Appeal P09-00005

OFFICE OF THE DIRECTOR OF ARBITRATIONS

SONIA BAINS

Appellant

and

RBC GENERAL INSURANCE COMPANY

Respondent

BEFORE:	Delegate Lawrence Blackman
REPRESENTATIVES:	Mr. Hassan Fancy and Ms. S. Singh for Mrs. Sonia Bains Mr. Robert Robinson for RBC General Insurance Company
HEARING DATE:	February 3 and 4, 2010 Subsequent written submissions were received by May 13, 2010

APPEAL ORDER

Under subsection 283(5) of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. This appeal is allowed and the Arbitrator's January 16, 2009 order is rescinded. The preliminary issue of catastrophic impairment is returned to arbitration for a new hearing.

2. If the parties are unable to agree on the legal expenses of this appeal proceeding, an expense hearing shall be requested within thirty days of the date of this decision, as specified herein.

Lawrence Blackman
Director's Delegate

June 3, 2010
Date

REASONS FOR DECISION

I. BACKGROUND and NATURE OF THE APPEAL

In her January 16, 2009 decision, the Arbitrator found that the Appellant, Mrs. Sonia Bains, had not sustained a catastrophic impairment ("CAT") within the meaning of clauses 2(1.2)(f) or (g) of the *Schedule*[1] as a result of the Appellant's May 12, 2004 accident.

The essence of the Appellant's 135 alleged errors of law set out in her 33 page Notice of Appeal, amplified in 104 pages of written submissions and oral submissions over the course of two days, is that the arbitration hearing was a travesty such that all of the Arbitrator's findings should be nullified. The Appellant's primary requested relief is that an appellate officer should make new findings of fact, including assessments of credibility and the necessary impairment ratings under the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993 (the "*Guides*") to support a finding of catastrophic impairment.

The Appellant does not provide any statutory authority or case law that directly allows this specific remedy. Rather, the Appellant relies on a broad interpretation of subsection 283(5) of the *Insurance Act*, R.S.O. 1990, c. I.8, as to the powers delegated pursuant to subsection 6(4) of the *Insurance Act* by the Director of Arbitrations to an appellate officer.

I do not accept the Appellant's characterization of the arbitration hearing, but, in any event, I would decline this specific requested relief.

Subsection 283(5) of the *Insurance Act* does not provide an appellate officer with the powers that the Appellant urges I exercise. Further, and authoritatively, the Supreme Court of Canada, in *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235, stated that "an appeal is not a retrial of a case." Rather, the Supreme Court quoted with approval *Underwood v. Ocean City Realty Ltd.* (1987), 12 B.C.L.R. (2d) 199 (C.A.), that:

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

> The appellate court must not retry a case and must not substitute its view for the views of the trial judge according to what the appellate court thinks the evidence establishes on its view of the balance of probabilities.

The Ontario Court of Appeal, in *Rothwell v. Raes* (1990), 2 O.R. 332, likewise held that it is not for an appellate level "to weigh conflicting evidence or to reassess the relative merits of contradictory expert testimony." Subsection 283(5) of the *Insurance Act* allows an appellate officer to vary the arbitrator's order appealed from or substitute his or her order for that of the arbitrator. There is no provision for the appellate officer varying or substituting his or her findings of fact for that of the arbitrator.

The Appellant also requests that I recommend to the Superintendent of Financial Services, pursuant to section 288 of the *Insurance Act*, an investigation of the business practices of the Respondent, RBC General Insurance Company, on the basis that my review of the arbitration order reveals unfair or deceptive business practices.

I also decline this request. Again, my delegation in this matter is restricted to subsection 6(4) of the *Insurance Act*. The latter subsection provides that:

> The Director may appoint employees of the Commission or other persons to hold hearings on his or her behalf and to exercise the powers and perform the duties of the Director relating to such hearings.

The Director of Arbitrations has not delegated to me his review powers under section 288 of the *Insurance Act*. Accordingly, I direct the parties to the Director in this regard.

The Appellant requests that I set out her full name in this decision. The Respondent does not oppose this request. The Arbitrator did not give a reason in her decision as to why the Appellant's name is not set out in full. I allow the Appellant's request.

The Appellant alleges bias against the Arbitrator. In *Kahkesh and Lloyd's Non Marine Underwriters,* (OIC P-000378, August 19, 1992), Director Sachs states that "[b]ias on the part of an adjudicator against a party is a serious allegation. It should not be made lightly, nor as a catch-all ground for appeals." Citing the Supreme Court of Canada in *Newfoundland Telephone*

Company Limited v. Newfoundland (Board of Commissioners of Public Utilities), [1992] 1 S.C.R. 623, Director Sachs held that:

> The test for bias, and the reasonable apprehension of bias … is whether, taking all considerations into account, the arbitrator closed her mind to being persuaded, or prejudged the issues so as to preclude the acceptance of representations to the contrary and denied a party a fair hearing.

I agree with the Respondent that losing a case, no matter how confident one might be of success, does not equate to the arbitrator being biased. The Arbitrator not accepting the evidence or credibility of a party does not equate to bias. The Arbitrator accepting the evidence of expert witnesses with whom a party takes umbrage does not equate to bias.

Taking all of the circumstances of this case into account, I am not persuaded that the Arbitrator closed her mind to being persuaded, or prejudged the issues so as to preclude the acceptance of representations to the contrary, or that she denied a party a fair hearing. For the further reasons that follow, I am not persuaded that the Appellant has established that the Arbitrator was biased.

In this case the onus was on the Appellant, as the insured person, to establish on a balance of probabilities that she was catastrophically impaired. The role of an adjudicator is not simply limited to picking one side's theory or expert opinion over that of the other side.

An insured person, having the onus of proof, does not automatically win by allegedly discrediting the other side's witnesses. The Supreme Court of Canada stated in *United States of America v. Ferras*, [2006] 2 S.C.R. 77, "[t]he judge must act as a judge, not a rubber stamp." The Arbitrator, who gave eighteen pages of considered reasons as part of her 25 page decision, was by no means a rubber stamp in a difficult and perhaps emotionally charged arbitration hearing.

As cited by Delegate Naylor in *GAN Canada Insurance Company and McConachie*, (FSCO P97-00069, October 28, 1998), "[t]he standard is not one of perfection." Failing to address all of the evidence does not equate to bias. The Divisional Court, in *State Farm Mutual Automobile Insurance Co. v. Movahedi*, [2001] O.J. No. 5099, stated that "[n]ot reciting all of the evidence does not mean the arbitrator failed to consider it." Further, as stated in *F.H. and McDougall*,

[2008] 3 S.C.R. 41, "[n]or are reasons inadequate because in hindsight, it may be possible to say that the reasons were not as clear and comprehensive as they might have been."

I am persuaded, however, for reasons set out below, that the Arbitrator erred in law in:

1. Not rating the left upper extremity and right knee impairments on the basis that those impairments had not stabilized;

2. Determining that a sleep disorder could not be rated separately, in part, because sleep is one of the factors assessed under mental and behavioural disorders in Chapter 14 of the *Guides*, and then failing to address the submitted sleep disorder in rating the Appellant's mental and behavioural impairment; and,

3. Determining that chronic pain could not be rated separately on the basis (the Arbitrator omitting the word "generally") the impairment per cents in the chapters in the *Guides* that consider the various organ systems make allowance for accompanying pain, but then failing to address pain under any of the organ systems in dispute in this proceeding.

The Arbitrator found that the Appellant's combined impairments resulted in a 28% Whole Person Impairment ("WPI") under clause 2(1.2)(f). The Appellant submitted that her WPI was 75%. The Appellant's submissions regarding her left upper extremity and right knee, if accepted, when combined with the 28% WPI finding, would alone result in a WPI of 56%, sufficient for a finding of catastrophic impairment.

Accordingly, this preliminary issue shall return to arbitration for a new hearing. The Appellant submits that all of the areas of impairment should be readdressed. As there is an argued overlap between impairments that were not rated or addressed and impairments that were rated, I agree.

It is, therefore, unnecessary to address each of the 135 alleged errors of law raised by the Appellant. In this case, it would also be inappropriate to do so. Subsection 283(1) of the *Insurance Act* limits appeals from the order of an arbitrator to questions of law. Much of this appeal addresses the arbitrator's weighing of the evidence and her specific findings of fact. These questions should be left to the arbitrator rehearing this matter.

II. ANALYSIS

(a) Subsection 2(2.1) of the *Schedule* – "two years have elapsed"

For accidents that occur after September 30, 2003, the term "catastrophic impairment" is defined in subsection 2(1.2) of the *Schedule*. Clause (f) of that provision provides that for the purposes of the *Schedule*, a catastrophic impairment caused by an accident is,

> (f) subject to subsections (1.4), (2.1) and (3), 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;

The Arbitrator addressed seven areas of impairment in her decision. In discussing the Appellant's upper left extremity impairment, the Arbitrator stated that the Appellant was scheduled to have shoulder surgery. The Arbitrator found that:

> The *Guides* are clear that impairments are not assessable until a person's condition has stabilized and all necessary surgeries have occurred. However, [the Appellant's] upper extremity was assessed prior to the completion of her shoulder surgery and possible rehabilitative treatment in respect thereof, contrary to the *Guides*.

The Arbitrator noted that the *Guides* provide:

- At page 1/3 in section 1.2, under the heading "Structure and Use of the *Guides*," "[b]efore a judgment regarding impairment is made, it must be shown that the problem has been present for a period of time, is stable, and is unlikely to change in future months in spite of treatment."
- At page 2/9 in section 2.3, under the heading "General Comments on Evaluation," "[a]n impairment should not be considered 'permanent' until the clinical findings, determined during a period of months, indicate that the medical condition is static and well stabilized."
- At page 3/112 in section 3.3j, under the heading "General Measurement Principles" in the section entitled "The Range of Motion Model," "[a]n individual's impairment should be evaluated when the impairment has become stable after the completion of all necessary medical, surgical, and rehabilitative treatment."

- At page 315, in the Glossary to the *Guides*, that:

> *Permanent impairment* is impairment that has become static or well stabilized with or without medical treatment and is not likely to remit despite medical treatment.
>
> A permanent impairment is considered to be unlikely to change substantially and by more than 3% in the next year with or without medical treatment. If an impairment is not *permanent*, it is inappropriate to characterize it as such and evaluate it according to *Guides* criteria. [emphasis in original]

The Arbitrator held that the Appellant had not demonstrated that her upper left extremity impairment was "unlikely to change in future months" (page 1/3 of the *Guides*), was "static and well stabilized" (page 2/9 of the *Guides*) or was "unlikely to change substantially and by more than 3%" (page 315 of the Glossary). The Arbitrator found that the Appellant's:

> ... grip strength should not have been evaluated based on the requirement in the *Guides* that a patient must have reached "maximal medical improvement." Therefore, pursuant to the *Guides*, it is inappropriate to rate the [Appellant's] upper left extremity until the completion of her surgery and her recovery there from.

Likewise, the Arbitrator held that the Appellant's knee impairment was not assessable due to future knee surgery.

Subsection 2(2.1) of the *Schedule* provides that:

> (2.1) Clauses (1.2) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless,
>
> (a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
> (b) two years have elapsed since the accident. O. Reg. 281/03, s. 1 (7).

The Arbitrator did not address this provision in her decision. The Appellant submits that the Arbitrator "effectively nullified" subsection 2(2.1).

The Respondent argues that subsection 2(2.1) of the *Schedule* is a "gateway" provision that allows an insured person to apply for a CAT designation after two years have elapsed, even if the insured's condition may cease to be catastrophic. Clause 2(1.2)(f) of the *Schedule*, however, requires that the impairment or combination of impairments, "in accordance" with the *Guides*, results in 55 per cent or more impairment of the whole person. The Respondent submits that "in accordance" with the *Guides* in this context means, as stated by the Arbitrator, that the impairment is stable and unlikely to change. Simply put, it is argued that subsection 2(2.1) gets an insured to the *Guides*, it does not get the insured through the *Guides*.

As stated in *Elmer A. Driedger, The Construction of Statutes* (Toronto: Butterworths, 1974), reiterated in *Sullivan and Driedger, On the Construction of Statutes*, Fourth Edition, (Markham: Butterworths, 2002), the modern principle in statutory interpretation, is that "the words of an Act are to be read in their entire context, in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament."

In *Ms. G and Pilot Insurance Company,* (FSCO A04-000446, March 16, 2006), affirmed on appeal (FSCO P06-000004, September 4, 2007), I noted that:

> The *Guides* strongly state that the impairment percentages derived from the *Guides'* criteria should not be used to direct financial awards or to make direct estimates of disabilities. However, as noted both in *Desbiens v. Mordini* [2004] O.J. No. 4735 and *Snushall v. Fulsang* [2003] O.J. No. 1493 (S.C.J.), "the insurance legislation in Ontario appears to require precisely what the *Guides* themselves discourage."

A finding of catastrophic impairment, by itself, provides no compensation to an insured person. It simply opens the door to a higher threshold of possible benefit entitlement. An insured found catastrophically impaired must still meet the entitlement criteria to each benefit claimed. A CAT designation simply recognizes significant initial injury (for example, the requisite Glasgow Coma Scale score under paragraph 2(1.2)(e) of the *Schedule*) or significant impairment, as under clause 2(1.2)(f). It is the legislative means of differentiating, in a tiered system of first-party accident benefits, who has access to an upper tier of first-party automobile insurance coverage.

The Respondent agrees that a primary purpose of the *Schedule* is the timely provision of benefits to an insured person. The timely provision of benefits furthers the legislative goal of timely medical treatment and rehabilitation. Timely medical treatment and rehabilitation further the legislative goal enunciated in subsection 15(2) of the *Schedule* "to reduce or eliminate the effects of any disability resulting from the impairment or to facilitate the insured person's reintegration into his or her family, the rest of society and the labour market."

The Respondent notes the legislative change, effective October 1, 2003, in subsection 2(2.1). Medical confirmation is no longer required that an insured's condition has stabilized and is not likely to improve with treatment before an insured can be catastrophically assessed under clauses "f" and "g." Rather, the insured's health practitioner must now state in writing that the insured's condition is unlikely to cease to be a catastrophic impairment. Further, the alternative requisite three-year waiting period for assessments under "f" and "g" has been reduced to two years.

The Respondent submits that this change indicates a legislative commitment to timeliness. I agree.

Dr. A. Oshidari was called by the Respondent to give evidence at the arbitration hearing as an expert in physical medicine and rehabilitation. At page 231 of the arbitration transcript is found the following exchange between the Arbitrator and Dr. Oshidari:

> The Arbitrator: And just so that my notes are clear, you're saying that if the person is scheduled to have surgery, undergoes the surgery, you have to wait one year following the surgery [to do the assessment]?
>
> The Witness: Approximately one year, because after the surgery the individual definitely requires rehabilitation, and the rehabilitation takes about three to six months. And then provide some exercises for [the] individual to do it, to see how much recovery they made. And then when medically stable and is not going to change more than 3 or 5 per cent, then you have to measure impairment.
>
> And most of the time they don't do the surgeries together. You do one surgery. You wait for the patient to recuperate from surgery and then, when [the] response is good, then you go to the next surgery.

Dr. Oshidari testified four years after the Appellant's accident. His evidence essentially indicated that the Appellant, or someone in similar circumstances, may have to wait for several more

years, through successive surgeries and rehabilitation from each surgery, until certain impairments could be rated under clause 2(1.2)(f) of the *Schedule*, in a further time consuming, expensive process. That, again, would be followed by years of possible dispute resolution.

The submission that subsection 2(2.1) is subject to the *Guides*' requirement that impairments be rated only if they are permanent is inconsistent with the Respondent's own submissions as to the *Schedule's* legislative aim of timeliness. To use the words in *Sullivan and Driedger*, it is simply inconsistent with the scheme, object and intention of the legislation.

Subsection 2(2.1) of the *Schedule* specifically provides that clauses 2(1.2)(f) and (g) do not apply unless the insured's medical practitioner states in writing that the insured's condition is unlikely to cease to be a catastrophic impairment ***or*** two years have elapsed since the accident. The clear, grammatical and ordinary meaning of the provision is that if two years have elapsed since the accident, clauses 2(1.2)(f) and (g) apply.

Subsection 2(2.1) does not say two years, unless an impairment is not static, stable or permanent, or any words to that effect. Clauses 2(1.2)(f) and (g), by themselves, do not require that the impairments, to be given a percentage rating, must first be determined to be permanent, or restrict the word "impairment" by the words stable, static or other such modifiers. If this had been the legislative intention, it would have been a simple matter to have indicated such.

Rather, the essence of clause 2(1.2)(f) is that all impairments are to be rated. Indeed, subsection 2(3) of the *Schedule* provides that if a sustained impairment is not listed in the *Guides*, the impairment shall be deemed to be the impairment that is listed in the *Guides* that is most analogous to the impairment sustained by the insured person.

It would be contrary to the intent of the *Schedule* to require the piecemeal or repetitive assessments implicit in the Respondent's argument. Nor is the intent of the *Schedule* to sacrifice timeliness on the altar of medical certainty as to permanence. Respectfully, it would be illogical to allow an insured person to apply for a catastrophic designation two years post-accident in accordance with the *Schedule*, but then not rate impairments that are not permanent, stable or static.

The recent decision in *Aviva Canada Inc. and Wry et.al*, (FSCO P09-00016 and P09-00016C, March 12, 2010) pertained to a December 16, 2000 motor vehicle accident. Mr. Wry argued that he was not barred from proceeding to arbitration on a CAT reapplication based on a change in his condition. The insurer submitted that multiple CAT applications would create "chaos." I held that the parties were subject to the then subsection 40(4) limitation period. I stated, in part, that:

> To allow reapplications as argued herein would be inconsistent with a societal and systemic need for the finality of disputes. It would be inconsistent with a legislative framework that envisages a balanced, efficient and cost-effective means of determining first-party benefits.

In its submissions as to the relevance of *Wry*, if any, the Appellant stated that:

> At some point the medical debate on the future status of an insured's impairments stops and that point under [the] Ontario legislation is two years plus a day to avoid "chaos." The alternative is not only contrary to [the] legislation but [citing the insurer's submission in *Wry*] "both sides would have over their heads the spectre of lengthy and expensive reassessments of the same criterion or criteria for a CAT designation" as it is hard to imagine a medical condition that is not subject to fluctuations or open to some arguably beneficial medical or rehabilitative treatment.

The Respondent argued that *Wry* was distinguishable as it dealt with CAT DAC (Disability Assessment Centre) assessments and a limitation period that were no longer applicable, and there was no issue of reapplication or multiple applications in this case.

However, the wording in clause 2(1.2)(f) of the *Schedule* upon which the Respondent relies ("an impairment or combination of impairments … in accordance with the" *Guides*) is also found in clause 2(1.1)(f) for accidents occurring before October 1, 2003 and applied equally in *Wry*. Respectfully, the Respondent's position does raise the question of reapplications until some point in time when all of the Appellant's impairments are found by an adjudicator to be permanent, stable, static and unlikely to change.

Yet, in light of *Wry*, to follow the logic of the Respondent's argument, if an insured person involved in a pre October 1, 2003 accident applied for arbitration for a CAT designation within the requisite limitation period and, after the expiry of the limitation period, an adjudicator found that there would be future improvement ***or*** deterioration in certain impairments, the insured

person (1) could not be rated on those impairments; (2) could be found not catastrophically impaired as a result; and, (3) could not reapply for a catastrophic designation at a later date once the impairments stabilized, even if that stabilization was at the same or at a lower level.

I am not persuaded that this was the legislative intent.

Rather, I find that while clause 2(1.2)(f) of the *Schedule* states that impairments are to be rated in accordance with the *Guides*, the timing of all rating assessments are determined by subsection 2(2.1) of the *Schedule*, to which the *Guides* must defer. The *Guides* are indeed a guide to be applied, under the direction of and consistent with the purpose of the *Schedule*, in determining catastrophic impairment. The *Guides*, created for a purpose different than that of the *Schedule*, cannot be blindly obeyed in every procedural aspect as if the *Guides* exist in a statutory vacuum.

The Respondent raises a different, pertinent, hypothetical situation. What if, at two years post-accident, an insured is recommended for treatment that will probably eliminate his or her impairment. Nonetheless, the insured applies for a catastrophic impairment designation. Is it not contrary to the legislative framework and contrary to common sense to rate this impairment?

In my view, it is appropriate, and indeed mandatory, to rate such impairments. A finding of catastrophic impairment, as noted, does not, by itself, result in any compensation. Each benefit claim must still meet specific statutory requirements. If there is future improvement in an insured's condition, reasonableness and necessity remain as defences to benefit claims based on an earlier, more pessimistic prognosis. On the other hand, if the future surgery or treatment still anticipated two or more years post-accident does not improve an insured's impairment, it may do an insured person little good to be subsequently found catastrophically impaired and eligible to apply for CAT level benefits when the acute period during which such benefits were most needed has now passed.

Further, even if the future surgery or treatment is successful, immediate rehabilitation and other assistance may be necessary to cement those gains. However, as an example, under subsection 18(2) of the *Schedule*, a non-catastrophic insured person is not entitled (subject to the subsection 40(3) exemption, set out below) after 104 weeks post-accident, to any attendant care no matter

how crucial such assistance may be. Other assistance may also not be available if the non-catastrophic limits for medical and rehabilitation benefits have been exhausted.

I am not persuaded that it is the *Schedule's* intent to so thwart an insured's reintegration into his or her family, the rest of society and the labour market, being the *raison d'être* of rehabilitation benefits under subsection 15(2) of the *Schedule*. Nor am I persuaded that the two-year provision in subsection 2(2.1) and the two-year non-CAT limit on attendant care is merely a coincidence. Rather, I am persuaded that the legislative intent is a timely catastrophic determination that allows for a continuity of benefits.

This continuity is exemplified by subsection 40(3) of the *Schedule* that provides that if an application is made for CAT determination not more than two years post-accident and the insured was receiving attendant care benefits immediately before the application was made, those attendant care benefits shall continue during the period before the insurer makes its CAT determination.

I am further persuaded that the Legislature deems it inappropriate, at two years post-accident, for an insured person to have to exhaust further treatment before being able to access a higher level of possible entitlement. The purpose of future treatment is the legislative, and societal, goal of assisting an insured's recovery and reintegration. The legislative purpose of future treatment is not to insulate an insurer from a possible higher threshold of claims under the *Schedule*.

The consequences of following the *Guides* rigidly, with the presumption that it trumps the legislation, is further illustrated by also interpreting clause 2(2.1)(a) of the *Schedule* "in accordance with" the *Guides*. As noted, clause 2(2.1) (a) provides that clauses "f" and "g" apply where the insured person's medical practitioner states that the insured person's condition is unlikely to cease to be catastrophic. Nonetheless, following the Respondent's argument, where an adjudicator finds that an insured's combined impairments, if rated, are presently catastrophic, but that the impairments are not static, stable or permanent, but will get ***worse***, "in accordance with" the *Guides*, those impairments cannot be rated and the insured person cannot be found catastrophically impaired.

Respectfully, such a result would be an absurdity. I am not persuaded that the Legislature intended such a result.

(b) Arousal and Sleep Disorder

The Arbitrator gave a 0% WPI rating for the Appellant's claimed arousal and sleep disorder because the Appellant did not have a respiratory system disorder as required at page 5/163 of the *Guides*. Further, the Arbitrator found that sleep was assessed under Activities of Daily Living in Chapter 14 of the *Guides*, entitled "Mental and Behavioral Disorders."

The Respondent submitted that while the Arbitrator did not explicitly address arousal and sleep disorder in her discussion on the Appellant's mental or behavioural impairment, it was an implicit factor that caused the Arbitrator to raise the WPI rating to 20% from the 10% submitted by the Respondent as appropriate to this area of impairment.

The *Schedule* defines an impairment as "a loss or abnormality of a psychological, physiological or anatomical structure or function." Clause 2(1.2)(f) of the *Schedule* requires all impairments to be counted. Impairments cannot be double counted. Impairments, however, must be counted and must be shown to be counted.

When an arousal and sleep disorder is advanced as an impairment, it is insufficient to decline to rate it as a separate impairment because another section includes it as a factor to be assessed and then, when addressing the latter section, fail to assess as a component part of that impairment, the submitted arousal and sleep disorder.

Capturing and providing a percentage rating for a claimed impairment, either separately or, where appropriate, within a broader classification, is the statutory essence and a fundamental element of clause 2(1.2)(f) of the *Schedule*. Failing to evaluate a claimed impairment is not the same as not discussing specific evidence or not being as comprehensive as one might be.

The reader cannot presume that the Arbitrator considered the submitted arousal and sleep disorder within the 20% WPI assigned mental or behavioural impairment, especially when the

Appellant submitted that a 35% mental and behavioural WPI was appropriate, excluding the claimed arousal and sleep disorder. Nor does adjudicative silence regarding the argued arousal and sleep impairment within the mental or behavioural impairment discussion allow, as set out in *R. v. Sheppard*, 2002 SCC 26, [2002] 1 S.C.R. 869, for "meaningful appellate review." Respectfully, I find that the Arbitrator erred in law in this regard.

(c) Chronic Pain Impairment

The Arbitrator states that a WPI rating of chronic pain is inconsistent with the *Guides*. The *Guides* state, at page 2/9, that:

> In general, the impairment percents shown in the chapters that consider the various organ systems make allowance for the pain that may accompany the impairing conditions. Chronic pain, also called the chronic pain syndrome, is evaluated as described in the chapter on pain (p. 303).

This is reiterated at page 15/304 of the Guides, including the use of the words, "in general."

The Appellant submits that the Arbitrator did not consider pain in rating, amongst other impairments, her upper left extremity. The Appellant further submits that chronic pain is distinct from the pain accompanying the impairing conditions and that such distinct pain was not rated by the Arbitrator.

The Respondent argues that the Arbitrator did address chronic pain by including it within the mental and behavioural impairment. The Respondent was, however, unable to locate specifically where in that discussion the Arbitrator evaluated pain, although the Respondent states that the Arbitrator acknowledged there was evidence before her that the Appellant completed tests that dealt with her perceived pain and its interference with her life. The Respondent submits that the Arbitrator's 20% WPI for mental and behavioural impairment rather than the Respondent's 10% submission also implied a consideration of pain.

The Respondent was further unable to point to any of the Arbitrator's assessments on the various organ systems as including a discussion of the accompanying pain.

In using, at both pages 2/9 and 15/304, the qualifying words "in general," the *Guides* indicate that while the various organ systems usually make allowance for pain, that is not always the case. Again, when pain is advanced as an impairment, that impairment must be addressed and accurately captured in the per cent impairment rating.

The *Guides* set out at page 15/304 what it states is a basic assumption that the "important task of evaluating impairment due to pain is difficult but not impossible." On the same page, the *Guides* define impairment as involving interference with the individual's performance of daily activities. They provide that "[i]n this context, pain may be viewed as an impairment that should be assessed according to the individual's residual functional capacity." At pages 15/312 and 15/313, the *Guides* provide examples of evaluating pain.

In my view, it is insufficient for the reader to have to presume that the per cent set out in the chapter or chapters of the *Guides* respecting the organ systems under consideration make allowance for any accompanying pain impairment. Further, as the Appellant submitted that a 35% mental and behavioural WPI was appropriate, it cannot be presumed that the Arbitrator's finding of a 20% WPI included a consideration of pain. Respectfully, I find that the Arbitrator erred in law in this aspect of her decision.

III. EXPENSES

If the parties are unable to agree on the legal expenses of this appeal, in accordance with Rule 79.2 of the *Dispute Resolution Practice Code* (Fourth Edition, Updated – October 2003) (the "*Code*"), an expense hearing shall be requested within thirty days of the date of this decision. A request for an expense hearing shall be accompanied by a Bill of Costs describing the expenses claimed, services received and the costs, as well as written submissions (no longer than five, double-spaced pages) addressing entitlement to and the quantum of legal expenses solely of this appeal proceeding.

I decline the Appellant's request to make an award of legal expenses regarding the arbitration hearing. There is no arbitration decision on legal expenses and I do not have jurisdiction to award such expenses at first instance.

The party responding to the request for legal expenses of this appeal shall, within 10 days of receipt of the moving party's expense submissions, serve and file a written response to the account, identifying the items in dispute and the reasons for disputing entitlement and/or quantum. The responding party's written expense submissions are also limited to five, double-spaced pages.

The moving party shall then have ten days from receipt of the responding party's submissions to provide copies of any supporting documentation as well as any reply submissions. The reply submissions shall be limited to three, double-spaced pages.

I will then determine, in accordance with Rule 56.5 of the *Code*, whether an expedited oral expense hearing is required by telephone conference call. The parties shall address in their written submissions whether and, if so, why additional oral expense submissions are reasonably necessary.

Lawrence Blackman
Director's Delegate

June 3, 2010
Date