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Recent Cases

ANCILLARY AND THIRD PARTY MOTOR VEHICLE PROTECTION PRODUCTS CONSIDERED INSURANCE IN ALBERTA

— Darcy Ammerman and Mathurhaen Siri of McMillan LLP.

Following the issuance of a draft bulletin with comments invited in June, on October 18, 2024, the Alberta Superintendent of Insurance ("**Superintendent**") issued *Interpretation Bulletin 05-2024: Motor vehicle warranty contracts, dealership loyalty programs and vehicle protection products**.

The bulletin characterizes motor vehicle protection products as (i) motor vehicle warranty contracts, (ii) motor vehicle dealership loyalty programs, (iii) ancillary motor vehicle protection products, and (iv) motor vehicle service plans.

(i) Motor vehicle warranty contracts

Motor vehicle warranty contracts respond to inherent deficiencies in the workmanship or materials arising from the production of the vehicle. Motor vehicle warranty contracts (including extended warranties) issued by OEMs or a wholly-owned subsidiary are not considered insurance. Similarly, warranties provided by repair facilities covering inherent deficiencies in their workmanship are not considered insurance. However, motor vehicle warranty contracts issued by third parties are considered equipment warranty insurance and must be underwritten by an insurer authorized to conduct equipment warranty insurance business in the province of Alberta.

(ii) Motor vehicle dealership loyalty programs

These products provide a dealership discount on a future replacement motor vehicle in the event of damage or total loss of the vehicle. Since they indemnify consumers for part of the cost of a replacement vehicle upon the occurrence of risks or perils such as theft or collision), the Superintendent considers them to be GAP insurance. Note that a debt waiver underwritten by the relevant finance company are not considered insurance.

(iii) Ancillary motor vehicle protection products

The bulletin provides the following non-exhaustive list of common vehicle protection products that the Superintendent considers to be insurance:

Description	Categorization
Deductible reimbursement or monetary credit for loss, damage, or theft of a motor vehicle	GAP insurance
Non-manufacturer tire and rim warranty providing for tire and rim replacement (does not include warranties provided by the OEM for tires and rims it included in the vehicle's assembly)	Equipment warranty insurance
Glass protection products covering windshield replacement	Automobile insurance
Theft-deterrent products with a promise to make a payment in case of theft or non-recovery	Automobile insurance
Key fob replacement	Automobile insurance
Vehicle rental coverage provided alongside a vehicle protection product that is considered to be insurance	Automobile insurance

Note that the above categorizations may be subject to change following the Superintendent's announcement on October 21, 2024, and November 15, 2024, regarding a revised bulletin, which is pending release.

(iv) Motor vehicle service plans

Importantly, the Superintendent has carved out motor vehicle and roadside service plans that provide for minor repairs for reasonable and expected wear and tear routine to the ownership of a motor vehicle from the gambit of insurance. Examples include windshield repairs, tire and rim repairs and scuff, ding, chip, cut, tear, and scratch repairs (interior or exterior). This differentiates the bulletin from the recent Regulatory Statement issued by the British Columbia Financial Services Authority ("**BCFSA**") which does not contain a similar carve-out.

The curious treatment of glass protection

As noted above, glass protection products promising to pay some or all of the cost of a windshield replacement are considered automobile insurance, while minor windshield repairs for reasonable and expected wear and tear are considered service plans. It is unclear what is considered a glass protection product and how product warranty insurance may interact with its treatment under this bulletin. It is also odd that service plans must be limited to repairs. Many existing service plans provide for windshield replacement if the technician is unable to reasonably repair a chip or crack. Stripping out the replacement option may result in technicians being pressured into repairing a windshield that should be replaced, resulting in a sub-par product that may be dangerous for consumers. Alternatively, the consumer will likely be left to pay for a replacement out-of-pocket, as the relatively low cost means that consumers are unlikely to submit a claim under their primary automobile insurance (which would require the payment of a deductible and a likely increase in their premiums going forward).

Faced with the Superintendent's interpretation as set out in the bulletin, OEMs, dealers and third-party providers are left to make the difficult decision of whether to modify or pull "offending" motor vehicle protection products from the market, or to engage with an insurer authorized to conduct insurance business in Alberta to underwrite their contracts. This comes at a time when the industry is still reeling from the BCFSA's Regulatory Statement issued in April of this year and adds to the significant compliance burden.

*Note: As of October 25, 2024, the Superintendent has retracted *Interpretation Bulletin 05-2024*. A revised bulletin is expected to be released by the Superintendent, pending further review and amendments.

RECENT CASES

Insurance Decisions

Insurance Company Was Obligated to Indemnify Mortgage Lender for Interest Portion of Loan

Ontario Superior Court of Justice, June 5, 2024

The plaintiff, a private mortgage lender, lent $600,000 to the impersonator of the owner of a property in Toronto. The insuring agreement contained a limitation of liability clause indicating that the defendant insurance company's liability shall not exceed the least of the amount of unpaid principal indebtedness secured by the insured mortgage at the time the loss or damage insured against occurred, together with interest. Once the parties became aware of the fraud, the mortgage was discharged. Since the mortgage included prepaid interest and various fees, the actual net advance was $509,939.12. The plaintiff recovered $498,256.40 through the cheque clearance process of the Canadian Payments Association ("CPA"). The defendant indemnified the plaintiff $79,366.45, which included the difference between the net advance and the recovery, and various other amounts. The plaintiff brought an action for summary judgment, claiming that the defendant was obligated to indemnify the plaintiff for an additional $72,000, equal to the interest portion of the loan.

The motion for summary judgment was granted. The insurance agreement required the Court to consider what "actual monetary loss or damage" the plaintiff sustained or incurred. The plaintiff entered a mortgage loan with a principal value of $600,000, with the expectation that it would be repaid that amount with interest of $72,000, for a total of $672,000. If the borrower had been the true owner, the lender would have $672,000 by deducting $72,000 from the advance and being repaid $600,000 at the end of the term. If not for the CPA recovery, the actual loss or damage suffered by the plaintiff would have been $600,000, not $672,000, since the plaintiff received $72,000 by not advancing it. The use of a set-off to effect the prepayment feature of the loan meant that the borrower paid no interest up front. The interest would have been paid at the end, by repaying $600,000, which was $72,000 more than the original loan advance. Crediting the borrower with a "payment" of prepaid interest when the borrower never made such a payment would result in a false accounting of the plaintiff's loss by reducing the principal indebtedness from $600,000 to $528,000. The prepayment feature only meant the borrower was not expected to pay interest in monthly installments, and the actual monetary loss or damage to the plaintiff, whether characterized as principal or interest, was $600,000. After the CPA recover, the indemnity from the defendant, and the exclusion of ineligible items, a plain reading of the coverage grant produced an insured loss of $72,000. The insurance contract limited the amount of insurance liability, by disqualifying any loss that was not principal indebtedness or interest. The loan provided for the borrower to repay $600,000 at the end of the term. That being the indebtedness at the time of the loss, the fact that it included an accounting for withheld or prepaid interest did not change the fact that it was the full amount of principal owed by the borrower at the end of the term. The words "at the time the loss or damage ... occurs" did not cap the insurance on the interest on the unpaid principle to the interest earned to that time, and the words "together with the interest thereon" included the interest on the unpaid principal indebtedness for the full term. The plaintiff's actual loss under the coverage grant, after the CPA recovery and the insurance payout, was $72,000, and the limiting clause did not affect the defendant's liability to indemnify the plaintiff for that remaining amount.

AllenDB Holdings Limited v. Stewart Title Guaranty Company, [2024] I.L.R. ¶I-6458

Insured Failed to Meet Condition Precedent to Insurance Coverage by Not Reporting Securities Commission Investigation

Ontario Court of Appeal, July 22, 2024

The appellant, the insured, was the directing mind of Go-To. The respondent issued a series of Directors and Officers insurance policies from 2016 to 2021, and each policy provided coverage on the condition that claims were made against the insured and reported to the insurer during the policy period. The policy's insuring agreement clause provided for losses arising out of a "Wrongful act" giving rise to a claim made during the policy period reported in writing to the insurer under the terms of the policy. The insured was required to provide written notice of any claim to the insured as soon as practicable, either during the policy period or within 30 days after its expiry, or during the discovery period if the insured became aware of any facts or circumstance which may reasonably be expected to give rise to a claim or an allegation of a wrongful act. A suspension clause suspended the notification requirement while communication or notification was prohibited by confidentiality orders imposed if the insured was involved in an investigation by a Regulator.

On March 29, 2019, the appellant was summoned by the Ontario Securities Commission ("OSC") to an examination about Go-To's business activities in May 2019. He was informed that the OSC had opened an investigation, which could reasonably be expected to give rise to a claim. Under the *Securities Act*, a person subject to such an order was prohibited from disclosing the nature or content of the order to anyone except counsel, and the appellant did not disclose the summons to the insurer. On December 10, 2019, the *Securities Act* was amended to permit disclosure to insurance companies and brokers if advance notice was provided to the OSC, and written acknowledgement was obtained from the insurer/broker that it was bound by the confidentiality requirements. The appellant received four different summonses, which drew his attention to the legislative changes. On December 6, 2021, the OSC froze all funds in the appellant's primary investment account and began a receivership application against Go-To, the appellant, and others, claiming they breached the *Securities Act*. The receivership application was granted, and on March 30, 2022, the OSC began enforcement proceedings against the appellant and various Go-To entities. The receivership and enforcement proceedings were claims within the meaning of the insurance policy. On January 5, 2022, Go-To notified the insurer, which denied coverage on September 22, 2022. The application judge denied the appellant coverage or relief from forfeiture under the policy. The appellant appealed.

The appeal was dismissed. Claims-made insurance policies focus on when the claim was made, not when the negligent or injurious occurrence took place. Coverage was subject to the conditions precedent that the claim be both made and reported to the insurer during the policy period. Relief from forfeiture can be granted under s. 129, but it only applied to those policy conditions, either statutory or contractual, that related to proof of loss, and therefore did not apply. There could be no relief from forfeiture where there was an obligation on the insured to satisfy claims-made and reported conditions before the obligation to provide coverage arose. Where the wording of a claims-made and reported policy made clear that the making and reporting of a claim were the triggering events for coverage, the failure to comply with a notice provision constituted non-compliant with an essential condition of coverage such that there could be no relief from forfeiture.

The insuring agreement clauses in this situation were intended to be a form of claims-made and reported policy. In May 2019, during the policy period, the appellant was asked to attend the OSC offices for an investigation of Go-To's business activities, which could reasonably be expected by the appellant to give rise to a claim or an allegation of a wrongful act. From then until the end of the policy period on October 25, 2019, the appellant was not permitted by law to advise the respondent of the investigation. After the legislative amendments, on December 10, 2019, subjects of investigations could notify insurers on certain terms. The appellant was specifically advised of these changes in his summonses from the OSC, starting on February 16, 2021. His delay in providing notice, once he was permitted to do so, constituted "non-compliance with a condition precedent to coverage", for which no relief from forfeiture could be granted. The appellant did not report anything to the respondent until February 2022, almost three years after the investigation began, more than two years after the law changes which permitted him to advise the insurer of the investigation, and more than two years after the policy term expired. By failing to meet the condition precedent to coverage, namely reporting the OSC investigation once the prohibition on disclosure was altered by law, the appellant failed to meet the requirements for coverage, and coverage was never triggered.

Furtado v. Lloyd's Underwriters, [2024] I.L.R. ¶I-6459

Possible Concussion Suffered by Driver in Accident Provided Important Context to Assess Reasonableness in Failing to Immediately Pull Over

British Columbia Court of Appeal, July 24, 2024

While driving through an intersection on October 21, 2016, the appellant was sideswiped by another vehicle. The appellant caught a brief glimpse of the other vehicle prior to impact, and described it as a silver or grey minivan, but did not note the licence plate number. The other vehicle struck the right side of the appellant's vehicle, and the collision caused significant damage to the passenger side of the appellant's vehicle. After the collision, the appellant continued to drive over an overpass, prior to stopping. He claimed that he was in shock, having hit his head in the accident, and was trying to maintain control of his vehicle. After pulling over, the appellant called 911, and the police and fire personnel attended. The appellant was transported to the hospital, where he was diagnosed with a concussion and cervical spine injury. The next day, the appellant asked a friend to put up signs at the scene asking for witnesses but received no response. The driver of the vehicle that struck the appellant was never identified. The appellant was diagnosed in 2019 with ankylosing spondylitis, an autoimmune condition affecting the spine. At trial, the defendant, the Insurance Corporation of British Columbia, denied liability on the basis that the appellant had not made all reasonable efforts to ascertain the identity of the driver or owner of the other vehicle as required under s. 24(5) of the *Insurance (Vehicle) Act*. The trial judge found the appellant could have reasonably stopped when he was hit or engaged his hazard lights and waived the driver of the minivan to follow him. The trial judge did not find the appellant to be a credible witness, and that he failed to meet the burden of demonstrating that he had undertaken all reasonable efforts to identify the other driver. The trial judge dismissed the action, and the appellant brought an appeal.

The appeal was allowed, and the matter was remitted for a new trial. The appellant's failure to comply with the requirement under s. 68(1)(a) of the *Motor Vehicle Act* to remain at the scene of the accident did not, on its own, mandate the dismissal of an action against the respondent under s. 24 of the *Insurance (Vehicle) Act*. The trial judge did not find s. 68 determinative and considered the reasonableness of the appellant's conduct in failing to remain at the scene of the accident, and there was no legal error in this finding. There was a sound basis in the evidence for the trial judge to be concerned about the appellant's credibility. However, the appellant's evidence that he was injured and in shock, to explain his actions immediately following the collision, was supported by photographs of the damage to his vehicle consistent with an impact severe enough to cause him to strike his head, police notes, medical notes that he suffered a concussion, and evidence from family members and friends that he experienced concussion symptoms after the accident. It was insufficient for the trial judge to decide the case based on a finding that the appellant was not credible without considering the totality of the evidence bearing on his condition at the time of the accident. Beyond concluding that the appellant was not a credible witness, the trial judge made no findings regarding his condition at the time of the accident. The trial judge's error in ignoring relevant evidence was palpable and overriding, as the ignored evidence may well have altered the outcome of the analysis. If the appellant had been injured and concussed in the accident, this would provide important context for assessing the reasonableness of his actions in failing to immediately pull his vehicle over at the time of impact.

Takhar v. ICBC, [2024] I.L.R. ¶I-6460

Insurance Policy and Septic System Endorsement Clearly Set Out What Risks Were, And Were Not, Covered

British Columbia Supreme Court, July 8, 2024

The plaintiff purchased title insurance from the defendant when she purchased her home in 2012. Covered title risks included any adverse circumstance affecting the land which would have been disclosed by a Local Authority Search of the land at the policy date, and excluded risks were those created, allowed or agreed to by the signee, those known to the signee but not the insurance company on the policy date, those resulting in no loss, and those first affecting title after the policy date. A septic system endorsement provided coverage for the septic system.

On April 17, 2020, the plaintiff notified the defendant that her septic system was not constructed to Building Code. The defendant investigated and asked for further information. The plaintiff provided several documents, including a form with a blank Permit to Construct attached, but no permit was granted. She also provided an inspection report, dated September 30, 1982, which indicated system would be left until it malfunctioned, which was signed by a public health inspector. The plaintiff had these documents prior to purchasing the property, and the defendant determined there was no coverage, as she was not insured against losses resulting from issues or circumstances created, allowed, or agreed to by the insured on the policy date. Since the plaintiff had a copy of the septic records prior to the policy date, she knew a permit had not been issued for the septic system and purchased the land anyway, so she accepted the risk of bearing the cost to repair the unpermitted septic system. The plaintiff requested reconsideration, since her septic system failed in 2020 and the former owner provided information that it had been rebuilt in 1995 without plans, permits, inspections, or approvals. The defendant reconsidered and determined there was no coverage. The unpermitted 1995 septic system rebuild was not found to trigger coverage because a Local Authority Search would not have disclosed the absence of a permit. The plaintiff brought a claim for expenses associated with the septic system replacement.

The claim was dismissed. The plaintiff knew that no permit had been issued prior to the purchase of the property, and knowingly accepted the risks associated with the septic system being unpermitted. The exclusion in the policy clearly applied to deny coverage for any risk created by the 1982 septic system. While the process of dealing with septic system problems, along with the insurance claim and the litigation, was stressful for the plaintiff, the defendant did not act in bad faith or treat the plaintiff unfairly. There was no need to undertake any independent investigation, since the claim could be fairly determined on the information the plaintiff provided. The defendant was entitled to deny coverage to the plaintiff. The septic endorsement provided insurance for loss or damage "in the event that a Local Authority Search would have disclosed" either that a permit issued for the septic system did not conform with the current nature of construction, or a permit was not issued when the septic system was constructed. At the time of the 1995 rebuild, no permit was applied for, and a search of the relevant local authorities would not have revealed the absence of a permit or that construction was non-conforming. The septic endorsement in the insurance policy did not insure against loss or damage related to the functionality or age of the septic system, and problems arising from the 1995 rebuild were not covered by the policy.

Section 32 of the *Insurance Act* provided that unjust contract provisions were not binding on the insured, but the plaintiff did not specify which term or condition in the title insurance policy was unjust or unreasonable. While it appeared unfair that there was no insurance coverage for something that could not be discovered, that was clearly the effect of the policy and septic endorsement, and there was no condition under the policy that was unjust or unreasonable when applied to the plaintiff. The defendant was not negligent and did not make any negligent misrepresentations to the plaintiff. The policy and septic endorsement were clear about the risks they did and did not cover.

Vogt v. Stewart Title Guaranty Company, [2024] I.L.R. ¶I-6461

New Prejudgment Interest Rate Did Not Apply to Period Preceding the Amendment Coming into Force

Alberta Court of Appeal, August 21, 2024

A motor vehicle accident occurred on October 21, 2015. Prior to a trial, the *Insurance Act* was amended to modify the rate of prejudgment interest applicable to non-pecuniary damages in motor vehicle accidents (the "Amendment"). The rate had previously been 4 per cent per annum under s. 4(1) of the *Judgment Interest Act* and was changed to be the annual rates prescribed in the *Judgment Interest Regulation*, which for the five years prior to 2020 were 1.05%, 0.55%, 0.53%, 0.87%, and 2.2%. The appellants admitted liability, and the trial was limited to the question of damages. The trial judge applied the new rate of prejudgment interest only after the Amendment came into force on December 9, 2020, rather than over the entire period for which prejudgment interest was calculated, since prejudgment interest was a substantive right and the presumption against retroactivity applied, so the presumption was not displaced. The appellants appealed.

The appeal was dismissed. Prejudgment interest was not a vested right, since it only crystalized after the trial judge decided. Prejudgment interest, particularly the right to a particular rate of interest, was not a vested right prior to interest being awarded, and the application of the Amendment to the calculation of prejudgment interest did not engage the presumption against interference with a vested right. However, the fact that the respondent had no vested right in a particular rate of prejudgment interest when the Amendment came into force did not mean that other presumptions of statutory interpretation did not apply.

The trial judge found that prejudgment interest was a substantive right which recognized the value of the damages award, specifically the use the money could have been put to if it was paid at the time the claim arose. The Amendment affected a substantive right, which meant that the presumption against retrospective application was engaged, and the Amendment was presumed to have prospective effect. Contrary to the trial judge's finding, the application of the rate specified in the Amendment to calculate interest for the period prior to its coming into force was not a retroactive effect, since such an application did not amount to operation of the Amendment "as of a time prior to its enactment". The Amendment imposed a "future consequence", namely a different and lower prejudgment interest rate, in respect of a "past event", namely the injuries sustained by the respondent in the motor vehicle accident and the passage of time without payment. Applying the lower prejudgment interest rate to the period preceding the Amendment coming into force would give it retrospective effect, and the trial judge found nothing to suggest that the Amendment should be applied to calculate interest in the period prior to its coming into force. No specific cost-reduction threshold or timeline was identified with respect to the Amendment, and the other two substantive amendments introduced at the same time had language specifying that they would be applied prospectively.

A dissent would have allowed the appeal. Pre-judgment interest compensated the appellant for the otherwise diminished value of the damages awarded due to the passage of time between the date of the injury and the date of judgment, including lost investment opportunity and inflationary loss. The application of s. 582.2(2) to all the respondent's pre-judgment interest did not amount to retrospective application, and the presumption against retrospective application was not engaged.

Jackson v. Cooper, [2024] I.L.R. ¶I-6462

Security Negligence Claims Were Covered Under Insurance Policy, Not Statutory Negligence Claims

Ontario Court of Appeal, August 27, 2024

On September 1, 2016, Nimmo attended a concert at the Budweiser Stage, which was promoted by the respondents. Nimmo alleged she was injured when security personnel removed an unruly patron and brought a claim against the respondents and NorthWest Protection Services Ltd. ("NorthWest"), among others. Nimmo alleged that NorthWest was negligent in providing security services, and that the respondents failed to properly train, supervise, and instruct their security personnel to deal properly with unruly patrons and were liable for NorthWest's actions. In addition, Nimmo alleged that the respondents failed to comply with their obligations under the *Liquor Licence Act* and the *Occupiers' Liability Act*. NorthWest was contracted by the respondents to provide "crowd management services" at the concert, and there was an insurance policy between NorthWest and the appellants (the "Aviva policy"). This policy included Commercial General Liability coverage for "bodily injury and property damage liability" resulting from NorthWest failing to meet the required performance level. NorthWest's security services agreement with the respondents required it to maintain insurance, with the respondents as additional insureds under the Aviva policy, indemnifying the respondents from claims and losses arising from acts or omissions by NorthWest. The respondents had an insurance policy with Starr Indemnity & Liability Company (the "Starr policy"), which included Commercial General Liability coverage for bodily injury and property damage liability. The respondents had a self-insured retention ("SIR") of $1 million, with insurance under the Starr policy applying beyond the SIR. The respondents brought an action against the appellants for declaratory relief, claiming reimbursement by the appellants for all past and future defence costs on a full indemnity basis. The application judge found that the essence of the claim related to Nimmo being struck by NorthWest personnel while they were removing an unruly patron, and it was appropriate to require the appellants to pay all the past and future defence costs. The application judge declined to order the removal of the respondents' current counsel. The appellants brought an appeal.

The appeal was allowed, in part. The appellants had a duty to defend the covered claims under the Aviva policy, which was triggered by the claim of negligence against their insured, NorthWest. The Aviva policy was the primary policy covering the respondents and additional insureds. The appellants had a duty, as the primary insurer, to defend the covered security negligence claims, but the application judge erred in finding that all the pleaded claims were covered by the policy. The application judge mistakenly conflated the pleaded factual case of Nimmo's injuries with the substance of her pleaded claim against the respondents and NorthWest. The security negligence claims against NorthWest and the respondents depended on the failure to properly carry out security services, resulting in injury to Nimmo. However, the separate statutory negligence claims against the respondents had nothing to do with the security negligence claims against NorthWest and the respondents. The statutory negligence claims stood on their own and could form the basis for a finding of liability against the respondents, even without a finding of liability against them for the security negligence claims.

The application judge could only determine the extent of the appellant's duty to defend and pay defence costs under the Aviva policy, since Starr was not a party to the proceedings. The application judge failed to consider whether there was justification to impose an obligation on the appellant to pay defence costs not clearly covered by the contract of insurance. While there were overlapping security negligence claims that could potentially trigger indemnity under the Aviva policy, there were also separate statutory negligence claims clearly not covered under the Aviva policy. As additional insureds, the respondents only enjoyed coverage provided under the Aviva policy, which was restricted to the activities of NorthWest and the security negligence claims. The application judge failed to consider whether any portion of the defence costs related solely to the statutory negligence claims, which should be allocated to Live Nation. The appellants were not the primary insurers and were not responsible to defend claims not clearly covered under its policy, but this did not practically affect the mechanics of the order that the appellants must fund, at present, all the respondents' defence costs, subject to reallocation at the end of trial or settlement. This order was open to the application judge to make, subject to the appellants' right to seek reallocation of costs from the respondents after trial or settlement.

If equitable contribution was available, that remedy should be sought against Starr, not the respondents, who were not an insurer. The existence of the SIR did not turn the respondents into an insurer. It was a contractual provision between the respondents and Starr affecting the timing of when Starr's duty to defend was triggered, and merely represented a sharing of the potential costs by an insured under its contract with its insurer. The application judge did not err in determining the application without Starr. At issue was the extent of the appellants' duty to defend the respondents in relation to the mixed claims, not Starr's duty to defend. Whether the statutory negligence claims were covered under the Starr policy was not relevant to determining whether they were covered under the Aviva policy, or whether a portion of the defence costs should be allocated to the insured as not being covered under the Aviva policy. With respect to reallocating costs at the end of the trial or on settlement, only the security negligence claims were covered under the Aviva policy, not the statutory negligence claims, and the appellants were not liable to pay defence costs solely related to the uncovered statutory negligence claims.

Live Nation Ontario Concerts GP, Inc. v. Aviva Insurance Company of Canada, [2024] I.L.R. ¶I-6463

Other Insurance Decisions

Both Parties Required to Engage in Cooperative Process of Appointing Umpire to Assess Property Damage Due to Fire — *Definity Insurance Company v. 725360 NB Inc.*, [2024] I.L.R. ¶I-6464, New Brunswick Court of King's Bench - Trial Division (July 26, 2024)

CERB and CRB Payments Due to COVID-19 Were Deductible from Damage Award for Motor Vehicle Accident — Ferreira v. Hopper, [2024] I.L.R. ¶I-6465, Ontario Superior Court of Justice (September 27, 2024)

Torts — Motor Vehicle

Driver With a Trailer Full of Wooden Planks Was Not Negligent in Accident Where He Was Rear-Ended by Plaintiff's Vehicle

Nova Scotia Supreme Court, July 12, 2024

On August 24, 2016, the plaintiff and the defendant were involved in a motor vehicle accident. The defendant was towing a flatbed trailer containing wooden planks. The plaintiff alleged that, as he was closing in on the truck, which was ahead of him, a piece of wood bounced on the ground and made impact with his vehicle, wedging into his vehicle and causing his brakes to fail to engage. He claimed his vehicle was dragged down the highway until it detached from the trailer, at which point he regained control of his brakes and came to a complete stop. The defendant's truck pulled over, while the trailer continued down the highway and hit a guard rail. The plaintiff brought an action, alleging that the defendant failed to properly load, strap, and secure the wood placed on the trailer, and failed to place a proper marker on the wood, as required by s. 185 of the *Motor Vehicle Act* ("MVA"). The plaintiff also claimed that the defendant failed to place a yellow or red light visible at the rear of the load and did not properly secure the boards as required by the *Securing Loads on Vehicles Regulation*.

The action was dismissed. The burden was on the plaintiff to rebut the common law presumption that the driver of the rear vehicle was negligent in a rear-end motor vehicle accident. The *Automobile Insurance Fault Determination Regulations* provided that the vehicle which rear-ended another vehicle was fully at fault for the incident. The plaintiff was driving 110 km/hr on cruise control and did not slow his speed as he approached the defendant's truck. The plaintiff could tell that the truck was pulling a trailer with a load of lumber, but somehow did not see the plank of wood come off the trailer. The plaintiff rear-ended the back of the trailer with such force that it caused significant damage to his vehicle and the trailer, which was a write-off. The impact shifted the wood forward, damaged the defendant's truck, broke the hitch and caused the truck to spin and the trailer to continue down the highway. The damage to the plaintiff's vehicle was more consistent with driving into a fixed or secure board, rather than a loose one, which then pushed the trailer into the rear of the defendant's vehicle. The plaintiff failed to prove, on a balance of probabilities, that he was not negligent or that the defendant was negligent. Section 185 of the MVA required a light if the load extended more than one metre beyond the flatbed, but there was no reliable evidence that the wood extended that far past the end of the trailer. Regardless, it was unclear how a light would have addressed a wooden board coming off the trailer and impaling the plaintiff's vehicle, causing him to rear-end the trailer.

The defendant was experienced in hauling trailer loads, from working on a grain farm as a child, at a dairy farm, and as a carpenter. His general practice was even weight distribution over the dual axles, so that the weight would be evenly spread and to keep tension on the load. One wooden board was placed over the other to prevent gaps or holes in the load, with a minimum of two straps to secure the load. The defendant would check the load and strapping to ensure it was taut and touch each board to make sure none were loose. A passenger in the truck had a specific recollection of the defendant securing the load, namely ratcheting the straps until they were taut, then touching each board to check for movement. The trailer was not required to have an endgate to secure the load. Section 10(1) of the *Securing Loads on Vehicles Regulations* indicated a load could be secured by an endgate and sideboards, or at least one tiedown, or any other means to prevent the load from shifting or falling that was similar and equally effective to the endgate or tiedown process. The defendant was experienced, conscientious, and took all proper and reasonable steps to secure the load and ensure it remained secure. He carefully secured the load with straps and checked each board to ensure it was not moving. He stopped twice to check the tautness of the strapping and was driving slowly on the highway with a securely strapped load with running lights on the trailer. Therefore, he operated his vehicle to a standard of a reasonable and prudent driver and was not negligent.

Graca v. Carter, [2024] I.L.R. ¶M-3436

Loss of Future Earning Capacity Award from Trial Upheld on Appeal

British Columbia Court of Appeal, June 18, 2024

The respondent was injured in a motor vehicle accident in 2017, and the appellants were found 100 per cent at fault for causing the accident. The trial judge awarded $160,000 non-pecuniary damages, $99,321.75 past loss of income, $163,980.64 loss of future earning capacity, and other incident awards. The respondent had been an elite field hockey player at a university in the United States, but her career was cut short by injury and concussions, so she returned to Canada and attended UBC beginning in fall 2004. The respondent had dyslexia and struggled with her studies at UBC, eventually withdrawing in 2015. While the respondent had a high energy level prior to the accident, she had suffered anxiety and depression since 2014, which she treated with medication and exercise. In February 2016, the respondent went to the hospital suffering from a panic attack. Prior to the accident, the respondent worked as a lifeguard and fitness instructor at UBC, BC Ferries from 2015-2016, and the Watson Centre for Brain Health, where she worked at the time of the accident.

Post-accident, the respondent returned to part time work at the Watson Centre from July to October 2018 but left because she found the work too demanding. She worked part time as a ticket taker at Grouse Mountain, beginning in December 2018, and was promoted twice. She was required to take time off work on occasion, at least in part because of the accident. The Watson Centre had closed during the COVID-19 pandemic, but the respondent potentially could have worked at another start-up related to the Watson Centre, ABI, where she claimed she would have worked in sales and marketing as part of the "executive team", even though she had no related experience. The trial judge rejected estimates that the respondent would receive raises of $20,000 per year from 2018 to 2021, and a further salary increase of $105,000 in 2022, concluding that the respondent had a real and substantial possibility of earning $65,000 annually, which was slightly higher than her actual earnings at Grouse Mountain.

The trial judge found that the respondent's "chronic injury" disclosed a potential future event that could lead to a loss of capacity. The trial judge accepted that the respondent would continue working to age 70, with similar earnings to her current salary. Without the accident, the trial judge was satisfied that the respondent would have earned about $10,000 more annually, owing to her pre-accident qualifications and "go-getter" personality. The appellants appealed the damages awarded for past and future loss of income earning capacity. The respondent cross-appealed, claiming the trial judge erred in assessing the quantum of damages for loss of future earning capacity.

The appeal was dismissed and the cross appeal was dismissed. While the trial judge did not explicitly engage in the analysis for loss of future earning capacity as set out in *Rab v. Prescott*, [2022] I.L.R. ¶M-3366, the basis of the award was consistent with the *Rab* approach. The trial judge found a "real and substantial possibility" of only a small loss of earning capacity for the respondent, as the respondent had demonstrated that she could beat the averages for individuals at her education level working in the industry she primarily worked in, notwithstanding her challenges and difficulties. The award recognized that the accident caused her loss of earning capacity, but she would do almost as well as she could have done if not for the injury. This conclusion was open to the trial judge. The trial judge did not apply the wrong evidentiary standard in awarding loss of future earning capacity. He properly stated the *Rab* test and did not misapply it, even though he did not expressly progress through the stages. The trial judge found it purely speculative to assume the respondent would be the director of sales and marketing, given her education and experience, and that the prospect of ABI being a potential employer, given the lack of evidence of its viability and earnings, was also speculative. It was untenable to assume the respondent would earn incomes between $200,000 and $240,000, and the respondent failed to demonstrate a real and substantial possibility that, without the accident, she would have worked for ABI or earned the income as claimed.

The award of loss of future earning capacity recognized that the respondent had suffered a real and substantial possibility of a small loss of earning capacity in each year for the rest of her working life. This conclusion was rooted in the trial judge's assessment of her pre-accident prospects, along with the degree to which the accident exacerbated pre-existing conditions and caused other injuries which limited her prospects. It was open to the trial judge, on the facts, to conclude that the respondent's employment prospects were diminished over the long term by the accident, to some degree.

Tigas v. Close, [2024] I.L.R. ¶M-3437

Other Motor Vehicle Tort Decisions

Drivers Found Equally Responsible for Accident When Motorcycle Travelling Straight Was Hit by Car Turning Left — *Ferrill v. Cockburn*, [2024] I.L.R. ¶IM-3438, British Columbia Court of Appeal (June 28, 2024)

Settlement Offer Between Plaintiff and Insurance Company Was Not Unconscionable and Should Be Enforced — *Kimberley v. Riggi*, [2024] I.L.R. ¶IM-3439, Ontario Superior Court of Justice (July 24, 2024)

Torts — General

"But For" Doctor's Negligence, Plaintiff Suffering from Stroke Would Have Received the Appropriate Treatment and Recovered

Ontario Court of Appeal, July 25, 2024

The plaintiff went to the emergency department on December 3, 2011, complaining of dizziness, nausea, and vomiting, and was diagnosed with "probable peripheral vertigo", prescribed some medication, and was discharged. Later that morning, he saw his family physician, who advised him to go directly to the emergency department at the respondent, Trillium Health Partners - Mississauga Hospital, and wrote a referral note requesting the hospital "rule out organic cause (brain lesion or stroke)". At Trillium, Dr. Campbell documented the plaintiff's symptoms, but did not see or document the family physician's note. Dr. Campbell conducted a physical examination, but not a gait assessment, and ordered a CT scan which did not show any acute abnormalities and some symptoms had improved. The plaintiff was diagnosed with "Dizzy- Bell's Palsy - Peripheral Vertigo" and was discharged with medication. His symptoms worsened on December 4, and he returned to Trillium by ambulance. Dr. Campbell consulted a neurologist when the plaintiff's condition deteriorated further, and he had to be intubated. The plaintiff's care was handed over to an internist, and Dr. Campbell had no further contact with him. A brain MRI on December 8 showed the plaintiff had suffered an "acute infarct" and loss of normal blood flow in the proximal basilar artery. A CT angiogram confirmed he had suffered a stroke. The plaintiff suffered permanent and disabling injuries and required assistance for almost all activities of basic living.

The trial judge found Dr. Campbell negligent in treating the plaintiff, and "but for" Dr. Campbell's breach of the standard of care, the plaintiff would have been assessed and received treatment in a timely manner, which would have resulted in a successful treatment and recovery. The appellant appealed the finding of liability on the basis that Dr. Campbell's negligence caused the plaintiff's injuries.

The appeal was dismissed. Dr. Campbell owed the plaintiff a duty of care as an emergency room doctor, and he breached the applicable standard of care. Remoteness was not an issue, so the only remaining question was whether Dr. Campbell's breach caused the plaintiff's injuries. In *Sacks v. Ross*, 2017 ONCA 773, the "but for" test involves determining what likely happened, and then what likely would have happened had the defendant not breached the standard of care.

The trial judge found that the plaintiff suffered an embolic stroke, and rejected the theory that the stroke was caused by a perforator ischemia, caused by a dissection. Several uncontested facts supported the embolic stroke theory, and the type of dissection suggested was so rare that none of the experts had ever seen one. The plaintiffs' experts were objective and comprehensive, while the defendants' experts were absolute and dismissive of competing theory, and the critiques of the plaintiffs' experts were ill-founded. The plaintiffs' experts used a blind review methodology, while the defence experts had a theory in mind that they sought to prove, and they ignored evidence supporting the embolic stroke theory, including the plaintiff's atypical anatomical configuration making him more prone to such a stroke. Finally, the defence experts' analysis contained errors in the understanding of the progression of the plaintiff's symptoms. Dr. Campbell's breach of the standard of care resulted in an evidentiary gap where there was no imaging showing the progression of the stroke over time, but Dr. Campbell could not rely on this evidentiary gap to support his defence.

The trial judge found that, but for Dr. Campbell's negligence, the plaintiff would have been assessed by a neurologist, would have received a timely CT angiogram, and would have received appropriate treatment, including aspirin and heparin and "recanalization", or opening of the blockage. The trial judge was satisfied that the plaintiff would have been properly treated by one of the three available modes and would have had a successful recanalization. This decision was

based on his imaging and clinical presentation, his unique anatomical considerations, and the medical literature on recanalization. The plaintiff's clot burden was not known on December 3 and 4, because of a lack of contemporaneous CT angiograms, and the slow progression of symptoms meant there was no evidence that recanalization would have failed. The plaintiff was young and in good health, and his initial symptoms were mild, which were good prognostic factors for a good recovery, and the medical literature supported a successful outcome after receiving one of the available forms of recanalization.

Hasan v. Trillium Health Partners - Mississauga, [2024] I.L.R. ¶G-2924

Dentist Was Not Negligent in Removing Plaintiff's Tooth in an Emergency Extraction

Ontario Superior Court of Justice, August 6, 2024

The plaintiff made an emergency appointment with her dentist on March 23, 2012, for pain in the upper right quadrant of her mouth. Her dentist documented pus, a sign of infection, and prescribed an antibiotic. An appointment was made for a tooth extraction a week later, but the plaintiff went to the hospital the next day with pain. She made another emergency visit to the dental clinic on March 25, 2012, and was seen by Dr. Qazi, who extracted tooth 18, relying on an x-ray from January 2009. The plaintiff was in too much pain to open her mouth wide enough to perform a periapical X-ray, and the panoramic X-ray was not working. Dr. Qazi observed no pus on tooth 18 or tooth 48, but saw inflammation at tooth 48, with pain on the upper and lower right-hand side wisdom tooth areas. Tooth 18 was mobile and impinging on the tooth below, so Dr. Qazi removed it. The plaintiff was told to continue taking antibiotics, and tooth 48 would be assessed later. The next day, the plaintiff returned to the hospital emergency room in pain. She saw a plastic surgeon on March 28, 2012, but was not comfortable with the surgeon's proposed treatment plan and returned to the hospital. A contrast CT scan showed an abscess in direct proximity to the tooth 18 extraction site. She was admitted to the hospital for 20 days to drain the infection and was readmitted ten days after discharge for another drainage procedure and intravenous antibiotics, which continued for two months. The infection damaged the plaintiff's jawbone, and she was referred to an oral surgeon. The plaintiff brought an action claiming she did not provide informed consent for Dr. Qazi to remove tooth 18, that he fell below the standard of care in removing tooth 18 instead of tooth 48, and this breach caused her damages.

The action was dismissed. The plaintiff signed the consent form providing consent to the removal of tooth 18. Dr. Qazi discussed the consent form with the plaintiff prior to the procedure, which was his usual practice. He took her pre-operative blood pressure reading, as noted on the consent form, and the form set out the risks of the procedure, including pain, swelling, bleeding, and infection. The form set out alternatives to extraction and potential risks of not having the extraction, and the plaintiff provide her informed consent to the extraction of tooth 18.

A dentist in an emergency dental appointment is expected to take immediate steps to alleviate a patient's acute distress and minimize future risk. The plaintiff's tooth needed to come out quickly, and the infection was completed unpredictable. Dr. Qazi did not err in removing tooth 18, given the plaintiff's presentation on March 25, 2012. All indications were that the antibiotic was not having the desired effect, and Dr. Qazi should not have gone off notes from the plaintiff's dentist which were two days old. There was nothing Dr. Qazi did, or did not do, or should have done, to alter the course of the plaintiff's infection. Given the plaintiff's severe headaches and the pus seen at the appointment on March 23, 2012, the infection was likely already beneath the surface of the gums at that point. There were no signs, however, that any of the treating practitioners should have seen, including Dr. Qazi, to find that the plaintiff likely had a facial space infection. The infection was too small to be seen on the CT scan conducted at the hospital on March 24, 2012, and there was no detectable abscess, swelling, or other abnormality until the contrast CT scan performed at the hospital on March 28, 2012. The extraction of tooth 18 ameliorated and mitigated the course of the infection's progress, allowing drainage to occur, and tooth 18 appeared to be the source of the issue. Dr. Qazi could not have done anything to change the course of the plaintiff's infection or outcome. Tooth 48 was never noted to be the cause of infection and was never extracted during the months that the plaintiff was treated for the infection. There was no reason for Dr. Qazi to refer the plaintiff to a specialist, since the reason for extraction, and the extraction itself, were straightforward, based on all available information. An X-ray or examination by an oral surgeon would not have revealed anything to

assist in finding the infection or treating it more aggressively. The manner of injection, volume, and administration of anesthetic was within the standard of care. Dr. Qazi did not fall below the standard of care in proceeding to perform the extraction without an updated X-ray, since the patient was in terrible pain, the infection at tooth 18 was the likely source of pain, and an up-to-day X-ray was unattainable, while a three-year-old X-ray showed root structure and morphology.

Muralla v. Qazi, [2024] I.L.R. ¶G-2925

Other General Decisions

Anaesthesiologist Did Not Fall Below the Standard of Care in Administering Epidural When Needle Broke — *Williamson v. Wang*, [2024] I.L.R. ¶G-2926, British Columbia Supreme Court (July 9, 2024)

Apartment Building Owners Were Not Responsible for Clearing Snow from Municipal Sidewalk Used to Access Apartment Building's Parking Lot — *Burley v. Ottawa (City)*, [2024] I.L.R. ¶G-2927, Ontario Superior Court of Justice (September 17, 2024)

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