2017 CarswellOnt 12889
Financial Services Commission of Ontario (Arbitration Decision)

Akeelah and Belair Insurance Co., Re

2017 CarswellOnt 12889

DAWOOD AKEELAH (Applicant) and BELAIR INSURANCE COMPANY INC. (Insurer)

Anne Morris Member

Heard: April 4, 2017; April 5, 2017; April 6, 2017; April 7, 2017; April 10, 2017; April 11, 2017; April 12, 2017
Judgment: July 31, 2017
Docket: FSCO A16-000951

Counsel: Ms Supriya Sharma, Mr. Gary Mazin, Mr. Joseph Filice, Ms Vasiola Bibolli (student-at-law), for Mr. Dawood Akeelah
Mr. Jason Goodman, Ms Nicole Dowling, for Belair Insurance Company Inc.

***Anne Morris Member*:**

Issues:

1 The Applicant, Mr. Dawood Akeelah, was injured in a motor vehicle accident on November 18, 2013 and sought accident benefits from Belair Insurance Company Inc. ("Belair"), payable under the *Schedule*. [1] The parties were unable to resolve their disputes through mediation, and Mr. Akeelah, through his representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

2 The issues in this Hearing are:

1. Did Mr. Akeelah sustain a catastrophic impairment within the meaning of the *Schedule* as a result of the accident?

2. Is Mr. Akeelah entitled to receive medical benefits as follows:

a) $9,492.00 for an OCF-18 (assessment and treatment plan) by Omega Medical Associates, dated August 21, 2015, for catastrophic assessments less amounts paid;

b) $2,865.63 for an OCF-18, dated May 12, 2016, for assistive devices, less any amounts paid;

c) $1,230.00 for an OCF-18, dated June 15, 2015, by Dr. Dina Savelli for Botox injections;

d) $897.63 for an OCF-6 (expenses claim form), dated December 7, 2014, for out-of-pocket expenses?

3. Is Mr. Akeelah entitled to attendant care benefits at the rate of $6,000.00 per month from October 15, 2014 to date and ongoing?

4. Is Mr. Akeelah entitled to payments for the cost of examinations as follows:

a) $200.00 for an initial assessment by Limeridge Physiotherapy, dated December 11, 2013;

b) $4,270.00 for a neuropsychological evaluation by ABI Community Services, dated February 10, 2015;

c) $2,825.00 for an assessment of attendant care needs (Form 1), conducted by Galit Liffshiz and Associates, dated November 7, 2014?

5. Is Belair liable to pay a special award because it unreasonably withheld or delayed payments to Mr. Akeelah?

6. Is Mr. Akeelah entitled to interest for the overdue payment of benefits?

7. Is either party entitled to its expenses of the Arbitration?

Result:

3

1. Mr. Akeelah sustained a catastrophic impairment within the meaning of the *Schedule* as a result of the accident.

2. The decision on entitlement to medical benefits is deferred for submissions.

3. Mr. Akeelah is entitled to attendant care benefits in the total incurred amount of $802.86 for the period from October 15, 2014 to January 30, 2017.

4. The decision on entitlement to expenses for costs of examination is deferred for submissions.

5. Belair is liable to pay a special award because it unreasonably withheld or delayed payments to Mr. Akeelah.

6. If the parties are unable to agree on the amount of the special award, or on the medical and cost of examination benefits payable in light of the other findings in this decision, they are to make submissions on the same within 30 days of this decision.

7. If the parties are unable to agree on the entitlement to, or quantum of, the expenses of this matter, the parties may make submissions in writing for determination of same within 30 days of this decision.

EVIDENCE AND ANALYSIS:

Summary

4 The most significant issues in this Arbitration are the determinations of catastrophic impairment, entitlement to attendant care benefits, and entitlement to a special award.

5 The Applicant claims that as a result of the accident on November 18, 2013, he is catastrophically impaired within the meaning of section 3(2) of the *Schedule*. The Applicant relies upon the 55% whole person impairment ("WPI") criteria of section 3(2)(e) and alternatively the "Marked Impairment" criteria of section 3(2)(f). The Insurer denies that the Applicant sustained a catastrophic impairment as a result of this accident. It is the Insurer's position that if he did sustain a catastrophic impairment, it was the result of a stroke suffered approximately two years after the motor vehicle accident.

6 The Applicant claims that as a result of the motor vehicle accident, he is entitled to monthly attendant care benefits, pursuant to sections 19 and 20 of the *Schedule*, to the maximum of $6,000.00 per month allowed for persons who are determined to be catastrophically impaired. It is the Insurer's position that the Applicant is not entitled to these benefits and not at the levels claimed. It is also the Insurer's position that attendant care benefits claimed which have been provided by family members are not payable because they have not been "incurred" within the meaning of section 3(7)(e) of the *Schedule*, in that there is no proof that the family members suffered economic losses as a result of providing services.

Background

7 The Applicant, Mr. Akeelah, was 38 years old at the time of the motor vehicle accident of November 18, 2013. He was on an expressway when the traffic ahead slowed abruptly because of an accident on the shoulder. The Applicant's car was rear-ended by a courier delivery van and the impact caused the Applicant's car to strike the car in front of him. The damage to the Applicant's 2007 car was significant (a little over $7,500.00), [2] and it was written off.

8 The Applicant did not immediately seek medical care and was able to drive his car home. He went to the emergency room of a local hospital the next day complaining of a stiff neck, pain all over, and headache. Advil did not provide relief. He indicated that he had felt dizzy at the time of the accident but that it had resolved. The discharge diagnosis was muscle pain secondary to an accident. Concussion was queried. [3]

9 The Applicant again went to the emergency room on December 19, 2013 complaining of a headache. [4] The attending doctor, Dr. Channan, diagnosed whiplash and post-concussion syndrome as a result of the November 19, 2013 accident, and referred the Applicant to the Acquired Brain Injury Program for rehabilitation. [5]

10 The Applicant had worked full-time as a general labourer for a local government facility for eight years prior to the accident. He has not worked since the accident except for a one day return attempt in January 2014, and a subsequent modified return to work attempt which lasted a little over a month, ending on March 5, 2014. [6]

11 The Applicant was involved in a subsequent motor vehicle accident on February 3, 2014. This accident did not result in significant injuries, as noted in an Insurer's Examination Report, dated January 6, 2015, by a psychologist, Dr. Salerno. Dr. Salerno opined that the Applicant's "significant accident related psychological impairment consistent with an Adjustment Disorder and Somatic Symptom Disorder" was the result of the previous accident of November 18, 2013, and not the February 2014 accident. [7]

12 The Applicant's main current complaints, discussed further below, are widespread pain and depression, with sleep dysfunction, difficulty walking and cognitive difficulties.

13 The Applicant suffered a stroke almost two years after the motor vehicle accident. He saw his family doctor, Dr. Hanna, on October 19, 2015. He "presented with acute confusion with expressive aphasia and dysarthria". [8] He attended the emergency room on October 19, 2015, where he was diagnosed on October 20, 2015 as having had a subacute left front parietal ischemic stroke. [9]

14 The Applicant's psychological status deteriorated over time and after the stroke, as evidenced, for example, by his assessment in an emergency ward on February 24, 2016 for suicidal ideation. [10]

Medical Evidence

Pre-Accident

15 The Applicant was generally in good physical health prior to the accident with some minor problems. An ultrasound of the left shoulder in November 2012 showed mild tendinitis and a very small tear on the tendon. [11] The Applicant complained of shoulder pain again in June 2013. [12] He had chiropractic treatment in 2009 for "elbow, knee, back and joints." [13] He also had chiropractic treatment in October 2012 for his lower back, joints, left shoulder and right foot pain. [14] There is no evidence that these conditions were significantly disabling prior to the accident.

16 A hospital record shows that on November 4, 2013, [15] the Applicant attended hospital complaining of overall weakness. He was diagnosed with a "presyncope-vasovagal" which, from evidence given by Dr. Hanna, the Applicant's family doctor, meant he almost fainted. He had been having abdominal pain and was in the bathroom at the time of the incident. The hospital record

indicated that he seemed anxious. He was discharged home. There is no evidence of further medical treatment in relation to this incident. There is no evidence of significant psychological problems prior to the motor vehicle accident of November 2013.

17 The Applicant testified that he had been physically beaten twice in his youth and these incidents, or at least one of them, are generally noted in the medical records as part of his medical history. Dr. Lara Davidson, for example, noted in her psychological assessment of the Applicant, dated February 27, 2017 (carried out as part of the Applicant's catastrophic determination assessment), [16] that the Applicant had been attacked at 18 years old by a group of men who punched and kicked him in the head. The Applicant told her that he experienced some cognitive difficulties after this which resolved over time. He had also been "jumped" at age 21 or 22, with a head injury. "He denied any residual problems related to either injury".

18 A chiropractic record, dated April 18, 2009, noted a "head trauma 18 yrs old concussion stitches." [17]

19 Dr. Chantal Vaidyanath, Physical Medicine and Rehabilitation, provided an independent Physiatry Assessment Report, addressed to the Applicant's lawyer, dated September 4, 2016. [18] She also noted the incidents where the Applicant was beaten in his youth at p. 24 of her report, and at p. 33 stated that the Applicant "may have also suffered two prior concussions, although the symptoms were self-limiting. The history of previous traumatic brain injury is a medical risk factor for persistence of post-concussive symptoms."

Physiotherapy, Chiropractic and Massage Treatment Post-Accident

20 The Applicant had physiotherapy, chiropractic treatment and massage therapy following the accident. He was assessed by Limeridge Physiotherapy and Rehabilitation on December 11, 2013. Active therapy was not pursued at that time until post-concussion syndrome and/or nerve irritation was ruled out. [19] He subsequently attended the chiropractic facility that he had attended prior to the accident, discussed above. It appears from an official tax receipt from the facility, dated February 14, 2017, that he attended between December 12, 2013 and January 30, 2014. [20]

21 He attended another facility for treatment between January 3, 2014 and February 26, 2014. [21] His attendance towards the end was uneven until he stopped going. From his evidence at the Hearing, he was unhappy with the treatment there. His lawyer submitted [22] that because there was no funding, the Applicant was forced to stop treatment. The official tax receipt tends to confirm that the Applicant paid out-of-pocket for some of this treatment.

22 The Applicant attended Work Fit Total Therapy Centre, a Program of the Oakville Hospital Foundation, from May 16, 2014 to July 3, 2014. [23] Treatment in excess of the Minor Injury Guidelines ("MIG") was denied by the Insurer at the time. [24] His lawyer submitted that the Applicant paid out-of-pocket for his treatment sessions. [25]

23 The Applicant also underwent a work hardening programme by Lifemark Health in September 2015. [26]

Acquired Brain Injury (ABI) Diagnosis and Follow-Up

24 The Applicant was diagnosed on December 19, 2013, at an emergency room visit noted earlier, with whiplash and post-concussion syndrome, as a result of which he was referred to the Acquired Brain Injury Program intake. A report from the Acquired Brain Injury Program (ABI Report), dated April 2, 2014, was addressed to Dr. Channan, who made the referral, and to the Insurer. [27] The report identified symptoms of headaches; pain daily in the neck, head, shoulder, arm; and numbness/tingling in both hands. It identified mood concerns as follows: "Mr. Akeelah reported and it was observed by this writer, Mr. Akeelah is tearful, isolated socially, irritable and anxious". The report also identified noise sensitivity, photophobia, balance changes, low cognitive tolerance and low physical energy levels daily, and sleep problems. The report noted as follows in regard to cognitive symptoms: [28]

> Mr. Akeelah reported and it was clearly observed, the following cognitive difficulties: attention, easily distracted, memory, unable to stay focused on a task, low initiation, requires support to make decisions, unable to recall text information, organization and problem solving difficulties, slow response time, low cognitive tolerance, unable to multitask, word finding, expressive and receptive difficulties.

25 The report sought to clarify for the Insurer as to why the Applicant "requires additional funding due to his post concussive symptoms." The report recommended that the Insurer fund: a neuropsychological assessment; occupational therapy; psychological counselling; and physiotherapy with a therapist with brain injury experience. [29] The Insurer denied all treatment as indicated in a clinical note, dated August 28, 2014. [30]

26 The ABI Report also suggested that Dr. Channan make some referrals: to a sleep disorder clinic; for an EMG of both hands; and to a physiatrist for pain. There is no evidence that the Applicant has attended a sleep disorder clinic. He first saw Dr. Demian, a chronic pain specialist of CPM Centres for Pain Management, on August 4, 2014, [31] and the evidence suggests he still sees this doctor. Dr. Savelli, a neurologist who first saw the Applicant on June 18, 2014, [32] conducted the EMG.

27 Dr. Savelli, on June 18, 2014, diagnosed right carpal tunnel syndrome, borderline on the left and noted radicular findings at C5 and C7. [33] She wrote on June 24, 2014 that the MRI of the brain had been normal. An MRI of the cervical spine showed disc degeneration and bulging C6/7 with borderline or mild central canal stenosis. A lumbar spinal MRI showed a bilateral L5 spondylolysis grade 1, bilateral L5/S1 foraminal narrowing, and multilevel disc bulging.

28 The Applicant saw Dr. Mehdi Shahideh on June 29, 2015, apparently for a surgical consultation. [34] Dr. Shahideh indicated that he had reviewed the MRI scan, which in his opinion showed no significant disc herniation or compression of the spinal cord or any of the exiting nerve roots. There was no indication that any of the Applicant's symptoms were related to the cervical MRI.

29 The Applicant takes strong pain medications. The letter from Dr. Demian, dated April 13, 2015, for example, indicated that the Applicant was currently on strong pain medications including Lyrica, Tramadol, Cipralex, and Percocet for pain management.

Psychology Assessment Report by Dr. Fabio Salerno, dated January 6, 2015 [35]

30 Dr. Salerno, a psychologist, conducted an Insurer Examination on December 22, 2014 in relation to an assessment and treatment plan submitted for occupational therapy and social work. His report was dated January 6, 2015. The date of loss was noted as February 3, 2014, and not the subject motor vehicle accident of November 18, 2013. It appears that the Insurer Examinations conducted at this time referred to the February 3, 2014 accident, which appears not to have contributed in any significant way to the Applicant's ongoing symptoms.

31 In his summary of clinical findings and conclusions, [36] Dr. Salerno noted that the Applicant described "depressed mood and associated symptoms, irritability, social withdrawal, sleep disturbance, marked memory and concentration difficulty, vehicular anxiety, mild symptoms of posttraumatic stress, health related anxiety and pain."

32 Dr. Salerno indicated [37] that the Applicant met the DSM-5 diagnostic criteria for "Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Somatic Symptom Disorder with Prominent Pain, Persistent, Mild". He stated, though, that this was attributable to the motor vehicle accident of November 18, 2013 and not to the February 2014 accident.

Neuropsychological Assessment Report by ABI Community Services, dated February 10, 2015

33 Dr. Diana Velikonja and Stephanie Hornyak, psychometrist, of ABI Community Services provided a Neuropsychological Evaluation Report, dated February 10, 2015, at the request of the Applicant's lawyer. [38] Dr. Velikonja noted on the first page of the report that a review of the Applicant's "psychological status indicated substantial distress and physical symptoms

that demonstrated inconsistent and highly fluctuating performance, indicating that reliable data could not be obtained and neurocognitive testing could not be interpreted. Thus, a Psychological Report was completed to evaluate his psycho-affective status".

34 Dr. Velikonja noted that the information for the evaluation was gathered from a clinical interview, a review of the medical document, the results of the current assessment and feedback from the Applicant.

35 She noted, in part, with regard to neurotrauma severity indicators that:

> ...physical symptoms at the time of the accident include pain in his head, neck and shoulders, in addition to neurological symptoms typically associated with concussion such as dizziness, fogginess, confusion and disorientation. Taken together, these indicators would show that Mr. Akeelah likely suffered a concussion secondary to a whiplash injury in the indexed accident. [39]

36 Dr. Velikonja noted [40] of the report that the Applicant's cognitive test results were not felt to be valid, but were rather an indication of the extent of his pain and physiological symptoms. She stated:

> Overall, results obtained from psychometric tests assessing effort, examination of internal consistency indicators, and qualitative observations made throughout the assessment, Mr. Akeelah's test results are not felt to be an accurate and valid reflection of his current cognitive status. Rather the psychometric results and semi-structured interviewing related to his psychological functioning provides an indication of the extent of emotional distress he currently experiences on a daily basis related to adjustment and stress. It also provides an indication of the extent his pain and physiological symptoms are impacting his cognitive ability, and negatively impacting several areas of his life such as work, social and household functioning.

37 In discussing the Applicant's current status and symptoms, Dr. Velikonja noted, regarding his basic activities of daily living, that he reported being independent in all activities. He was independent in most of his instrumental activities of daily living, but his sister assisted with outdoor activities requiring physical exertion. She also assisted with household cleaning and cooking. She noted that the Applicant was currently driving.

38 Dr. Velikonja indicated in discussing the Applicant's psychological functioning that his:

> ...response pattern on a psychometric measure evaluating personality and emotional factors suggests he is also experiencing significant distress with particular concerns about his physical functioning to which he finds his life to have been severely disrupted by his physical problems and chronic pain he endures on a daily basis. He also endorsed changes in his emotional functioning related to persecution and resentment, feeling that family members and friends do not understand what he is going through physically and emotionally since the indexed accident, and that he does not know how to explain to family members and friends how is he feeling and why he is unable to return to work at this time. [41]

39 Dr. Velikonja indicated that, from a psychological perspective, the Applicant currently endorsed severe levels of depression and anxiety in response to the difficulties he had been having physically and cognitively subsequent to the accident, and the negative impact these difficulties had on his life. She diagnosed: [42]

- Major Depressive Disorder, Single Episode, Chronic, Moderate
- Pain Disorder Associated with both Psychological Factors and a General Medical Condition
- Adjustment Disorder with Anxiety, Chronic
- Post-Traumatic Stress Disorder, Chronic

40 She diagnosed general medical conditions of concussion secondary to whiplash, neck and shoulder pain, headaches and sleep disturbance. She considered the Applicant to be competitively unemployable at that time, and made recommendations for treatment including psychological, occupational/rehabilitation, and chronic pain management.

Catastrophic Impairment

Applicant's OCF-19 Assessments

41 The initial catastrophic impairment assessments for the purpose of preparing an OCF-19 [43] were arranged prior to the Applicant's stroke of October 2015, and took place shortly after the stroke.

42 Dr. Sangha, a physiatrist, conducted the physical impairment rating on November 26, 2015. He assigned a 15% WPI rating for radiculopathy in the C-Spine, and 5% for a mild lumbar spine impairment based on previous notes showing sciatica and x-rays showing scoliosis suggestive of spasm. [44] He also assigned 3% for medications, the highest rating allowed under the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993 ("*Guides*") [45] for the effects of treatment. He noted that that the Applicant was on numerous centrally-acting agents, which were almost certainly contributing to his cognitive symptomatology. He indicated that neuropsychological evaluation did not deem his cognitive complaints to be due to organic brain injury, and felt it to be due to psychological impairment. The combined rating for physical impairment was 22%.

43 Dr. Lara Davidson conducted the mental health/behavioural evaluation on November 24, 2015. Her report is dated December 10, 2015. [46] Ms. Beth Crystal conducted an occupational therapy in-home assessment on December 3, 2015.

44 Dr. Davidson, in her report, noted the Applicant's cognitive and emotional symptoms since the accident worsened after the stroke. [47] She indicated (at p. 10 of her report) that the Applicant met the criteria for Major Depressive Disorder, Single Episode, Moderate, Chronic; an Adjustment Disorder with Anxiety, Chronic; as well as a Pain Disorder Associated with Both Psychological Factor and a General Medical Condition, Chronic. Having regard to her assessment and the in-home assessment by Ms. Crystal, she found that the Applicant had Class 3 Moderate Impairments in functioning in the areas of Activities of Daily Living, Social Functioning, Concentration and Adaptation. This was with regard to Criterion 8 [48] and chapter 14 of the *Guides*. Having regard to Criterion 7 (WPI), [49] and Table 3, chapter 4 of the *Guides*, she suggested a WPI rating of 30-40% for the Applicant's mental and behavioural impairments. Dr. Davidson, in discussing causality (at p. 10 of her report), acknowledged the effect of the stroke but noted the presence of substantial emotional symptomatology prior to the stroke, as documented by prior reports.

45 Dr. Lisa Becker and Dr. Harold Becker of Omega Medical Associates prepared the Summary and Analysis Report with respect to catastrophic impairment on January 7, 2016. They noted, at p. 3 of the Summary Report, that the 22% WPI for physical impairment did not independently meet the catastrophic threshold. They also noted the absence of at least one area of Marked Impairment under Criterion 8. They combined the physical and mental and behavioural impairments under Criterion 7, using the highest rating of 40% "in keeping with the severity of mental and behavioural impairment as well as the AMA Guides' directive to choose the highest rating". They arrived at a WPI of 53%, a score that, according to Drs. Becker, meets the catastrophic threshold as 53% can be rounded to 55% in accordance with the rounding directive on page 9 of the *Guides*.

Insurer's Catastrophic Determination Reports

46 Dr. Ben Morton, chiropractor of Cira Medical Services, reviewed the OCF-19 and attached reports in a report, dated March 9, 2016. [50] Dr. Ian Derby provided the Neurological Assessment Report, dated September 9, 2016. [51] The assessment took place on April 21, 2016. Dr. Derby indicated that apart "from his complaint of dizziness immediately following the subject accident, and since, and his reported feeling of imbalance [he] could identify no objective neurological deficit or impairment". He recommended that the Applicant have an ENT assessment with respect to the dizziness and feeling of imbalance. There is

no evidence that an ENT assessment was carried out, or that it was recommended by any other medical professional involved with the Applicant.

47 Dr. Greg Jaroszynski, an orthopaedic surgeon, provided a report, dated September 9, 2016, based on an assessment of April 18, 2016. [52] He reviewed the documentation provided to him and the Applicant's reported symptoms. He noted (at p. 6 of the report) that the Applicant walked with "an unusual almost ataxic looking gait using a cane". (He noted earlier on the same page that the Applicant had been using a cane since 2015 because of balance issues). He thought that "there was a fair amount of inhibition of effort and some element of non-organic symptom magnification". He indicated that the spine examination showed no abnormal curvatures. He noted that there were no obvious motor deficits on neurological examination. He reported his clinical findings of the upper and lower extremities noting significant pitted edema on the legs. He summarized (at p. 8 of the report) that from a musculoskeletal perspective alone, the accident appeared to have produced a whiplash-associated disorder. He indicated that his examination did not suggest radiculopathy, and deferred issues pertaining to an apparent abnormality on the EMG to the appropriate assessor. He indicated that musculoskeletal impairment of traumatic origin "were otherwise noted in the upper or lower extremities". He deferred the musculoskeletal impairment rating to the executive summary.

48 Dr. Lawrence Tuff, a psychologist, provided a Psychological Report, dated September 9, 2016, based on assessments on April 20, 2016 and August 4, 2016. [53] Dr. Tuff administered a number of psychological tests, but found the responses invalid. He stated at p. 17 that the Applicant's:

> ...responses (invalid) to a mood questionnaire (CAD) placed him in the 'Very Significant Clinical Risk' range. His responses (valid) to a pain questionnaire (P-3) reflected above-average and near maximal depression, anxiety and somatization levels relative to the normative sample of chronic pain patients. His responses (invalid) on a symptom validity test were well in the abnormal range and suggestive of exaggerated to frankly disingenuous reporting.

49 Dr. Tuff opined that it was difficult to determine with any confidence whether the Applicant met the diagnostic criteria for any accident-related disorder. "Invalid responding was present across multiple psychometric instruments." He opined with respect to chapter 14 of the *Guides* (Mental and Behavioural Disorders) that it was not objectively possible to estimate the overall level of impairment, if any, due to negative impression management.

50 He went on to note that in April 2016, a social worker accompanied the Applicant to hospital because of suicidal ideation. He stated with respect to this incident that some level of genuine affective distress could be inferred by history. It was his impression, however, that the suicidal ideation reflected acute rather than chronic conditions.

51 In conclusion, Dr. Tuff found that there was no objective evidence that the Applicant met the threshold for catastrophic impairment under Criterion 8 (Marked Impairment). He deferred his opinion under Criterion 7 (WPI) to the Neuropsychological Report which he also prepared.

52 Dr. Tuff's Neuropsychological Report was dated September 9, 2016, and was also based on assessments on April 20, 2016 and August 4, 2016. Dr. Tuff stated at p. 18 of his report with respect to "validity" as follows:

> In any modern neuropsychological assessment, it is now widely accepted that it is essential to employ objective tests to measure the amount of effort being applied during testing. This is especially important when there are potential issues of secondary gain from appearing impaired...

53 Dr. Tuff went on to say that overall, the results of effort testing showed significant response bias and inconsistent effort. This suggested "possible underlying exaggeration of cognitive difficulties". He went on to note in his summary (at p. 23) that given "his poor effort on testing it was not even possible to detect any residual stroke-related impairment". He went on to state (at p. 23) that:

> ...it is my opinion that it is not objectively possible to estimate overall level of impairment, irrespective of etiology, due to negative impression management. There is no objectively discernable neurocognitive impairment by either history or

testing. I am of the opinion, however, that Mr. Akeelah does not suffer from any form of acquired neurocognitive disorder in relation to the November 18, 2013 motor vehicle accident.

54 Dr. Tuff assigned a 0% rating under Criterion 7 from a neuropsychological perspective. He deferred a Criterion 8 rating to his psychological assessment, already discussed.

55 Ms. Ranya Ghatas conducted an in-home occupational therapy assessment and provided a report, dated September 9, 2016.[54] Ms. Ghatas noted (at pp. 10 and 11) the Applicant's physical complaints of pain and his emotional complaints: "I reach the point of trying to kill myself". He expressed anger at "they" and hoped that "...everybody of them get into an accident every person get through what I went through and I came to a point where I was dying and I want to kill myself...". He described difficulties with concentration, crying and poor decision-making. He stuttered and his speech was delayed. He lived in a basement with his parents living upstairs. They took down the door to the basement because he was "too dangerous". Ms. Ghatas noted (at p. 13) that the Applicant's bedroom was unkempt. She also noted that the bathroom was carpeted and the area around the toilet appeared to have cigarette burns. The Applicant stated that at times he fell asleep when smoking on the toilet, and his mother currently sat by the bathroom waiting for him to ensure his safety. Ms. Ghatas noted (at p. 15) that the Applicant walked using a cane. He demonstrated an uneven gait with a significant limp. He declined to participate in formal testing following the clinical interview process due to reported pain, fatigue and symptoms.

56 Dr. Ben Meikle completed the catastrophic WPI Report, dated September 13, 2016.[55] A zero rating was applied for physical and psychological impairment. 3% was allowed for medication. Dr. Avi Orner completed the executive summary, dated September 13, 2016.[56] The overall impairment rating was 3%.

Applicant's Review of Insurer's Catastrophic Impairment Reports

57 Drs. Lisa and Harold Becker of Omega Medical Associates reviewed the Insurer's reports in a Review Report, dated December 19, 2016.[57] Of particular note in my view is Drs. Beckers' disagreement with Dr. Meikle's assignment of a zero rating for cervical and lumbar spine impairment. It appears to me from Dr. Jaroszynski's report discussed above that he anticipated his clinical finding with respect to musculoskeletal impairment would be rated in the executive summary. He also deferred issues pertaining to an apparent abnormality on the EMG to the appropriate assessor. Instead, Dr. Meikle, who did not examine the Applicant, concluded that the Applicant's "perceived widespread chronic pain and symptoms do not follow anatomic pathways for radiculopathy and cannot be properly categorized as radiculopathy-like complaints." He did not assign any rating with respect to Dr. Jaroszynski's clinical findings. This was pointed out at p. 4 of the Review Report by Drs. Becker and I agree with their comments in this regard. I also agree with their comments about Dr. Meikle's failure to categorize the Applicant's complaints as radiculopathy-type complaints given the findings of Dr. Savelli, a treating neurologist, who conducted EMG studies and who documented her findings in 2014 as discussed above.

58 Drs. Becker also noted that Dr. Meikle had assigned a zero rating for mental and behavioural impairment. They noted (at p. 6) that Dr. Tuff's opinion was that he could not determine the level of impairment, not that there was No Impairment. They also indicated (at p. 4) that an increased rating for L5 radiculopathy might apply.

59 In the end, however, in my view, whether or not the Applicant meets the catastrophic impairment threshold depends less on a fine calculation of rating for a physical impairment, and more on his psychological status which appeared from the evidence to decline following the stroke.

60 Omega Medical Associates conducted further catastrophic impairment assessments following the Insurer's assessments.

Applicant's Subsequent Catastrophic Impairment Reports

61 The Applicant saw a neurologist, Dr. Robinson, and his assessment is part of the catastrophic impairment assessment by Omega Medical Associates, dated February 27, 2017.[58] Dr. Robinson opined (at p. 40) that on the balance of medical probabilities, the Applicant had sustained a mild traumatic brain injury (concussion) in the accident. He also stated that in

his opinion "it is more likely that there is a combination of cognitive dysfunction related to brain trauma and psychological effects of the index accident and subsequent course." Dr. Robinson opined that the Applicant's presentation was complicated by apparent possible psychological features, noting some functional overlay on his evaluation. He thought that this was also complicated by polypharmacy and significant side effects. He noted that at the ABI clinic evaluation on April 2, 2014, it was felt that the Applicant had post-concussion syndrome. Commenting on Dr. Derby's report, he indicated (at p. 42) that Dr. Derby's history of the present problem was "less than comprehensive". He found Dr. Derby's physical examination to be very different to his experience of the Applicant. Dr. Derby had stated that the Applicant did not appear to be in distress or discomfort. Dr. Derby had indicated that he had walked normally without a cane, changing dramatically when he left, walking quickly but in a lurching fashion. Dr. Robinson noted that he too had glanced out his window after the assessment. He saw the Applicant below him, labouring with a walker to get into a cab. His impression of the Applicant's mobility issues was not changed by this chance observation.

62 Dr. Robinson suggested some neurological physical impairment ratings. He stated:

> Mr. Akeelah's presenting complaints are overwhelmingly those of a chronic pain syndrome and significant psychological issues and, as described above, these certainly complicate his neurological presentation. However, in my opinion it is reasonable to provide the ratings from Chapter 4 suggested to accurately reflect the neurological injury and subsequent impairment sustained by Mr. Akeelah in the indexed accident.

63 Dr. Robinson testified that he did not believe that neurologically the stroke was connected to the concussion.

64 Ms. Shahla Kara conducted an in-office occupational therapy functional assessment on January 24, 2017 and her findings are reported starting at p. 78 [59] of the Catastrophic Impairment Report, dated February 27, 2017. Ms. Kara indicated at the outset of her report that the assessment lasted approximately three hours and fifteen minutes, with the Applicant requesting to terminate early due to increased pain, fatigue and anxiety.

65 Dr. Lara Davidson conducted a further psychological assessment on January 23, 26 and 30, 2017. Her report [60] starts at p. 44 of the Catastrophic Impairment Report, dated February 27, 2017. Dr. Davidson's report is detailed and comprehensive. In describing the Applicant's deteriorating emotional symptoms (at p. 53); she noted that the Applicant worried about his health. "He worries about having another stroke, his future, 'what is going to happen to me?', and his inability to work. He stated: 'I can't live my life like this. I'm not alive. I'm dead.'"

66 Dr. Davidson described (at p. 56) what appeared to be the Applicant's deteriorating social/recreational functioning since she had assessed him in November 2015. At that time, he had indicated that he occasionally spent time in the garage tinkering with his car. He no longer engaged in that activity. He spent most of his time in bed or on the toilet. When Dr. Davidson had last seen him he was going out with a friend for a coffee once a month. He no longer did that, and he still did not see pre-accident friends.

67 Dr. Davidson noted (also at p. 56) that the Applicant attributed not seeing friends to loss of interest, irritability, depression, pain, anxiety about leaving home, and embarrassment about cognitive problems and unemployment. He stated that "he was embarrassed about his situation since the accident, and he is even more embarrassed after the stroke due to communication problems."

68 The Applicant did psychometric testing on January 23 and 30, 2017. [61] It was time-consuming due to frequent breaks. He was unable to complete testing after the interview with Dr. Davidson on January 26, 2017, citing extreme fatigue, pain and concentration problems, and visual disturbance.

69 Dr. Davidson noted (at p. 58) that overall "there was substantial evidence of an effortful distortion of clinical symptomatology on psychometric measures."

70 Dr. Davidson addressed validity issues further (at p. 68 of the report) as follows:

> ...However, it is important to recognize that effortful distortion is not a black-and-white issue. There is a continuum of distortion ranging from effortfully exaggerating genuine psychological symptomatology to overtly lying about non-existing symptoms. Furthermore, individuals can experience and accurately report some psychological symptomatology while effortfully distorting the presence or experience of other symptomatology. Motivation for negative response bias may include, but is not limited to the following: an effort to communicate distress and the need for help; a desire for the examiner to be aware of the severity of distress; an extremely negative view of oneself and one's life; frustration with testing or towards the assessment process; primary or secondary gain.

71 Dr. Davidson also noted that the Applicant had not been born in Canada. "It is acknowledged that language and cultural factors may influence the results of psychometric testing..."

72 Dr. Davidson stated that in determining impairment, it is important to consider all available avenues of information. After reviewing the information available to her, she diagnosed a Major Depressive Disorder, Severe; an Adjustment Disorder with Anxiety, Chronic; a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, Chronic; and a Somatic Symptom Disorder, with predominant pain, Persistent, Severe.

73 Having regard to her own findings, as well as those of the occupational therapy functional assessment by Ms. Kara in January 2017 (discussed above), and having regard to Criterion 8 and Chapter 14 of the *Guides*, she found provisionally that the Applicant had a Class 4 Marked Impairment in the following areas: Activities of Daily Living, Concentration, and Adaptation. She found a Class 3 Moderate Impairment in Social Functioning. Her ratings were provisional, noting validity concerns with respect to psychometric testing. She noted in terms of stability that more than two years had passed since the subject accident. She stated (at p. 71) that given the chronicity and severity of symptomatology and impairment, she did not anticipate an appreciable improvement in functioning in the foreseeable future.

74 Drs. Becker then provided the Catastrophic Impairment Report, dated February 27, 2017. [62] Under Criterion 7, Physical Impairments, they utilized the physical impairment WPI ratings from the OCF-19 assessments as follows: 3% for medication use; spine impairment at 15%; and lumbosacral impairment at 5%. They added to this the Criterion 7 ratings suggested by Dr. Robinson in his report as follows:

- Mental status impairment at 1-14%
- Impairment of sleep and arousal at 1-9%
- Cranial nerve VIII impairment (imbalance/falls) at 1-9%

75 Using the highest ratings, they arrived at a WPI rating under Criterion 7 of 50% for physical impairments (at p. 4 of the report). The number varied between 46% and 50%, depending on whether a DRE III or II rating was used. They assigned (at p. 5) a 49% rating for mental and behavioral impairments, for a total impairment rating (at p. 6) of 72% or 75%. They also noted that the Applicant met the threshold under Criterion 8, given the finding by Dr. Davidson of a Marked Impairment in activities of Daily Living, Concentration, Persistence and Pace, and Adaptation.

Is the Applicant Catastrophically Impaired? (regardless of cause)

76 The Insurer submitted that the Applicant is not credible. The Insurer pointed to inconsistencies in his evidence at the Hearing, and suggested that leading questions by counsel detracted from the credibility of the Applicant's evidence. The Applicant's evidence was very difficult. He was very late to the Hearing to give his evidence. He appeared very fatigued. In reviewing the totality of the evidence, however, I find that the manner in which he gave his evidence, and likely any inconsistencies in his evidence, is due to the symptomatology described in the various Medical Reports, and not to the lack of credibility.

77 I acknowledge Dr. Tuff's position with respect to the validity of psychometric testing and his perceived inability to provide an impairment rating because of invalidity. Dr. Tuff did not, however, say that the Applicant was not impaired. He said he was unable to provide a rating. Therefore, the zero impairment assigned by Dr. Meikle for neuropsychological and psychological impairment was inappropriate.

78 If I were to accept the 3% overall rating provided by the Insurer, I would have to conclude that there is nothing wrong with the Applicant, or at least nothing besides the effects of medication. I have reviewed all of the evidence, however, including the Applicant's demeanor at the Hearing, and I am not persuaded that there is nothing wrong with him, or even that medication is his only difficulty. There are multiple reports of underlying problems with depression and other diagnosed psychological conditions, including those discussed above.

79 I note that, after the stroke, the Applicant was assessed at a local hospital on February 24, 2016 because of suicidal ideation. The hospital record shows that when asked how the hospital could help him, he responded by saying that if he could get back to work, that would help him most. [63] While Dr. Tuff characterized this event as "acute", rather than "chronic" distress, the evidence at the Hearing of Dr. Hanna, the Applicant's family doctor, was that suicidal ideation by the Applicant was not unusual. I note in that regard that Dr. Hanna's clinical note of October 5, 2015, prior to the stroke, indicated that the Applicant was not getting better either mentally or physically. Dr. Hanna noted emotional symptoms at that time including feelings of worthlessness, anxiety, depression, and suicidal thoughts.

80 While Dr. Tuff suggested financial gain as motivation for invalid testing, I note the discussion of motivations alluded to in Dr. Davidson's report and discussed above. She mentioned secondary gain as a possible motivation, but she noted other motivations including frustration with the assessment process and a desire to communicate the level of distress to the assessor.

81 I agree with Dr. Davidson that in assessing the level of impairment it is important to look at all the information available. She stated at p. 68 of the February 2017 report as follows:

> In determining impairment, it is important to consider all available avenues of information. In this case, Mr. Akeelah's presentation was consistent with his self-report of symptoms. He appeared to have substantial difficulty expressing himself. His speech was quite circumlocutious and he tended to ramble until redirected. He had significant difficulty recalling dates and time frames. His affect generally was restricted and subdued, interspersed with occasional agitation/anger. He presented with reduced energy throughout the interview as evidenced by frequent yawning. Diminished stamina was evidenced by the need to complete the measures over two days, and the inability to complete any measures on the day of the interview. Mr. Akeelah presented as very pain focused. His conversation frequently returned to pain symptoms even when other topics were being discussed. Mr. Akeelah's presentation in the Occupational Therapy Examination with Ms. Shahla Kara suggested an individual in emotional distress. During this interview for this examination, Mr. Akeelah did not report bizarre symptoms and he did not indiscriminately endorse symptoms. Mr. Akeelah's report or symptomatology and his presentation appear to be generally consistent with the nature and course of symptoms outlined in the medical file.

82 Dr. Davidson opined that the likely explanations for the effortful distortion of symptomatology were a desire for the assessor to be aware of the severity of his distress, perceived injustice and a sense that medical professionals and the Insurer did not understand or empathize with his distress, an extremely negative view of himself and his life, and depressogenic thought patterns common in Major Depressive Disorder.

83 Dr. Davidson noted that other medical professionals had diagnosed depression and pain which psychologically contributed to the Applicant's pain, including a report by psychologist, Dr. Jeremy Frank, dated November 4, 2016. [64] Dr. Davidson referred to a report, dated January 10, 2017, in which "psychiatrist Dr. M.A. Warsi suggested TMS or ECT as possible treatments, which typically are used for relatively severe depression where other treatment modalities have been unsuccessful".

84 I find Dr. Davidson's report persuasive. I also note (as did Drs. Becker at p. 4 of the February 2017 report) that Dr. Davidson in the 2017 assessment had felt confident in the validity of the testing at her November 2015 assessment. Drs. Becker noted that

the Applicant's depression had become more severe since then, as evidenced by the reports of Dr. Warsi and Dr. Frank. I agree, noting also the visit to hospital because of suicidal ideation in February 2016. The evidence shows that the Applicant's emotional condition deteriorated between her assessments in November 2015 and January 2017. She found Moderate Impairments in 2015 and Marked Impairments in 2017.

85 I have considered all of the evidence and I agree with Dr. Davidson's assessment that the Applicant has demonstrated Class 4, marked levels of impairment in activities of Daily Living, Concentration and Adaptation. I therefore find that the Applicant has met the threshold for catastrophic impairment.

Causation

86 There is evidence of physical and significant psychological impairment affecting the Applicant's perception of pain, and impeding his functioning prior to the stroke, which likely met the catastrophic level of impairment. This is based on the OCF-19 assessments. The Insurer's Catastrophic Impairment Reports provide little if any reason, as discussed above, to dispute the findings in those reports. It also appears from the evidence, however, that the Applicant's physical and particularly his emotional state deteriorated after the stroke.

87 Both Dr. Derby and Dr. Robinson, neurologists who gave evidence at the Hearing, agreed that the stroke was not neurologically connected to the concussion identified by the ABI clinic as resulting from the accident.

88 Dr. Chantal Vaidyanath provided a Physiatrist Report on behalf of the Applicant, dated September 4, 2016.[65] She stated as follows at p. 35 of her report:

> On a balance of probabilities, given the increased smoking he reports and his significantly decreased activity level and increased stress levels resulting from his MVA-related injuries and impairments, while his prior smoking history would have put him at increased risk of stroke, it is more likely than not that his MVA-related injuries materially contributed to him having suffered a stroke at such a young age, in October 2015.

89 The evidence at the Hearing was that the Applicant's smoking increased from one pack to two or three packs per day after the accident. The Insurer pointed to the hospital record of November 4, 2013,[66] just before the accident, which indicated that the Applicant smoked three packs a day. The Applicant did not really explain this information, which was apparently given to the hospital at the time of the note, but he indicated that while he was working, he could not have smoked that much, at least not in a work day, which seems plausible. I note, however, that Dr. Vaidyanath points to other lifestyle changes following the accident besides smoking. They include decreased activity levels and increased stress.

90 I am inclined to agree that it is more likely than not that the Applicant's lifestyle changes and other effects of his impairments following the accident contributed in a material way to his stroke at such a young age. I also note Dr. Davidson's comment at p. 70 of the February 2017 report, that "in consideration of the available information, and consistent with the medical file and the opinions of most previous examiners, it is reasonable to conclude that but for the November 18, 2013 motor vehicle collision, Mr. Akeelah would not present with the current constellation of psychological symptoms and impairments".

91 It appears to me that the psychological effects of the subject motor vehicle accident were such that the Applicant would have been ill-equipped to deal with the effects of a stroke at such a young age, even if that stroke had not been related to the accident. As it is, I have found that it was.

92 I agree with Dr. Davidson that were it not for the motor vehicle accident of November 18, 2013, the Applicant would not have presented with his current range of symptoms, which I find meet the threshold for catastrophic impairment. Given this finding, I do feel the need to address the question of WPI (Criterion 7) further.

Attendant Care

93 The Pre-Hearing Letter, dated November 10, 2016, refers to two periods of attendant care benefits claimed — from November 18, 2015 to December 9, 2015 and from December 10, 2015 to date and ongoing. The initial Form 1 (Assessment of Attendant Care Needs) [67] was signed on October 15, 2014, and the parties clarified that this was the start date for attendant care benefits, although the Applicant submits that benefits should be payable retroactive to the date of the accident.

94 Dealing with the first time period, up to December 9, 2015, Galit Liffshiz & Associates conducted an Occupational Therapy Attendant Care Assessment, dated November 7, 2014, in relation to the Form 1. The total monthly amount was $7,979.36 per month, $198.51 of which appears to be for meal preparation. The rest was for supervision 24 hours a day, seven days a week.

95 The attendant care during this time period was provided by family members, which means that an economic loss in providing attendant care benefits has to be demonstrated to establish entitlement to them.

96 Two of the Applicant's sisters gave some very vague evidence with respect to the economic loss they incurred when assisting the Applicant while living at home before they moved out, and afterwards when they came to his home from time to time to assist. No evidence of economic loss sustained by the Applicant's parents was offered. From the evidence overall, it appears that the parents with whom the Applicant lives - they upstairs and he in the basement - provide most of any care which is provided to him. As put by the Applicant, before the accident, the Applicant took care of his parents. After the accident, his parents took care of him.

97 While some attendant care at the time of the November 2014 assessment may have been reasonable, if incurred, supervisory care 24 hours a day was not, in my view of the evidence. The reason given for 24-hour care (at p. 21 of the report) was due to the Applicant's inability to be self-sufficient in an emergency situation, as well as cueing and prompting during the day to complete activities of daily living.

98 The evidence, however, shows that in September 2014, the Applicant was able to arrange a flight to Jordan and to negotiate the trip, travelling by airplane. While the Applicant submits that this demonstrated impulsiveness and a lack of judgment, it also demonstrated the functional ability to plan, pay for and complete that trip. In addition, the Applicant drove at the time of the November 2014 assessment, and continues to drive. He has a valid driver's licence. While this was suspended for medical reasons for a few months following his stroke in October 2015, it was reinstated. The ability to drive unsupervised, and the possession of a valid driver's licence, is in my view incompatible with a need for 24-hour supervisory care.

99 I would allow meal preparation of $198.51 per month if incurred, but I do not find that there is sufficient evidence of economic loss. While oral evidence of economic loss might be acceptable, it depends on the quality of the evidence. Again, no evidence was offered in relation to the parents. One sister who gave evidence testified that she declined clients for her daycare services to help assist her brother, and that she incurred driving expenses in taking him to appointments. There was no detail of any kind offered as to when these expenses might have been incurred, or for what appointments, given that the Applicant attended some appointments on his own, and given that if care was provided, it was provided by more than one person. There was no detail as to the sister's income or by how much it might have been affected, or when. The evidence with respect to the other sister was similarly vague. She missed some classes to assist her brother after the accident. Helpful and sincere as the sisters' evidence was in describing changes in their brother's life after the accident, it was vague in the area of economic loss. The standard of proof was not met.

100 The trip to Jordan was offered as evidence of economic loss sustained by the Applicant's sisters who live in Dubai, and who purchased tickets to visit their brother in Dubai to insist that he return home. Again, the evidence with respect to this incident is vague. It appears that the Applicant met a woman online and travelled to Jordan to meet her. His sisters apparently feared, so far as I can determine, that this woman's brothers posed a risk to the Applicant. Errors in judgment occur even without cognitive impairment. If in fact this incident was an error in judgment, which is not clear, it is up to the Applicant to demonstrate that this incident was due to a cognitive impairment caused by the accident. He has not discharged that onus.

101 The other proof of economic loss offered was a receipt for the purchase of a mattress by one of the Applicant's sisters who gave evidence. The sister testified that she purchased the mattress on October 8, 2015 because the Applicant was complaining of pain. It is not clear why the Applicant could not pay for the mattress himself, given that he had continuously been in receipt of income replacement benefits from his work since the accident. If anything, the mattress appeared to be in the nature of an assistive device, although the medical need for a mattress was not supported by a treatment plan at the time, so far as I can tell. The sister, if anything, funded a medical assistive device. The proper recourse in my view would have been to apply to the Insurer for a medical benefit. Any act of providing attendant care in this scenario would be the act of purchase and the cost of carrying out the purchase. For example, the cost of driving to the store might be part of the act of purchasing the mattress. No evidence of that was provided. I do not find the purchase of a mattress to be evidence of economic loss for the purpose of attendant care benefits being incurred further to the date of the Form 1, October 15, 2014, and therefore no attendant care benefits are payable in relation to that form.

102 A second Form 1, dated December 8, 2015, was provided by Key Rehab Services. [68] It is clear from the evidence that by this time, the Applicant's medical condition had deteriorated since the earlier Form 1, reflected in the attendant care assessment, dated December 10, 2015. This Form 1 provides for $7,995.00 per month, $297.76 per month of which is for meal preparation. The balance is for 24-hour supervisory care, both for safety and to assist with activities of daily living.

103 My comments with respect to driving and 24-hour care discussed above apply. The Insurer conducted surveillance in January and February 2017, which showed the Applicant driving his brother to school. But the surveillance was otherwise consistent with other evidence which indicated that the Applicant spends most of his time at home. It showed him using a cane when filling his car with gas. The Applicant testified that he does not usually drive his brother to school, and that on these occasions, he had to because his father could not. This, in my view, demonstrates an ability to respond to emergency situations.

104 The Form 1 of December 2015 is therefore not reasonable in my view, insofar as it provides for 24-hour care. That is not to say that some supervision might be necessary, to help the Applicant organize his daily activities and appointments, for example. But the Insurer's Form 1s provide for no attendant care. [69] This position is also not reasonable. As noted earlier, Ms. Ghatas, who conducted an occupational therapy assessment as part of the Insurer's Catastrophic Impairment Reports, noted cigarette burns in the carpeted area around the toilet in the Applicant's bathroom as the Applicant sometimes fell asleep while smoking on the toilet. His mother waited outside for him for safety reasons. I note that the Insurer approved fire retardant material for the bathroom further to that assessment. In my view, a more limited period of supervision, perhaps one to two hours per day, contained in a Form 1, might be reasonable, provided it is incurred.

105 The Applicant submitted that the accident occurred prior to the legislative amendment of February 2014, when the amounts payable under a Form 1 in relation to services provided by non-professionals were limited to the amount of the economic loss sustained. He submitted that if economic loss was shown, the full amount of the Form 1 was payable, regardless of economic loss in accordance with case law decided prior to the amendment. The Insurer pointed to the binding case of Director's Delegate Rogers in *Motor Vehicle Accident Claims Fund v. Barnes*, [70] which held that for services provided after February 2014, even in relation to accidents which occurred before that time, the amount of attendant care payable is limited to the economic loss sustained by a non-professional service provider. The parties are bound by that decision.

106 I note that some attendant care services were provided by professional care-givers and amounts incurred. Access Personal Support provided services in November 2016 [71] in the amount of $325.44. Home Instead Senior Care provided services in January 2017 in the amount of $477.42. [72] The Applicant was resistant to receiving these services, as is apparent from the session notes from Access Personal Support. [73] While I do not find a need for supervisory care 24 hours a day, I accept the need for some supervision, and I find these incurred amounts of $325.44 and $477.42 were reasonable and payable.

Special Award, Other Benefits in Dispute, and Expenses

107 I find that there is liability for a special award. It was unreasonable for the Insurer to maintain the Applicant within the MIG following the report to the Insurer by the Acquired Brain Injury Program in April 2014. The Applicant, as discussed earlier, was diagnosed with concussion by a treating emergency room doctor and referred by that doctor to the Acquired Brain Injury Program for treatment, which the Insurer denied. The Insurer continued to deny treatment even when its own psychologist, Dr. Salerno, indicated in his report of January 6, 2015 that the Applicant's injuries from the November 2013 accident took him outside the MIG. There appears to have been some confusion as the Insurer assessments at this time gave opinions on the February 2014 accident, [74] but they referred to the November 2013 accident, and the Insurer should not have relied on these reports to make decisions about the November 2013 accident. The Insurer's conduct was not reasonable and a special award will follow.

108 In that regard, I note that the amounts of special awards are tied to benefits. There are a number of medical benefits in dispute in this Hearing besides catastrophic determination, attendant care and a special award. The parties, however, made virtually no submissions with respect to the other medical benefits in dispute, as to whether they were reasonable or not reasonable, or even why they were denied. I find myself confronted with a vast amount of evidence and documentation in this Hearing. Without further submissions from the parties I am unable to pick out the evidence with respect to the medical benefits to try to infer with any degree of confidence what was denied and when and why.

109 I suggest that the parties attempt to resolve the remaining issues among themselves having regard to my findings on catastrophic impairment, attendant care, and liability for a special award.

EXPENSES:

110 I also suggest that the parties attempt to resolve the issue of entitlement to and quantity of expenses among themselves. If they are unable to do so, they may make submissions in writing to me with respect to these remaining issues within 30 days of this decision.

***Anne Morris Member*:**

111 Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1. Mr. Akeelah sustained a catastrophic impairment within the meaning of the *Schedule* as a result of the accident.

2. The decision on entitlement to medical benefits is deferred for submissions.

3. Mr. Akeelah is entitled to attendant care benefits in the total incurred amount of $802.86 for the period from October 15, 2014 to January 30, 2017.

4. The decision on entitlement to expenses for costs of examination is deferred for submissions.

5. Belair is liable to pay a special award because it unreasonably withheld or delayed payments to Mr. Akeelah.

6. If the parties are unable to agree on the amount of the special award, or on the medical and benefits cost of examinations payable in light of the other findings in this decision, they are to make submissions on the same within 30 days of this decision.

7. If the parties are unable to agree on the entitlement to, or quantum of, the expenses of this matter, the parties may make submissions in writing for determination of same within 30 days of this decision.

Footnotes

1 *The Statutory Accident Benefits Schedule - Effective September 1, 2010*, Ontario Regulation 34/10, as amended.

2 Joint Document Brief, Tab J 2, Property Damage File.

3 Joint Document Brief, Tab H 1, Medical Records from Hamilton Health Sciences, November 19, 2013, p. 10.

4 *Ibid*., p. 50.

5 *Ibid*., p. 18.

6 Joint Document Brief, Tab H 12, Medical Records from Work Fit Total Therapy Centre, Functional Abilities Evaluation Report, dated April 3, 2014, p. 18.

7 Joint Document Brief, Tab G 2.

8 Joint Document Brief, Tab H 3, Medical Records from Joseph Brant Hospital, p. 3.

9 Joint Document Brief, Tab H 18, Medical Records and Progress notes from Dr. Samim Hanna, p. 25 (copy of Hospital Discharge Summary).

10 Joint Document Brief, Tab H 2, Medial Records from St. Joseph's Healthcare, p. 15.

11 Joint Document Brief, Tab H 11, Medical Records from Stoney Creek Medical Walk-in Clinic, p. 16.

12 *Ibid*., p. 21.

13 Joint Document Brief, Tab H 8, Medical Records from Back On Track Chiropractic and Wellness Centre, p. 2.

14 Joint Document Brief, Tab H 8, Medical Records from Back On Track Chiropractic and Wellness Centre, p. 14.

15 Joint Document Brief, Tab H 1, Medical Records from Hamilton Health Sciences, p. 1.

16 Joint Document Brief, Tab E 14, p. 2.

17 Joint Document Brief, Tab H 8, Medical Records from Back On Track Chiropractic and Wellness Centre, p. 3.

18 Joint Document Brief, Tab F 8.

19 Joint Document Brief, Tab F 1.

20 Joint Document Brief, Tab H 8, Medical Records from Back On Track Chiropractic and Wellness Centre, at an unnumbered page at the end of that Tab.

21 Joint Document Brief, Tab H 12, Medical Records of Victoria Community Physical Rehab, pp. 32 and 36.

22 Written Submissions of the Applicant, p. 7, para 15.

23 Joint Document Brief, Tab H 9, Medical Records of Work Fit Total Therapy Centre, pp. 1, 2.

24 *Ibid*., p. 42.

25 Written Submissions of the Applicant, p. 7, para 15.

26 Joint Document Brief, Tab H 15, Medical Records from Lifemark Health, p. 60.

27 Joint Document Brief, Tab H 1, Medical Records from Hamilton Health Sciences, p. 67.

28 *Ibid.*, p. 68.

29 *Ibid*., p. 70.

30 *Ibid*., p. 72.

31 Joint Document Brief, Tab H 6, Medical Records of CPM Centres for Pain Management, p. 3.

32 Joint Document Brief, Tab H 17, p. 3.

33 Joint Document Brief, Tab H 17, p. 5.

34 Joint Document Brief, Tab H 20.

35 Joint Document Brief, Tab F 2.

36 Joint Document Brief, Tab F 2, p. 9.

37 Joint Document Brief, Tab F 2, p. 10.

38 Joint Document Brief, Tab F 3.

39 Joint Document Brief, Tab F 3, p. 3 of Report.

40 Joint Document Brief, Tab F 3, p. 6 of Report.

41 Joint Document Brief, Tab F 3, p. 8 of Report.

42 *Ibid*.

43 Application for the Determination of Catastrophic Impairment.

44 Joint Document Brief, Tab E 2, p. 5 of Dr. Sangha's assessment.

45 American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Ed. C. 2, p. 9.

46 Joint Document Brief, Tab E 2.

47 At pp. 4 and 5 of Dr. Davidson's Report.

48 Section 3(2)(f) of the *Schedule*.

49 *Ibid*.

50 Joint Document Brief, Tab E 3.

51 Joint Document Brief, Tab E 4.

52 Joint Document Brief, Tab E 5.

53 Joint Document Brief, Tab E 6.

54 Joint Document Brief, Tab E 8.

55 Joint Document Brief, Tab E 9.

56 Joint Document Brief, Tab E 10.

57 Joint Document Brief, Tab E 11.

58 Joint Document Brief, Tab E 12, starting at p. 36 of that Report.

59 Joint Document Brief, Tab E 13.

60 Joint Document Brief, Tab E 14.

61 See p. 57 of the Report.

62 Joint Document Brief, Tab E 15.

63 Joint Document Brief, Tab H 2, pp. 15-16.

64 Joint Document Brief, Tab F 9.

65 Joint Document Brief, Tab F 8.

66 Joint Document Brief, Tab H 1, Medical Records from Hamilton Health Sciences, p. 1.

67 Joint Document Brief, Tab F 2.

68 Joint Document Brief, Tab F 4.

69 See the attendant care assessments conducted at the request of the Insurer in October 2015 and September 2016, located at Tabs 6 and 9 respectively of the Joint Document Brief.

70 *Motor Vehicle Accident Claims Fund v. Barnes* [2017 CarswellOnt 5680 (F.S.C.O. App.)], FSCO Appeal P16-000087.

71 Joint Document Brief, Tab B 1.

72 Joint Document Brief, Tab B 2.

73 Joint Document Brief, Tab B 7.

74 See the Reports at Tab G of the Joint Document Brief.