CITATION: Co-Operators General Insurance Company v. Branden, 2022 ONSC 2473
DIVISIONAL COURT FILE NO.: 654/20
DATE: 2022/04/29

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Swinton, Lederer, Mew JJ

BETWEEN:	)	
CO-OPERATORS GENERAL INSURANCE COMPANY	)	*Eric K. Grossman* and *Suzanne Clarke*, for the Appellant
Appellant	)	
– and –	)	
PATRICIA BRANDEN	)	*Roger Foisy* and *Christopher I.K. Morrison*, for the Respondent
Respondent	)	
	)	**HEARD:** at Toronto (by video conference): March 1, 2022

Lederer J.

Introduction

[1] This is an appeal from a decision of the *Licence Appeal Tribunal* dated September 18, 2020. This case tests the parameters of the policy against double recovery where an individual involved in a motor vehicle accident obtains, through the *Statutory Accident Benefits Schedule-Effective September 1, 2010* ("SABS") [1], an income replacement benefit while at the same time receiving some other payment that may be on account of income loss or loss of earning capacity.

Background

[2] Following a motor accident in 2017, pursuant to the SABS, the Respondent, Patricia Branden, applied for and received an income replacement benefit from her insurer, the Appellant Co-Operators General Insurance Company. She also sought a long-term disability benefit, from a policy held by her employer and issued by Empire Life Insurance Company. Empire rejected the application. Patricia Branden commenced an action against Empire claiming "payments due from the Defendant to the Plaintiff" and under a separate subclause "aggravated, exemplary and punitive

[1] O. Reg. 34/10

damages in the amount of $100,000"[2]. In time, on October 18, 2018 the action settled. In exchange for $120,000, Patricia Branden signed a release that suspended her long-term disability claim for a two-year period from the date of the settlement.

[3] Having been provided with a copy of the release, Co-Operators recalculated the income replacement benefit it had been paying to Patricia Branden, taking into account the $120,000 she had received through the settlement with Empire. As perceived by Co-Operators this payment was a duplication of at least part of the income replacement benefit already paid by it under SABS which, taken together, represented double recovery. Co-Operators determined that it had overpaid Patricia Branden in the amount of $3,369.72. Co-Operators advised her that it would reduce the amount she was paid from $400.00 to $224.49 per week. On a recalculation, subsequently delivered, Co-Operators advised that it would "continue to withhold 20% of IRBs in the amount of $52.45 per week so P.B. would only receive $209.80 per week."[3]

[4] On July 13, 2019, Patricia Branden filed her application with the Licence Appeal Tribunal. In its Amended Decision released on September 18, 2020, the Licence Appeal Tribunal found that Patricia Branden was entitled to an income replacement benefit, under SABS in the amount of $400.00 per week for the period in dispute. The Co-Operators was not allowed the repayment it had claimed. The settlement with Empire had not been shown to be accounted for as compensation for loss of income. As a settlement it was a compromise. Through it, Patricia Branden had settled all her past and present claims under the long-term disability policy, all future claims up to October 18, 2020; and "specifically, all other claims for extracontractual damages [aggravated, exemplary and punitive] sought in the action:"[4]

> …I find that the LTD settlement between P.B. and Empire does not provide appropriate details to allow The Co-Operators to deduct the settlement from P.B.'s past IRB calculation because the settlement was not confined to payment for her LTD claims alone.[5]

[5] The settlement was not limited to long-term disability. There was no double recovery.

[6] Not content with this result Co-Operators asked the Licence Appeal Tribunal to reconsider its decision.[6] The submissions made on behalf of Co-Operators were directed to a specified

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[2] *Statement of Claim,* issued February 21, 2018, at para. 1(c) and (d) (Caselines A28)
[3] *P.B. v. Co-Operators Insurance Company,* 2020 CanLII 72511 (ON LAT), at para.14: I do not understand how $52.45 can represent 20% of either $400.00 or $224.49 (5x 52.45= 262.25). As it turns out, it does not matter to the decision being made.
[4] *Ibid* at para. 23
[5] *Ibid* at para. 28
[6] *Common Rules of Practice and Procedure Licence Appeal Tribunal, Animal Care Review Board, Fire Safety Commission, October 2, 2017* at Rule 18:

> 18.1 REQUEST FOR RECONSIDERATION
> The Tribunal may, on its own initiative or upon request of a party, if the request is made within 21 days of the date of the decision, reconsider any decision of the Tribunal that finally disposes of an appeal.

criterion being that the Licence Appeal Tribunal had made an error of law or fact such that it would likely have reached a different result had the error not been made.[7] The Reconsideration was undertaken by the same adjudicator who had made the initial determination. He upheld that decision. There had been no error of law of fact.

The appeal

[7] Co-Operators is still not prepared to accept the decision and brings this appeal, as it is entitled to do pursuant to the *Licence Appeal Tribunal Act, 1999* [8], s. 11(6) albeit limited only to questions of law:

> An appeal from a decision of the Tribunal relating to a matter under the *Insurance Act* may be made on a question of law only.

The standard of review

[8] As a statutory appeal the applicable standard of review on a question of law is correctness.[9] There is no appeal on questions of fact, or questions of mixed fact and law.[10]

Analysis

[9] Section 7 of SABS provides the means by which an income replacement benefit is to be calculated. The fundamental determination is found in s.7(1):

> **7.** (1) The weekly amount of an income replacement benefit payable to an insured person who becomes entitled to the benefit before his or her 65th birthday is *the lesser of "A" and "B"* where,
>
> "A" is the weekly base amount determined under subsection (2) *less the total of all other income replacement assistance,* if any, for the particular week the benefit is payable, and
>
> "B" is $400 or, if an optional income replacement benefit referred to in section 28 has been purchased and applies to the person, the amount fixed by the optional benefit.
>
> [Emphasis added]

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[7] *Ibid* at Rule 18(2)(b): The Tribunal noted that Co-operators had also identified Rule 18(2)(a) suggesting that it had acted outside its jurisdiction or violated the rules of procedural fairness but had not made any submissions to explain that position (*Branden v. Co-Operators General Insurance Company,* 2021 CanLII 18917 (ON LAT), at para.7).
[8] S.O. 1999, c. 12, Sched. G
[9] *Canada v. Vavilov,* 2019 SCC 65, at paras. 36 and 37; *Housen v. Nikolaisen,* 2002 SCC 33, at para. 8 and *Aviva General Insurance Company v. Khan,* 2020 ONSC 1290 (Div. Ct.), at para. 3
[10] *Yatar v. TD Insurance Meloche Monnex,* 2021 ONSC 2507, at para. 25 referring to *Oliver v. Brant Mutual Insurance Company,* 2018 ONSC 3716 (Div. Ct.). at para. 17

The term "other income replacement benefit" is defined in s. 4(1) as "the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan" subject to exclusions that do not apply here.

[10] As already noted, before the settlement with Empire, Co-Operators was paying Patricia Branden $400 per week on account of lost income. With the settlement in place, Co-Operators, presumably relying on s. 7(1)(A), made deductions on account of the money received by Patricia Branden through the settlement. Co-Operators reduced its payments to values less than $400. The issue that the adjudicator dealt with was whether the deductions that reduced the value of those payments fell within the direction found in s. 7(1)(A). Were they "other income replacements benefits", as defined by s. 4 (1) of SABS?

[11] The adjudicator noted that there were six IRB calculations that had been proposed between August 2017 and June 2020: four on behalf of Co-Operators and two on behalf of Patricia Branden. The latter two were the "Insignia Report", on behalf of Co-Operators and the "ADS Report" on behalf of Patricia Branden. He observed that the difference between them was "largely attributable to whether the LTD settlement should be deducted from the IRB."[11]

[12] The adjudicator found that there should be no deduction based on the settlement. He disagreed with Co-Operators that the settlement was equivalent to income replacement assistance. Rather, the $120,000 settlement encompassed all of her claims against Empire as a result of its denial of her LTD claim.[12]

[13] Co-Operators disagrees with this finding. It relies on a series of cases dealing with damages after trial. This is specifically provided for by s. 267.8 of the *Insurance Act* (see: para. 17 below). It follows that these cases deal with a different circumstance, a deduction from a tort award of a benefit paid pursuant to SABS. Nonetheless, Co-Operators submits that these cases, point to the need for the reduction of any payments made pursuant to SABS where other payments have been or are being received, in this case, for income loss. This is in furtherance of avoiding what it asserts would otherwise lead to double recovery. What these cases demonstrate is a change in how the relationship between the subject of the SABS payment (in this case income loss) is to be measured as against the tort award that is made, are they to be the same (strictly match) or can there be a less exacting relationship:

- In *Cobb v. Long Estate*[13] the jury awarded $50,000 for "Past Lost Income" and $100,000 for "Future Loss of Income" from which the judge deducted $159,300 representing $29,300 received as income replacement benefits and a further $130,000 in income replacement benefits received as part of a "global settlement" that totalled $152,000 (which also included $20,000 for past and future medical benefits and $2,000 for other benefits). The plaintiff argued that the onus for the deduction to be made had not been satisfied. The "global settlement" did not distinguish between past and future income replacement as "strict matching" would

[11] *P.B. v. Co-Operators Insurance Company, supra* (fn. 3) at para. 17
[12] *Ibid* at paras. 20 and 21
[13] 2017 ONCA 717

require. The Court of Appeal found that given that "the purpose of the statutory deduction procedure is to prevent double recovery for a single loss, there was no reason in principle to distinguish between pre-trial and post-trial 'income loss and loss of income capacity' when deducting SABS from damages."[14] It upheld the deduction.

- In *El-Khodr v. Lackie*[15] the jury awarded $395,593 for "Future Loss of Income". The court recognized the obligation to assign the income replacement benefits payable by the plaintiff's accident benefit insurer to the defendant's insurer. The issue for the Court of Appeal was how long the assignment would go on. Ultimately it decided that the jury must have concluded that the plaintiff (the respondent on the appeal) would have retired at age 64 had the accident not occurred.

  It was in the context of future care costs (all of medication, assistive devices, professional and rehabilitation services and attendant care) that the question of the propriety of an assignment of SABS payments arose. Having initially indicated an inclination to order an assignment of those future collateral benefits, in the end the trial judge did not. This was because despite her suggestion that they do so, the parties had not requested a breakdown of the award of future care costs. Rather the jury was asked to provide global figures for "Future Professional Services" and "Future Medication and Assistive Devices". The judge found that in these circumstances "the Defendants [were] unable to meet their onus to demonstrate that the jury award compensated the Plaintiff for the same loss in respect of which the Defendants now claim an assignment of benefits."[16] The Court of Appeal determined that this "strict matching approach… does not apply to the particular facts of this case"[17] and allowed the appeal. In doing so, it ordered that any amounts payable for future medication and assistive devices and for future professional services be assigned until the amounts awarded by the jury on those accounts (respectively $82,429 and $424,550) were received.[18]

- *Nemchin v. Green*[19] also dealt with the assignment of future payments under SABS. Following a trial, the jury awarded non-pecuniary damages of $125,000 and damages for loss of future income of $600,000. There was a deduction for contributory negligence. The issue was the prospective assignment of payments the plaintiff was receiving from her long-term disability insurer. The plaintiff sought a narrow form of matching the damages awarded to the long-term disability payments being made. The defendant had opposed the jury being required to answer a question identifying both the annual loss of income and the number of years that loss would continue. As a result, it was not possible to match, on a temporal basis, the long-term disability benefits received over time against a specific annualized

[14] *Ibid* at para. 52
[15] 2017 ONCA 716
[16] *Ibid* at para. 31, quoting the decision of the trial judge, 2015 ONSC 5244, at para. 5
[17] *Ibid* at para. 37
[18] *Ibid* at para. 87
[19] 2018 ONSC 2185

loss of income. That kind of specific matching was not required. The judge, based on the record, was able to "accurately determine" the portion of that award that was "mirrored" by the plaintiff's entitlement to LTD benefits.

- In *Carroll v. McEwan*[20] the SABS payment to be deducted was for future care costs, not income loss. The amount awarded by the jury (even after accounting for the plaintiff's contributory negligence) exceeded the available insurance. The trial judge made a conditional order that if the two insurers paid the full amount of the judgment, they would receive an assignment of the future SABS payments that the plaintiff was entitled to receive (as distinct from a deduction for payments already made). The insurers were left to determine whether they were better to pay the limits of the policies without recourse to the assignment or to pay the full amount and take advantage of the assignment. This approach was upheld on appeal even though the matching of the basis for any SABS payment to the award made by the jury was "not strict". A "silo approach" had been adopted in respect of the deduction of payments made pursuant to SABS and was held by the Court of Appeal to apply. For the purposes of the decision being made, I point out that the monetary value for each of the pertinent factors was known. The two insurance policies were limited at $1,000,000 each, for a total of $2,000,000. The jury award, after the deduction for contributory negligence, was $2,610.774.32 which included a lump sum of $2,232,000 for "future care costs". The issue for the insurers was whether the future SABS payments would exceed the $2,000,000 they would be required to pay under the policies by more than the additional $610,774.32 awarded at the trial.

- In *Girao v. Cunningham*[21] the plaintiff had settled her SABS claim for $82,300. The Court of Appeal, having recognized that a trial judge would be required to deduct whatever payments had been made as income replacement under SABS from any award made by a jury, sent the matter back for a new trial. The plaintiff (the Claimant) was self-represented and the settlement of her SABS benefits was referred to at trial and used as an evidentiary demonstration that she was a malingerer.

  The case accepts the matching of the tort award against payments made under SABS is to be undertaken based on silos: the first silo is income loss and loss of earning capacity, the second silo is health care expenses, which includes attendant care costs; and the third silo is other pecuniary losses such as housekeeping costs.[22] The tort award is to be reduced by the amount of statutory accident benefits received by the plaintiff on the basis of these three silos.

[14] The issue to be developed through these cases is the basis on which a deduction is made where the jury or judge, on account of a tort claim dealt with at trial, makes an award in response

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[20] 2018 ONCA 902
[21] 2020 ONCA 260
[22] *Ibid* at para. 89

to the same damage or loss to which SABS has already responded, in this case, loss of income. As a general proposition, these cases demonstrate an evolution away from strict matching of these awards and payments to a less exacting or more general approach referred to as "silos".

[15] Strict matching was based on the decision in *Bannon v. McNeely*.[23] The case came after one legislative change and preceded another further change. Accidents occurring between October 1989 and January 1994 were subject to what was a revised provision in the *Insurance Act*, which remains today as subsection 267(1)[24]:

> The damages awarded to a person in a proceeding for loss or damage arising directly or indirectly from the use or operation of an automobile shall be reduced by,
>
> *(a) all payments that the person has received or that were or are available for statutory accident benefits and by the present value of any statutory accident benefits to which the person is entitled;*
>
> (b) all payments that the person has received under any medical, surgical, dental, hospitalization, rehabilitation or long-term care plan or law and by the present value of such payments to which the person is entitled;
>
> (c) all payments that the person has received or that were or are available for loss of income under the laws of any jurisdiction or under an income continuation benefit plan and by the present value of any such payments to which the person is entitled; and
>
> (d) all payments that the person has received under a sick leave plan arising by reason of the person's occupation or employment.
>
> [Emphasis added]

[16] The accident considered in *Bannon v. McNeely* took place on January 27, 1991. The decision in that case addressed whether a deduction of no-fault benefits could be made against any head of damage under a tort award or whether the deduction must be from a head of damage covering the kind of loss to which the no-fault benefit could be attributed. The Court of Appeal described an onus that was strict:

> Goudge J.A. in *Chrappa* examined the relevant case-law and concluded that [at p. 657] "the jurisprudence supports the view that where the concept of entitlement to future long-term insurance benefits is used as a basis for reducing the plaintiff's

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[23] 1998 CanLII 4486 (ON CA), 38 O.R. (3d) 659 (C.A.)
[24] As reported in *El-Khodr v. Lackie, supra* (fn. 15), at para. 41, this subsection originated in S.O. 1990, c. 2, s. 57.

> damage recovery it must be strictly interpreted to require that it is beyond dispute that the plaintiff qualifies for these future payments in every respect".[25]

[17] The subsequent amendment was enacted in November of 1996 as s. 29 of the *Automobile Insurance Rate Stability Act*[26] which amended the *Insurance Act* and provided separately for the treatment of collateral benefits dealing with "income loss and loss of earning capacity, health care expenses, other pecuniary loss, non-pecuniary loss and future collateral benefits. In respect of income loss that legislation included section 267.8(1) in the form that continues today:

> **267.8** (1) In an action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of an automobile, the damages to which a plaintiff is entitled for income loss and loss of earning capacity shall be reduced by the following amounts:
>
> *1. All payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for statutory accident benefits in respect of the income loss and loss of earning capacity.*
>
> 2. All payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for income loss or loss of earning capacity under the laws of any jurisdiction or under an income continuation benefit plan.
>
> 3. All payments in respect of the incident that the plaintiff has received before the trial of the action under a sick leave plan arising by reason of the plaintiff's occupation or employment.
>
> [Emphasis added]

[18] The legislation also takes account of the assignment of future collateral benefits:

> **267.8** (12) The court that heard and determined the action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of the automobile, on motion, may order that, subject to any conditions the court considers just,
>
> (a) the plaintiff who recovered damages in the action assign to the defendants or the defendants' insurers all rights in respect of all payments to which the plaintiff who recovered damages is entitled in respect of the incident after the trial of the action,
>
> (i) for statutory accident benefits in respect of income loss or loss of earning capacity,

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[25] *Bannon v. McNeely, supra* (fn. 23) at p. 673, as quoted in *El-Khodr v. Lackie, supra* (fn. 15), at para. 45. The reference within the quotation is to *Chrappa v. Ohm* (1998), 1998 CanLII 893 (ON CA), 38 O.R. (3d) 651 (C.A.),
[26] S.O. 1996, c. 21

> (ii) for income loss or loss of earning capacity under the laws of any jurisdiction or under an income continuation benefit plan,
>
> (iii) under a sick leave plan arising by reason of the plaintiff's occupation or employment,
>
> (iv) for statutory accident benefits in respect of expenses for health care,
>
> (v) under any medical, surgical, dental, hospitalization, rehabilitation or long-term care plan or law, and
>
> (vi) for statutory accident benefits in respect of pecuniary loss, other than income loss, loss of earning capacity and expenses for health care; and
>
> (b) the plaintiff who recovered damages in the action co-operate with the defendants or the defendants' insurers in any claim or proceeding brought by the defendants or the defendants' insurers in respect of a payment assigned pursuant to clause (a).

[19] What these changes brought about was a required breakdown into specified or defined categories to which the application of payments under SABS (or other collateral benefits) were to be aligned, in any tort recovery, for the purposes of those payments being deducted to avoid double recovery. It is this change that has led to the determination that matching is to be undertaken in the context of the broader silos rather than strictly as in *Bannon v. McNeely*:

> I agree with Sanderson J. that the present legislation does, to a limited extent, import a matching requirement. The court is required only to match statutory benefits that fall generally into the "silos" created by s. 267.8 of the *Insurance Act* with the tort heads of damage. Income awards are to be reduced only by SABs payments in respect of income loss and health care awards only by SABs payments in respect of health care expenses. The latter item is, I suggest, deliberately broad enough to cover all manner of expenses that relate to health care and would include medications, physiotherapy, psychology sessions, assistive devices and the like. All manner of other expenses that are covered by SABs and that do not fall under the income category or the health care category fall into the "other pecuniary losses" category.
>
> There is nothing in the language of the current Ontario statutory scheme that would require any further subdivision based on common-law heads of damage. In other words, although the legislation requires us to match apples with apples, the relevant categories of "apples" are the statute's categories, not the common law's….[27]

[20] In this case, Co-Operators is attempting to move even further away from the strict matching approach. This is not a dispute that is between insurers as under s. 267.8 where the defendant's

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[27] *El-Khodr v. Lackie, supra* (fn. 13), at paras 60-61. The reference to Sanderson J. is to her decision in *Mikolic v. Tanguay*, 2016 ONSC 71, 129 O.R. (3d) 24 (Div. Ct.), at paras. 30-32 quoted in *El-Khodr v. Lackie* at para. 59

insurer is able to deduct payments that have been made by the plaintiff's insurer pursuant to SABS. Rather this is a dispute between a plaintiff and her own insurer. In the context of that dispute, what Co-Operators is seeking is to have the right to a deduction determined outside the silo (income loss), on the basis that the settlement of the long-term disability claim can be inferred to be a payment for weekly income replacement benefits.

[21] The maximum coverage provided by the Empire policy for long-term disability was $5,000 per month, for a two year period, being $120,000:

> 66.67% of your monthly earnings to a maximum of $5,000 or 85% of your pre-disability take-home pay, which ever is less. Any amount of LTD Insurance over $1,500 is subject to approval of evidence of insurability.[28]

The settlement of the claim against Empire was in exactly that amount.

[22] Co-Operators says that this is more than a coincidence. The foundation of the payment is 100% recovery of the long-term disability benefit. Co-Operators submits that this assertion is sustained by a calculation sheet found in the Record.[29] On its face this sheet is nothing other than a calculation of Patricia Branden's entitlement under the policy. It was enclosed with a letter, dated November 14, 2018, sent by her counsel to Co-Operators. The letter says nothing other than that the calculation and other material that had been requested by Co-Operators was enclosed.[30] There is nothing to suggest that this calculation played any role in the approach taken on behalf Patricia Branden in any settlement negotiations that took place. I point out that also enclosed with the letter were the "LTD Release papers" that had been signed one month earlier, on October 18, 2018.[31] Could this calculation have been prepared, not as the foundation for the settlement as understood by Patricia Branden, but because Co-Operators asked for it? It may have been the basis on which Co-Operators understood the settlement but there is nothing that said that this was the understanding of either of the parties involved: Patricia Branden and Empire.

[23] The inference that Co-Operators relies on is made plain in its Factum:

> In both his decisions, Adjudicator Boyce wrongly afforded limited weight to the IRB/LTD Calculation Sheet that accompanied the executed Release for the settlement of Mrs. Branden's LTD benefits. It is incongruent that Adjudicator Boyce would accept the income documentation that was annexed to the IRB/LTD Calculation Sheet and Release but yet decided that the Statement of Claim and executed Release are the only reliable documentary evidence to provide insight into how the LTD action was negotiated. This reasoning by Adjudicator Boyce is illogical when one considers that the calculation sheet clearly outlines that during settlement negotiations, Mrs. Branden's counsel calculated her net LTD benefits to be $1,153.85. This amount equates to precisely $5000 a month or $60,000 a year. These amounts coincide with the maximum amounts Mrs. Branden was entitled to

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[28] Appellant's Appeal Book and Compendium, at Tab D (Great West Life Benefits Booklet), p. 5 (Caselines A47)
[29] *Ibid* at Tab F which includes "IRB/LTD Calculation Sheet" (Caselines A105)
[30] *Ibid* at Tab F, (November 14, 2018- Letter from Zoulfia Khassanova to Jody Hewitt) (Caselines A101)
[31] *Ibid* at Tab E, (Full and Final Release) (Caselines A97)

> under her LTD policy for a two year period. Therefore, Co-Op submits that it is clear that Mrs. Branden settled her claim for LTD benefits for precisely 2 years for the maximum amount she would have been entitled to under the LTD policy which was $120,000.[32]

[24] What this ignores, apart from the absence of any direct evidence relating the calculation sheet to the settlement or to Patricia Branden's understanding of that settlement, is what the adjudicator relied on in coming to the original decision and the Reconsideration. It should be remembered that the findings made by the adjudicator in support of his decisions are factual findings, and not open to question in an appeal limited to questions of law. These findings are relevant to demonstrate that the adjudicator did not misunderstand or make an error of law in interpreting the availability of a deduction from the SABS payments as a result of, or accounting for, the settlement of the long-term disability claim made between Patricia Branden and Empire.

[25] The adjudicator did not accept the IRB/LTD Calculation Sheet as demonstrating the foundation of the settlement or that it was necessarily used during the settlement negotiations:

> In submissions, The Co-Operators relies heavily on an "IRB/LTD calculation sheet" that was provided by P.B.'s previous counsel *allegedly* used during settlement negotiations.[33]
>
> [Emphasis added]
>
> …
>
> On this document [the calculation sheet] and the accompanying letter, I find there is no indication that this calculation sheet was actually used by P.B's previous counsel during negotiations or that it was not prepared sometime after the settlement, let alone that it constitutes evidence that P.B.'s settlement of her action replaced her actual LTD "received" payments.[34]

[26] Based on this evidence he found:

> I find that the calculation sheet submitted by The Co-Operators is not compelling evidence of the settlement breakdown between P.B. and Empire that would allow it to properly deduct from an IRB and I afford it limited weight.[35]

[27] The adjudicator came to his decision relying first on the Statement of Claim which asserted damages beyond the long-term disability benefits provided by the Empire policy. These are the claims for extracontractual damages (aggravated, exemplary and punitive) referred to earlier in these reasons. He accepted the settlement as a compromise that resolved all of Patricia Branden's claims as against Empire including her legal costs. This involved claims that were not and could

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[32] *Factum of the Appellant* at para. 44 (Caselines A766)
[33] *P.B. v. Co-Operators Insurance Company, supra* (fn. 3), (Amended Decision), at para.22
[34] *Ibid* at para. 23
[35] *Ibid*

not be the subject of deductions to the benefit of Co-Operators as the provider of the income replacement benefit authorized under SABS. This was confirmed by the Release signed as part of the settlement. It served to release Empire from:

> …any and all manner of claims, suits, debts, demands, actions, causes of action, whether in law or in equity, for insurance coverage or benefits, damages, interest, costs, loss or injury sustained by me of every kind, whether known or unknown or anticipated, which I have had, now have or may have in the future arising in any way connected to my coverage for disability benefits under Empire group policy no. BH147-001 (the "Policy"), or any disability I had, have, or may have in the future, including, without limiting the generality of the foregoing:
>
> (a) all claims, past and present under the Policy;
>
> (b) all Long Term Disability claims under the Policy in the future, for two years as of the date of the execution of this Release, that arise out of my alleged period of disability which commenced on or about July 20, 2017;
>
> *(c) all claims made or which could have been made by me in the action commenced by me on February 21, 2018 in the Ontario Superior Court at Barrie bearing action number 18-268*.[36]
>
> [Emphasis added]

[28] The settlement was for a lump sum not attributable to income replacement. The adjudicator made a factual finding that the settlement was not an income replacement benefit, as required by s. 7(1). This is a finding of fact and not subject to appeal. The cases relied on by Co-Operators and referred to earlier in these reasons are distinguishable because in each of them the court could identify a specific sum to be paid on account of lost income. In each case that sum was deductible from the tort damages because it falls within a "silo" of either lost income or health care costs.

[29] This is a fundamental finding of the adjudicator made in his initial decision and confirmed in his reconsideration:

> Based on the LTD Release, I find it clear that P.B. settled all past and present claims under the policy; all future claims up to October 18, 2020; and, specifically, all other claims for extracontractual damages sought in the action. It was not confined to LTD.[37]
>
> …
>
> I find the cases relied on by The Co-Operators are all distinguishable based on the fact that they all featured a breakdown of full and final settlements via Settlement

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[36] Appellant's Appeal Book and Compendium, at Tab E (Full and Final Release), at p. 1 (Caselines A97)
[37] *P.B. v. Co-Operators Insurance Company*, *supra* (fn. 3) (Amended Decision) at para. 23

> Disclosure Notices. I agree with P.B. that a specific breakdown of the heads of damages is what is distinguishable from the facts of this case where P.B.'s settlement was a lump sum meant to cover all of her claims against Empire. I further agree with P.B. that these decisions are distinguishable because the *Schedule* requires a proper breakdown of amounts and a timeframe that an LTD payment was *received* in order to include any deduction in the calculation of IRBs, as per s. 7…[38]

[30] Add to the cases already reviewed the considerations found in *Vanderkop v. Personal Insurance Company of Canada*[39] and *Cromwell v. Liberty Mutual Insurance Co.*[40] These cases confirm the approach taken by the adjudicator.

[31] In *Vanderkop v. Personal Insurance Company of Canada* the Court of Appeal considered a circumstance where the plaintiff was seriously injured in a car accident that had taken place on February 17, 1997. Her motor vehicle insurer, Personal Insurance, made payments under SABS.[41] She applied for long term disability from the applicable carrier, Manulife. It denied the application. The two insurers, the plaintiff and the defendant in the tort action attended a mediation. The plaintiff settled with Manulife. Following the settlement, Personal refused to provide income replacement benefits to the plaintiff. It contended that it could deduct the LTD payments that would have been made by Manulife had the plaintiff proceeded on and successfully sued Manulife. The trial judge found and the Court of Appeal agreed the settlement could not be found to be improvident[42] and determined:

> Based on these facts I conclude that the monies paid pursuant to the settlement cannot be characterized as *"net weekly payments for loss of income that are not being received by the person as a result of the accident"*. Rather, the funds represent a lump sum payment arrived at after a law suit was commenced and negotiated as a compromise. (see ***Tsiaprailis v. Canada*** [2005] S.C.C. 8)
>
> There is no allocation of the lump sum settlement as among the various heads of damage claimed. Under these circumstances I find that the defendant is not entitled to any deduction for a payment in respect of the lump sum settlement payment made by Manulife.[43]

[32] The Court of Appeal upheld the decision. Among its reasons was the determination that once refused, the long-term disability payments were not "available" to the plaintiff. "To treat LTD as being available would effectively oblige an insured to litigate with their collateral benefits

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[38] *Ibid* at para. 26
[39] 2009 ONCA 511
[40] 2008 CanLII 3409 (ON SC), 89 O.R. (3d) 352 (SCJ)
[41] *Vanderkop v. Personal Insurance Company of Canada,* 2008 CanLII 22926 (ON SC) (ONSC) at paras. 17 and 19
[42] *Ibid* at para. 95: To make the context clear, this finding was made in circumstances where it was determined that the benefits potentially available to the plaintiff under the Manulife policy were $700,000 (para. 54). The settlement was for $57,500 (para. 51). The plaintiff attempted to resile from the settlement but was compelled to accept it by an order of the court (Sproat J.) (paras. 62 and 66). Evidently, the plaintiff was considering suing the lawyer who represented her at the mediation and who had recommended the settlement for negligence (para. 64 and 65).
[43] *Ibid* at para. 81 and 82

insurer, at their own risk and expense, for the benefit and at the discretion of, their accident benefits insurer."[44] There is no reason that the same logic would not apply to this case where Empire refused the claim for long term disability and ultimately settled for an unallocated lump sum payment.

[33] In *Cromwell v. Liberty Mutual Insurance Company* payments were under SABS as an income replacement benefit. The plaintiff also made a claim for long term disability from Sun Life Assurance. Initially, Sun Life denied the claim. The plaintiff sued. After discoveries Sun Life made an advance payment of $78,485.70. The claim with Sun Life settled for $15,000 in benefits deemed to be taxable and $160,000 that were deemed by Sun Life to be non-taxable. Liberty Mutual, as the payor under SABS, claimed all these amounts to be subject to deduction from the SABS payments it had paid and would pay. The judge, relying on *Lee v. Certas Direct Insurance Co.*,[45] noted that only collateral benefits paid pursuant to an indemnity policy are deductible from income replacement benefits. Benefits paid under non-indemnity policies are not.[46] He found the Sun Life policy to be an indemnity policy. On this basis, Liberty Mutual was able to deduct from income replacement benefits, disability benefits received under the Sun Life Policy. The advance of $78,485.70 paid by Sun Life on July 7, 2003 and the $15,000 portion of the settlement with Sun Life in December, which was subject to taxes, were subject to deduction. But what about the $160,000? As understood by Sun Life this represented future payments and costs that were not taxable.

[34] The issue was whether the $160,000 lump sum payment was to be classified as a payment made "under any income continuation benefit plan." Liberty Mutual took the position that the payment was the capitalized value of future payments. As the plaintiff understood it, the payment was for past benefits plus punitive and aggravated damages as well as damages for mental distress as a result of Sun Life having refused to pay the benefits under the policy. The judge found that Sun Life was not obliged, under the terms of its policy to pay a lump sum with respect to future payments. There was no evidence that the $160,000 was calculated in a way that took into account the value of any future payments. Rather it was arrived at on the basis of the amount of money available under the authority of the person authorizing the settlement. The plaintiff's release of Sun Life included her claims for mental stress, aggravated and punitive damages. The judge determined that the payment of $160,000 did not qualify as "net weekly payments for loss of income . . . under any income continuation benefit plan" and, accordingly was not subject to deduction. In other words, like the case being decided, the payment did not fall within the loss of income "silo".

[35] In respect of these two cases the adjudicator noted:

> Had P.B. settled her LTD claim for only past and future income benefits then that amount would likely be deductible from the IRB. However, I agree with P.B. that, for the reasons cited in *Cromwell* and *Vanderkop*, there is no way to distinguish or break down P.B.'s LTD lump sum settlement, which included other heads of damages, interest, costs and disbursements, despite The Co-Operators urging that

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[44] *Vanderkop v. Personal Insurance Company of Canada, supra* (fn. 39) (ONCA) at para. 26
[45] [2006] O.F.S.C.D. No. 98
[46] *Cromwell v. Liberty Mutual Insurance Company, supra* (fn. 40) at para. 20

> it can be broken down based on the calculation sheet. On The Co-Operators' interpretation and given my findings above, I am not persuaded that *Cromwell* is no longer binding.[47]

[36] In his initial decision the adjudicator concluded:

> Accordingly, I find that the LTD settlement between P.B. and Empire does not provide appropriate details to allow The Co-Operators to deduct the settlement from P.B.'s past IRB calculation because the settlement was not confined to payment for her LTD claims alone. In turn, I follow the decisions in *Cromwell* and *Vanderkop* and find that P.B.'s LTD settlement with Empire cannot be deducted from her past IRBs because no breakdown is available to satisfy the requirements of the *Schedule*.[48]

The reconsideration

[37] In his Reconsideration decision the adjudicator considered each of the points raised including:

- what Co-Operators submitted was a lack of evidence that the "other claims" of Patricia Branden were included in the settlement with Empire,[49]
- what Co-Operators submitted was an inappropriate reliance on the Statement of Claim and the Release provided to Empire as part of the settlement,[50]
- what Co-Operators submitted was the selective ignoring of the Calculation Sheet,[51]and
- what Co-operators submitted was excessive importance to the need for a breakdown of benefits dealt with in the settlement.[52]

[38] The adjudicator found that he had made no error. As a result, the request for reconsideration did not meet the test that the adjudicator had made an error of law such that he would likely have reached a different result had the error not been made.[53] The adjudicator concluded:

> Accordingly, while I am alive to the case law on double recovery and the principles supporting its prevention, I am not persuaded that I committed a significant error

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[47] *P.B. v. Co-Operators Insurance Company, supra* (fn. 3) (Amended Decision*)* at para. 26
[48] *Ibid* at para. 28
[49] *Branden v. Co-Operators General Insurance Company, supra* (fn. 7) at para. 13
[50] *Ibid* at para. 14
[51] *Ibid* at para. 15
[52] *Ibid* at para. 16
[53] *Ibid* at para. 13 see fn. 7 which quotes Rule 18(2)(b) of the *Common Rules of Practice and Procedure Licence Appeal Tribunal, Animal Care Review Board, Fire Safety Commission, October 2, 2017*

of law or fact in finding, at para. 27 of my decision, that it did not apply on the facts and evidence before me.[54]

Conclusion

[39] The calculation of income replacement benefits pursuant to s. 7(1) of SABS specifically sets out that the amount deducted is only "the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan" and is only to be applied to the "particular week" the benefit is payable. The adjudicator found that the LTD settlement between Patricia Branden and Empire did not provide appropriate details to allow Co-Operators to deduct the settlement from her past IRB calculation because the settlement was not confined to payment for her LTD claims alone.

[40] The adjudicator made no error of law in his initial decision or his reconsideration of that decision that could sustain the appeal. The appeal is dismissed.

Costs

[41] As agreed to by the parties, costs payable to the successful party, Patricia Branden, payable by Co-Operators in the amount of $15,000.

Lederer, J.

I agree

Swinton, J.

I agree

Mew, J.

Released: April 29, 2022

[54] *Ibid* at para. 24

CITATION: Co-Operators General Insurance Company v. Branden, 2022 ONSC 2473
DIVISIONAL COURT FILE NO.: 654/20
DATE: 2022/04/29

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Swinton, Lederer, Mew JJ

BETWEEN:

CO-OPERATORS GENERAL INSURANCE COMPANY

Appellant

– and –

PATRICIA BRANDEN

Respondent

REASONS FOR JUDGMENT

Lederer, J.

Released: April 29, 2022