment procedure in motion, is dated December 9, 2005. Dr. Hoff stated:
>
> > [T.S.] meets Class 4 criteria in social functioning and adaptation and activities of daily living, Class 3 criteria in concentration. Overall, marked impairments severely limit useful functioning.

This does not set out how Dr. Hoff arrived at his decision. The Arbitrator went on to state: "Without considering the manner in which Dr. Hoff translates observed impairments into a disability rating, it is important to note that his opinion that T.S. suffers significant psychological impairments is not an isolated observation." The Arbitrator then referred to Dr. Gadon's report,

[4] I upheld the decision, other than correcting some mathematical errors, in *Economical Mutual Insurance Company and Ms. M.G.*, (FSCO P13-00001, July 21, 2014).

but never did return to considering how Dr. Hoff translated observed impairments into a disability rating.

Neither did Dr. Hoff's testimony provide any further illumination, as he had never observed or assessed T.S. outside of his office, or how she functioned at home or in the community. He had never reviewed her pre-accident records, and, apart from one or two reports that he obtained from T.S., had not reviewed any of her concurrent health records. He did not speak to any family members like T.S.'s daughter, any collateral sources, or any other treatment providers in order to arrive at his opinion that the catastrophic threshold had been met as of December 2005.

There was thus no medical evidence rating impairment under category (g) using the criteria and methods set out in Chapter 14 of the *AMA Guides*, other than bald, unsupported opinions. The Arbitrator implicitly recognized the frailty of the medical evidence when he stated that he was "convinced that an appropriate CAT DAC would have been of assistance in making a fair 'adjudicative assessment' on the issue of catastrophic impairment." However, the burden of proof rested on T.S. throughout, which the Arbitrator appears to have reversed here and, in any event, it was up to T.S. to prove her case, CAT DAC or no CAT DAC.

That only leaves T.S.'s evidence. As noted above, the Arbitrator found that T.S's evidence, which he accepted, was sufficient to establish at the very least a marked impairment in the four areas. However, the Arbitrator did not subject her evidence to any scrutiny as to its credibility. Instead, he stated the following:

> Briefly, T.S.'s social functioning was poor. There is clear evidence that she spent inordinate times in bed due to her pain perception. Her relationships with family and friends were frayed and difficult. Indeed, her reaction to the outside world was challenging as evidenced by her interpretation of the actions of the schoolchildren whom she believed were targeting her, causing her even to sell her house to avoid them.
>
> One of T.S.'s major complaints has been the lack of concentration. Her testimony mentioned the difficulties in doing banking among many other tasks which required concentration. This is echoed in Dr. Hoff's reports, which rate "Class 3 criteria in concentration."
>
> As well she appears to have been unable to stick to tasks to completion or pace herself so that she can undertake her activities of daily living without assistance.

> As to work adapting, given T.S.'s constant complaints of pain, her significant use of strong pain relief medication and her emotional outbursts, it is hard to imagine her surviving for any time in any competitive employment situation, notwithstanding the evidence that she worked at several jobs prior to the accident.

That falls far short of the assessment required to consider whether or not T.S. met the criteria under category (g). The Arbitrator also did not consider any frailties in T.S.'s evidence or her credibility, even though that is key to her case. He also did not take into consideration that, although relationships with family were supposedly "frayed," T.S.'s daughter did not testify, nor did any of the caregivers. As stated in *Kanareitsev v. TTC Insurance Co*., [2008] O.J. No. 2132, the factors to be considered in determining the adequacy of an adjudicator's reasons include

> The decision-maker setting out its findings of fact and the principal evidence upon which those findings were based. The reasons must address the major points in issue; it is insufficient for the decision-maker to summarize the parties' positions and "baldly state its conclusions"; and the reasoning process followed must be set out and reflect consideration of the main relevant factors.

However, the Arbitrator's consideration of T.S's evidence is conclusory, and he failed to address in any meaningful way the four areas of function under category (g). Furthermore, the focus on an applicant's evidence should not be on demeanour, but on the inherent plausibility, consistency and internal coherence of testimony, and whether it accords with evidence from other sources: *Wawanesa Mutual Insurance Company and Sorokin*, (FSCO P04-00008, August 9, 2005). But as already noted, there was no significant evidence from other sources regarding her mental or behavioural disorder.

As for the benefits themselves, the Arbitrator recognized that there was no relevant Form 1, and he had to come up with "scenarios" to explain why T.S. might need constant attendant care. As for the housekeeping claim, the Arbitrator's finding was vague at best. In any event, as set out earlier, neither ACBs nor housekeeping claims are payable more than 104 weeks after the accident where the impairment was not catastrophic.

In conclusion, I find that the Arbitrator failed to give adequate reasons for his decision, reversed the burden of proof at several key points of the decision, and failed to fairly consider the evidence from both parties. This is an error in law. This would be reason enough to order a

rehearing, but I find a rehearing would be a colossal waste of time after all that has gone before. As noted above, there were several arbitration orders issued, and the arbitration hearing itself took a number of days. However, I have no confidence that repeating the process would result in any better evidence. I find that, considering the dearth of medical and other supporting evidence, as well as the weakness in T.S.'s own evidence, the Arbitrator erred in finding that T.S. had discharged her burden of proof.

As for the earlier interim benefits orders, those interim benefits are no longer payable either, as Allstate was entitled to cease paying them when the hearing resumed in July 2010. Allstate seeks repayment of the interim benefits paid pursuant to those orders. As the Arbitrator noted, the second interim benefits order had been made repayable, and the Arbitrator said he remained seised of the issue. However, I see no reason why the benefits from the first order would not be repayable. And although the Arbitrator said he was still seised of the issue, T.S.'s accident happened 13 years ago, she applied for arbitration nine years ago, and the appeal was commenced three years ago. In my view, any further delay in finally resolving the parties' disputes would be unjust.

Subsection 283(5) of the *Insurance Act* provides that "The Director [or his Delegate] may confirm, vary or rescind the order appealed from or substitute his or her order for that of the arbitrator." Accordingly, I revoke paragraphs 1, 2 and 3 of the Arbitrator's November 15, 2011 decision ordering that T.S. suffered a catastrophic impairment and was entitled to attendant care and housekeeping benefits. Further, I add a seventh paragraph to the Arbitrator's decision ordering repayment of the interim benefits paid.

IV. EXPENSES

Subsection 283(4) provides that "The Director [or his Delegate] may determine the appeal on the record or in such other manner as the Director may decide, with or without a hearing." The determination of appeal expenses will be on the record, meaning that the parties will provide written submissions and there will be no hearing.

The Arbitrator stated he was prepared to conduct an arbitration expense hearing based on a costs summary served within 30 days of the decision, which did not happen. Since all other issues in this case have been otherwise resolved, and to save time and expenses, I am prepared to receive brief submissions from the parties as to how they wish to deal with expenses, including whether they agree to have me resolve arbitration expenses as well. This would be consistent with Rule 1.1 of the *Code*, which provides that "These Rules will be broadly interpreted to produce the most just, quickest and least expensive resolution of the dispute."

In any event, both parties will have 60 days after the date of this decision to make submissions on entitlement to and the amount of appeal expenses and, if agreed, arbitration expenses. Responses to any submissions regarding expenses will be due 45 days thereafter.

David Evans Director's Delegate	September 25, 2014 Date