Most Negative Treatment: Distinguished
Most Recent Distinguished: State Farm Mutual Automobile Insurance Co. and TD Home & Auto Insurance Co., Re | 2016 CarswellOnt 10231 | (Ont. Arb. (Ins. Act), May 18, 2016)

2008 CarswellOnt 7839
Ontario Superior Court of Justice

Lombard Canada Ltd. v. **Royal** & **SunAlliance** Insurance Co.

2008 CarswellOnt 7839, [2008] O.J. No. 5239, [2009] I.L.R. I-4779, 70 C.C.L.I. (4th) 190, 94 O.R. (3d) 62

Lombard Canada Limited (Applicant) Royal & SunAlliance Insurance Company and Motor Vehicle Accident Claims Fund (Respondents)

G.R. Strathy J.

Heard: November 27, 2008
Judgment: December 19, 2008 *
Docket: 07-CV-329882PD3

Proceedings: additional reasons at ***Lombard** Canada Ltd. v. **Royal & SunAlliance** Insurance Co.* (2009), 2009 CarswellOnt 406 (Ont. S.C.J.); affirmed ***Lombard** Canada Ltd. and **Royal** and **SunAlliance** Insurance Co., Re* (2007), 2007 CarswellOnt 11769 ((Ont. Arb. (Ins. Act)))

Counsel: Lee Samis, for Applicant
Derek Greenside, for Respondent, **Royal** & **SunAlliance**
Glenn Williams, for Respondent, Motor Vehicle Accident Claims Fund

Subject: Insurance; Civil Practice and Procedure; Corporate and Commercial; Public

Related Abridgment Classifications
For all relevant Canadian Abridgment Classifications refer to highest level of case via History.
Insurance

XII Automobile insurance
XII.5 No-fault benefits
XII.5.j Miscellaneous

Headnote

Insurance --- Automobile insurance — No-fault benefits — General principles

Insurer L Ltd. cancelled insured's motor vehicle insurance policy — Insured allowed friend to drive vehicle — Friend did not have his own coverage but he was covered under his employer's policy with insurer R Co. — Friend was seriously injured when vehicle left road — Friend submitted application for accident benefits to L Ltd. — Disputes Between Insurers Regulation obliged insurer who received first application for benefits to pay those benefits pending resolution of any coverage dispute with another insurer — L Ltd. rejected friend's application but failed to serve Motor Vehicle Accident Claims Fund with notice of dispute within 90 days as required by regulation — L Ltd. learned about R Co.'s coverage about nine months later — Arbitrator held L Ltd. had been obliged to pay benefits pending resolution of dispute and could no longer dispute coverage due to failure to serve notices of dispute within reasonable time — L Ltd. appealed — Appeal dismissed — Standard of review was correctness in light of parties

having agreed appeal was available on questions of law or mixed fact and law — Arbitrator correctly concluded L Ltd. was insurer for purposes of regulation even though it had properly cancelled policy with insured — Authority indicated first insurer to receive application for benefits was required to pay them if there was sufficient nexus between claimant and insurer — Statutory scheme of "pay first, arbitrate later if necessary" would be frustrated if insurers could dispute liability at outset — L Ltd. was obliged to serve notice of dispute on fund but failed to do so — Fund was entitled to expect L Ltd. to comply with regulation — Arbitrator correctly concluded no basis existed for extending 90-day period in respect of R Co., as L Ltd. had not investigated other coverage at outset — L Ltd.'s liability for friend's claim was not unjust result in this case.

Table of Authorities

Cases considered by *G.R. Strathy J.*:

Allstate Insurance Co. of Canada v. Brown (1998), 40 O.R. (3d) 610, 1998 CarswellOnt 2363, 110 O.A.C. 24, 7 C.C.L.I. (3d) 196 (Ont. Div. Ct.) — considered

Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund (2007), 42 M.V.R. (5th) 165, 45 C.C.L.I. (4th) 1, [2007] I.L.R. I-4577, 84 O.R. (3d) 401, (sub nom. *Allstate Insurance Co. of Canada v. Ontario (Motor Vehicle Accident Claims Fund)*) 277 D.L.R. (4th) 720, 2007 CarswellOnt 396, 2007 ONCA 61 (Ont. C.A.) — followed

Kingsway General Insurance Co. v. Ontario (Minister of Finance) (2007), 42 M.V.R. (5th) 179, 45 C.C.L.I. (4th) 32, [2007] I.L.R. I-4580, 84 O.R. (3d) 507, 277 D.L.R. (4th) 711, 2007 CarswellOnt 405, 2007 ONCA 62 (Ont. C.A.) — followed

Liberty Mutual Insurance Co. v. Commerce Insurance Co. (2001), 2001 CarswellOnt 4710, 36 C.C.L.I. (3d) 269, [2002] I.L.R. I-4049, [2002] I.L.R. 7366 (Ont. S.C.J.) — referred to

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New Brunswick (Board of Management) v. Dunsmuir (2008), 372 N.R. 1, 69 Admin. L.R. (4th) 1, 69 Imm. L.R. (3d) 1, (sub nom. *Dunsmuir v. New Brunswick*) [2008] 1 S.C.R. 190, 844 A.P.R. 1, (sub nom. *Dunsmuir v. New Brunswick*) 2008 C.L.L.C. 220-020, D.T.E. 2008T-223, 329 N.B.R. (2d) 1, (sub nom. *Dunsmuir v. New Brunswick*) 170 L.A.C. (4th) 1, (sub nom. *Dunsmuir v. New Brunswick*) 291 D.L.R. (4th) 577, 2008 CarswellNB 124, 2008 CarswellNB 125, 2008 SCC 9, 64 C.C.E.L. (3d) 1, (sub nom. *Dunsmuir v. New Brunswick*) 95 L.C.R. 65 (S.C.C.) — considered

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Pezim v. British Columbia (Superintendent of Brokers) (1994), (sub nom. *Pezim v. British Columbia (Securities Commission)*) 46 B.C.A.C. 1, (sub nom. *Pezim v. British Columbia (Securities Commission)*) 75 W.A.C. 1, 1994 CarswellBC 1242, 4 C.C.L.S. 117, [1994] 2 S.C.R. 557, 114 D.L.R. (4th) 385, (sub nom. *Pezim v. British Columbia (Securities Commission)*) 168 N.R. 321, [1994] 7 W.W.R. 1, 92 B.C.L.R. (2d) 145, 22 Admin. L.R. (2d) 1, 14 B.L.R. (2d) 217, 1994 CarswellBC 232, [1994] 24 B.C.S.C.W.S. 23 (S.C.C.) — considered

Pilot Insurance Co. v. ***Royal & SunAlliance*** *Insurance Co. of Canada* (2006), 34 C.C.L.I. (4th) 279, [2006] I.L.R. I-4501, 80 O.R. (3d) 308, 2006 CarswellOnt 1048 (Ont. S.C.J.) — referred to

Primmum Insurance Co. v. Aviva Insurance Co. of Canada (2005), 23 C.C.L.I. (4th) 131, 2005 CarswellOnt 1463 (Ont. S.C.J.) — referred to

Pushpanathan v. Canada (Minister of Employment & Immigration) (1998), 43 Imm. L.R. (2d) 117, 226 N.R. 201, (sub nom. *Pushpanathan v. Canada (Minister of Citizenship & Immigration)*) 160 D.L.R. (4th) 193, (sub nom. *Pushpanathan v. Canada (Minister of Citizenship & Immigration)*) [1998] 1 S.C.R. 982, 11 Admin. L.R. (3d) 1, 6 B.H.R.C. 387, [1999] I.N.L.R. 36, 1998 CarswellNat 830, 1998 CarswellNat 831 (S.C.C.) — referred to

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Statutes considered:

Arbitration Act, 1991, S.O. 1991, c. 17
Generally — referred to

s. 45(1) — referred to

s. 45(2) — referred to

s. 45(3) — referred to

Insurance Act, R.S.O. 1990, c. I.8
Generally — referred to

s. 268 — referred to

Regulations considered:

Insurance Act, R.S.O. 1990, c. I.8
Disputes Between Insurers, O. Reg. 283/95

Generally — referred to

s. 1 — referred to

s. 2 — considered

s. 3 — considered

s. 3(2) — considered

s. 3(2)(a) — referred to

s. 3(2)(b) — referred to

s. 7 — referred to

APPEAL by insurer from decision of arbitrator finding insurer liable for payment of accident benefits.

G.R. Strathy J.:

1 This is an appeal from an arbitrator's award holding that **Lombard** Canada Limited ("**Lombard**") was responsible for the payment of statutory accident benefits under a policy of insurance that it cancelled two months before the accident. The result is that an insurer that had no policy covering the injured party is permanently liable to pay hundreds of thousands of dollars of accident benefits. This appeal raises the questions of the applicable standard of review of the arbitrator's decision, the sufficiency of the "nexus" between **Lombard** and the injured party and whether **Lombard's** failure to give timely notice of the claim to the other insurer should preclude it from shifting the loss to that insurer. It also raises the issue of the consequences to be visited on an insurer that fails to discharge its obligations under the accident benefits scheme.

Background

2 Eric Shapwaykeesic (the "Claimant"), was injured in a single vehicle accident on October 11, 2002, while operating a vehicle owned by Paul Achneepineskum. The vehicle went off the road and hit a rock outcropping, resulting in catastrophic injuries to the Claimant.

3 The policy of insurance on the vehicle (the "Policy") had been cancelled by **Lombard** on August 14, 2002, two months before the accident. The Claimant was neither named nor listed in the Policy as an insured or a driver.

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Background

2 Eric Shapwaykeesic (the "Claimant"), was injured in a single vehicle accident on October 11, 2002, while operating a vehicle owned by Paul Achneepineskum. The vehicle went off the road and hit a rock outcropping, resulting in catastrophic injuries to the Claimant.

3 The policy of insurance on the vehicle (the "Policy") had been cancelled by **Lombard** on August 14, 2002, two months before the accident. The Claimant was neither named nor listed in the Policy as an insured or a driver.

4 The police report showed **Lombard** as the insurer and identified the Policy number. The Claimant submitted an application for accident benefits to **Lombard** in January, 2003, indicating on the application that he was not covered by any other insurance policy and that he was applying to the insurer of the vehicle in which he was riding at the time of the accident.

5 By letter dated January 10, 2003, **Lombard** advised the Claimant's counsel that the Policy was not in force at the time of the accident and took the position that it was not responsible for the payment of benefits. The Claimant's counsel then wrote to the Motor Vehicle Accident Claims Fund (the "Fund") asking it to respond to the claim. The Fund declined to do so, taking the position that **Lombard**, as the first insurer to receive a completed application, was responsible to pay benefits to the Claimant pending the resolution of the dispute between insurers.

6 **Lombard** maintained its position that it was not liable to pay accident benefits, with the result that the Claimant received no benefits at all for about fifteen months.

7 On October 16, 2003, after retaining an adjuster and making searches, **Lombard** learned that the Claimant was actually a listed driver under a policy issued to his employer by **Royal & SunAlliance** Insurance Company ("RSA"). **Lombard** immediately gave RSA written notice of its intention to dispute priority.

8 The matter proceeded to arbitration before M. Guy Jones (the "Arbitrator"), a respected and experienced arbitrator of accident benefits disputes. **Lombard** maintained that either the Fund or RSA was responsible to pay accident benefits. The Fund said that it was not responsible because either **Lombard** or RSA had a valid policy at the time of the accident. It also claimed that **Lombard** had failed to serve the Fund with a Notice of Dispute within the 90 day time requirement in subsection 3(2) of O. Reg. 283/95 (the "Regulation"). RSA acknowledged that it had a valid policy and that it would have been liable to pay accident benefits to the Claimant, but for **Lombard's** failure to comply with the 90 day notice provision.

9 In an award dated February 20, 2007, which I shall review in more detail, the Arbitrator held that there was a "sufficient nexus" between **Lombard** and the Claimant to trigger an obligation on **Lombard's** part to respond to the claim pending resolution of the priority dispute. Notwithstanding the termination of the Policy two months before the accident, the Arbitrator held that **Lombard** was the "first insurer" to receive the accident benefits application and was obliged to pay in the first instance.

10 The Arbitrator also held that **Lombard** was precluded from contesting priority because it had failed to give RSA written notice of its intention to dispute priority within 90 days of receipt of the application. The effect of this is that although RSA was admittedly responsible for accident benefits under the only valid policy covering the Claimant at the time of the accident, **Lombard**, which had no policy in effect at the time, was held permanently responsible for paying the Claimant's benefits.

The Statutory Accident Benefits Scheme

11 Since the introduction of the "no fault" insurance scheme in Ontario in 1990, a person injured in an automobile accident is entitled to compensation for a portion of their financial loss, regardless of fault. In most cases, compensation is available from the person's own insurance company or from the insurer of the vehicle in which they were an occupant, but section 268 of the *Insurance Act*, R.S.O. 1990, c. I.8 (the "Act") sets out a range of policies that may ultimately be available to provide compensation. Section 268 establishes a system of priorities as between insurers where the claimant does not have a policy of his or her own or where coverage may be available under more than one policy. There are many circumstances in which disputes can arise between insurers as to which policy or policies are required to respond to a claim.

12 The Regulation was designed to deal with the invidious situation that had developed after 1990 where an accident victim did not receive immediate benefits because the insurers involved could not agree which one of them was responsible. Section 2 of the Regulation requires that the first insurer to receive an application must adjust the claim and pay the benefits to the insured person pending resolution of the dispute between insurers. The first insurer cannot refuse to pay benefits because it thinks that the insured person is more appropriately covered by another policy.

13 The Regulation also provides that if the first insurer believes that another insurer is responsible for the claim, it must notify that insurer within 90 days of receiving the application for benefits. It must also notify the claimant. The "first" insurer continues paying benefits. The dispute between insurers is resolved through private arbitration under the *Arbitration Act 1991* S.O. 1991, c. 17. The arbitration must be commenced within one year of the date that the first insurer gave notice to the other insurer.

14 The effect of this system is that a claimant receives benefits in spite of the dispute between insurers. The seeming arbitrariness of making the first insurer initially responsible, despite the potential liability of another insurer, is compensated for by the system of notice and arbitration. The notice requirement allows the second insurer to investigate the claim, to decide whether to accept responsibility, and to take appropriate investigative and loss control measures.

The Regulation

15 The relevant provisions of the Regulation, which I have summarized above, are as follows:

> 1. All disputes as to which insurer is required to pay benefits under section 268 of the *Act* shall be settled in accordance with this Regulation.
>
> 2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the *Act*.
>
> 3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the *Act* unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.
>
> (2) An insurer may give notice after the 90-day period if,
>
> (a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable

under section 268 of the *Act*; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7.

...

7. (1) If the insurers cannot agree as to who is required to pay benefits or if the insured person disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the *Arbitration Act, 1991*.

(2) The insurer paying benefits under section 2, any other insurer against whom the obligation to pay benefits is claimed or the insured person who has given notice of an objection to a change in insurers under section 5 may initiate the arbitration but no arbitration may be initiated after one year from the time the insurer paying benefits under section 2 first gives notice under section 3.

The Arbitrator's Decision

16 The Arbitrator accepted that **Lombard's** policy was properly cancelled in August, 2002.

17 Flowing from this, **Lombard** argued that only an "insurer" is required by section 2 to respond to an application for accident benefits, and that it was not an "insurer" because it had no contract in effect with any insured person. Thus, it said, it had no liability to pay accident benefits under section 2. **Lombard** noted that the result of this submission was simply that the Claimant would have recourse to the Fund in the first instance.

18 The Arbitrator decided this issue against **Lombard**, referring to the decision of the Divisional Court in *Allstate Insurance Co. of Canada v. Brown* (1998), 40 O.R. (3d) 610 (Ont. Div. Ct.) in which the Court held that as long as there is a "sufficient nexus" between the claimant and the insurer, the insurer receiving the first application should pay benefits and then dispute its liability with either the other insurer or the Fund. The Arbitrator also referred to his own decision in *Her Majesty the Queen v.* ***Royal & SunAlliance*** *et al.* (January, 2003, unreported) in which he had followed the decision of the Divisional Court in *Allstate v. Brown* in the case of a policy that had been cancelled some four years prior to the accident. He concluded:

> In this case, as in that case, while I am sympathetic to the insurer's position when faced with a potentially cancelled policy, the fact remains that there is a sufficient Nexus and in accordance with section 2 of the regulation, the benefits should be paid. Regulation 283/95 was enacted to avoid situations where an injured party went without benefits while the insurers argued as to which insurance company was responsible. Insurers must realize that when they receive the first completed application for accident benefits, if there is any nexus at all they should pay the benefits and dispute it in accordance with Regulation 283/95

19 The Arbitrator then considered whether **Lombard** was required to comply with the 90 day notice provision of section 3 of the Regulation and, if so, whether the saving provision of subsection 3(2) applied.

20 **Lombard** submitted that the 90 day notice provision did not apply to claims by insurers against the Fund. The Arbitrator noted that since the argument of the case, the Court of Appeal had released its decisions in *Allstate Insurance Co.*

of Canada v. Motor Vehicle Accident Claims Fund (2007), 84 O.R. (3d) 401, 2007 ONCA 61 (Ont. C.A.) and *Kingsway General Insurance Co. v. Ontario (Minister of Finance)* (2007), 84 O.R. (3d) 507, 277 D.L.R. (4th) 711, 2007 ONCA 62 (Ont. C.A.) ("*Kingsway General v. Ontario*"), to the effect that the Fund is an insurer for the purposes of the Regulation. The Arbitrator held that **Lombard** had an obligation to give notice to both the Fund and to RSA.

21 The final question, then, was whether the "saving provision" of clause 3(2)(a) and (b) applied. In order to obtain relief, **Lombard** was required to show that 90 days was not a sufficient time to make the determination that another insurer was liable *and* that it had made reasonable investigations to determine if another insurer was liable during the 90 day period. **Lombard** argued that the time should be extended because in the application for benefits the Claimant had incorrectly stated that he was not covered under any other policy of insurance.

22 The Arbitrator found, however, that from a very early stage, **Lombard** had taken the position that it had cancelled the Policy and there was no reason why it could not have put the Fund on notice within 90 days. The Arbitrator agreed that the "innocent misrepresentation" of the Claimant might have been a good reason why 90 days was not a sufficient period to determine that another insurer was liable; however, he found that **Lombard** failed to meet the test contained in clause 3(2)(b) — it failed to show that it had made reasonable investigations within the 90 day period to determine whether another insurer was liable. He found that in the initial 90 days **Lombard** "did little, if anything, to determine if there was another insurer responsible for payment of accident benefits. Rather it concentrated its efforts on showing that its policy of insurance with Mr. Achneepineskum had been cancelled."

23 The Arbitrator found that **Lombard** had failed to conduct a reasonable investigation during the 90 day period or for a considerable time thereafter and he refused to invoke the saving provision. In the result, he held that **Lombard** was precluded from continuing the arbitration and that it was responsible for the payment of accident benefits to the Claimant.

The Issues

24 There are four issues:

(a) what is the appropriate standard of review to be applied to this appeal from an arbitrator in light of the decision of the Supreme Court of Canada in *New Brunswick (Board of Management) v. Dunsmuir*, [2008] 1 S.C.R. 190, 291 D.L.R. (4th) 577 (S.C.C.)?

(b) applying the appropriate standard, should the court interfere with the Arbitrator's conclusion that there was a "sufficient nexus" between **Lombard** and the Claimant to require **Lombard** to pay statutory accident benefits on receipt of the application?

(c) applying that standard, should the court interfere with the Arbitrator's conclusion that **Lombard** was required to comply with the notice provisions of section 3 of the Regulation and that the "saving provision" in subsection 3(2) was not applicable?

(d) applying that standard, should the court interfere with or vary the result of the Arbitrator's decision?

Discussion

First Issue: Standard of Review

25 The Regulation provides that disputes between insurers concerning payment of benefits are to be resolved through arbitration under the *Arbitration Act, 1991*. Section 45 of the *Arbitration Act 1991* provides, in part:

45. (1) If the arbitration agreement does not deal with appeals on questions of law, a party may appeal an award to

the court on a question of law with leave, which the court shall grant only if it is satisfied that,

(a) the importance to the parties of the matters at stake in the arbitration justifies an appeal; and

(b) determination of the question of law at issue will significantly affect the rights of the parties.

(2) If the arbitration agreement so provides, a party may appeal an award to the court on a question of law.

(3) If the arbitration agreement so provides, a party may appeal an award to the court on a question of fact or on a question of mixed fact and law.

26 In this case, the parties had agreed that there would be a right of appeal on a question of law or of mixed fact and law.

27 **Lombard** says that the standard of review is correctness, relying on *Liberty Mutual Insurance Co. v. Commerce Insurance Co.* (2001), 36 C.C.L.I. (3d) 269, [2002] I.L.R. I-4049 (Ont. S.C.J.). RSA and the Fund submit that the landscape has changed as a result of the decision of the Supreme Court of Canada in *New Brunswick (Board of Management) v. Dunsmuir*, above, which collapsed the standard of review into two categories, correctness and reasonableness. They submit that the reasonableness standard should apply.

28 Prior to *Dunsmuir*, the overwhelming weight of authority, in appeals from decisions from an arbitrator under the Regulation, has been in favour of a "correctness" standard. Most of the cases have relied upon *887574 Ontario Inc. v. Pizza Pizza Ltd.* (1995), 23 B.L.R. (2d) 259 (Ont. Gen. Div. [Commercial List]) and *National Ballet of Canada v. Glasco* (2000), 49 O.R. (3d) 230, 186 D.L.R. (4th) 347 (Ont. S.C.J.). In the former case, Mr. Justice MacPherson held that, in providing for a right of appeal from the decision of a privately-appointed arbitrator, the parties had intended that there be "a full and clean appeal on the merits." He noted the decision of the Supreme Court of Canada in *Pezim v. British Columbia (Superintendent of Brokers)*, [1994] 2 S.C.R. 557 (S.C.C.) in which Iacobucci J. had stated, at 590, that a correctness standard would generally apply to cases in which there is a statutory right of appeal which allows the reviewing court to substitute its opinion for that of the tribunal, where the tribunal has no greater expertise than the court on the issue in question. Mr. Justice MacPherson held that since the issue before the arbitrator was essentially the interpretation of a contractual document, a matter in which the court had equal capability, there was no reason to defer to the arbitrator's specialized expertise.

29 In the subsequent case of *National Ballet v. Glassco*, a case dealing with an appeal from an arbitrator appointed under the *Arbitration Act*, Madam Justice Swinton referred to the decision of the Supreme Court of Canada in *Pushpanathan v. Canada (Minister of Employment & Immigration)*, [1998] 1 S.C.R. 982, 160 D.L.R. (4th) 193 (S.C.C.). She summarized the factors to be considered, including, whether there was a privative clause, the expertise of the tribunal, the purpose of the legislation being applied and whether the review is with respect to a question of law or fact. In the case before her, the appeal was on a question of law only. She held that the standard of review in that case was correctness.

30 In statutory benefit appeals under the *Arbitration Act 1991*, the cases prior to *Dunsmuir* generally followed *Pizza Pizza* and *National Ballet*. That was the case in *Liberty Mutual Insurance Co. v. Commerce Insurance Co.*, above, relied upon by **Lombard**. See also, for example: *State Farm Mutual Automobile Insurance Co. v. Ontario (Minister of Finance)* (2001), 53 O.R. (3d) 436, [2001] O.J. No. 1115 (Ont. S.C.J.), aff'd., *State Farm Mutual Automobile Insurance Co. v. Ontario (Minister of Finance)* (2002), 58 O.R. (3d) 251, [2002] O.J. No. 528 (Ont. C.A.); *Primmum Insurance Co. v. Aviva Insurance Co. of Canada* (2005), 23 C.C.L.I. (4th) 131, [2005] O.J. No. 1477 (Ont. S.C.J.); *Liberty Mutual Insurance Co. v. Zurich Insurance Co.* (2007), 88 O.R. (3d) 629 (Ont. S.C.J.); *TD Home & Auto & Security National v. CAA (Ontario) Insurance*, [2007] O.J. No. 5562 (Ont. S.C.J.). The *Pizza Pizza* and *National Ballet* cases were also relied on by my colleague, D. A. Wilson, J. in *Zurich Insurance Co. v. Co-operators General Insurance Co.* (2008), 62 C.C.L.I. (4th) 207, [2008] O.J. No. 1694 (Ont. S.C.J.), a case decided after *Dunsmuir*. It is fair to say that it is generally accepted by counsel and the courts that appeals under the Regulation were subject to a correctness standard: see also *Pilot Insurance Co. v.* ***Royal & SunAlliance*** *Insurance Co. of Canada* (2006), 80 O.R. (3d) 308 (Ont. S.C.J.). This standard has been applied to cases involving issues under subsection 3(2) of the Regulation concerning sufficiency of time and the reasonableness of the insurer's investigation.

31 The only exceptions I have found are two judgments of Mr. Justice Pitt of this Court. In the first, *Ontario (Minister of Finance) v. Co-operators General Insurance Co.* (2002), 62 O.R. (3d) 755 (Ont. S.C.J.), Pitt J. suggested that a "clearly wrong" or "reasonableness *simpliciter*" test would apply to an arbitrator's determination of certain questions of mixed fact and law, such as whether an insurer had had reasonable time within which to make an investigation under subsection 3(2) of the Regulation.

32 In a subsequent case decided by Mr. Justice Pitt, after *Dunsmuir*, ***Lombard*** *Canada v. Kent & Essex Mutual Insurance Co.*, [2008] O.J. No. 4314 (Ont. S.C.J.), the issue was entirely factual - whether an insurer had properly cancelled its policy. Mr. Justice Pitt held that this was a question of fact and not subject to appeal, but, if not, was certainly a question of mixed fact and law. After citing the test in *Dunsmuir*, he concluded that the reasonableness standard was applicable to the issue before him.

33 In *Oxford Mutual Insurance Co. v. Co-operators* (2006), 83 O.R. (3d) 591, [2007] I.L.R. I-4564, [2006] O.J. No. 4518 (Ont. C.A.), the Court of Appeal dealt with an appeal from a motion judge's decision allowing an appeal from an arbitrator's decision that an accident victim was not "principally dependent" on his mother for care. The issue was determinative of which insurer would be liable for payment of his statutory accident benefits — his mother's insurer or the insurer of the car in which he had been an occupant.

34 Madam Justice Lang, who delivered the judgment of the Court of Appeal, held that the question of "principally dependent" was one of mixed fact and law and closer to a factual determination. The question was one of the application of the correct legal principles to the arbitrator's factual findings about the circumstances of the claimant's relationship with his mother. Justice Lang observed, at paragraph 23, "Given the special expertise of arbitrators in evaluating facts for a determination of dependency for statutory accident benefits entitlement, unless the arbitrator's decision was unreasonable, it was entitled to deference." She added, "In any event, in my view, the arbitrator's decision was also correct." In the introduction to her reasons, Madam Justice Lang stated, at paragraph 2, "Since the arbitrator's decision was based on reasonable factual findings and the application of correct legal principles, I would restore the arbitrator's decision."

35 In *Dunsmuir*, the Supreme Court of Canada collapsed the standard of review into two tests: reasonableness and correctness. The reasonableness standard recognizes that there is no "right" result in the case of many decisions made by administrative tribunals and it asks whether the decision is defensible in respect of the facts and the law. As the majority said, at paragraph 47:

> Reasonableness is a deferential standard animated by the principle that underlies the development of the two previous standards of reasonableness: certain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of appreciation within the range of acceptable and rational solutions. A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

36 On the other hand, in the application of the "correctness" standard, the court will determine whether the decision is correct. If not, the court will make its own decision.

37 The Supreme Court tells us in *Dunsmuir* that to determine the appropriate degree of deference, we should look first to whether the issue has been determined by the existing jurisprudence. If so, the inquiry need not go further. If there is no clear guidance in the existing case law, it is necessary to undertake a standard of review analysis, which is contextual and which looks to, among other things: (1) the presence or absence of a privative clause; (2) the purpose of the tribunal as determined by the interpretation of the enabling legislation; (3) the nature of the question at issue; and (4) the expertise of the tribunal. I will return in a moment to the existing case law.

38 The Regulation provides for the resolution of disputes pursuant to the *Arbitration Act 1991* and that statute leaves it to the parties to determine the scope of appeals, including whether there is to be an appeal on any or all of questions of fact,

questions of mixed fact and law or questions of law alone. Thus, the determination of the criteria for appeal in this case was purely consensual and excluded only appeals on questions of fact. In a sense, then, there was a consensual privative clause which confined appeals to questions of law or questions of mixed fact and law. The parties wished to foreclose appeals based on pure questions of fact.

39 The purpose of the arbitral tribunal is to provide an efficient, reliable and credible system for the resolution of disputes between insurers with the goal of ensuring that benefits are extended to claimants and that obligations between insurers are efficiently and appropriately adjusted.

40 The nature of the questions at issue were, at their highest, issues of mixed fact and law: the determination of whether there was a sufficient nexus to trigger the insurer's obligation under section 2 of the Regulation and whether the saving provision of subsection 3(2) would extend the notice period.

41 Finally, the expertise of the tribunal. Although the selection of the tribunal is left entirely to the private choice of the parties, and is not a creation of the Regulation, the reality is that the parties — automobile insurers — are highly sophisticated litigants, represented by specialist counsel, and they invariably select arbitrators who are themselves accomplished, experienced and respected.

42 Considering all these circumstances, there would be much to be said for a deferential standard of review that would look to the reasonableness of the arbitrator's decision, particularly on questions of mixed fact and law, such as those at issue here. For two reasons, I do not think that "reasonableness" is the appropriate standard in this case. First, in both the *Act* and the *Arbitration Act 1991*, the Legislature has left it to the parties to define their appeal rights. It is reasonable to conclude, as did Mr. Justice MacPherson in *Pizza Pizza*, above, that the parties intended that there would be a "full and clean appeal on the merits" when they stipulated that either party could appeal on a question of law or of mixed fact and law. Their intentions in that regard should be respected. Second, the long and generally consistent line of authority on these issues has applied the "correctness" standard applicable to appeals in private arbitrations. The parties are entitled to have the appeal heard according to the standard of review — correctness — that has almost universally been applied to cases of this nature.

43 I therefore proceed on the basis of a "correctness" standard.

Second Issue: Sufficient Nexus

44 As I have noted, **Lombard's** principal submission to the Arbitrator was that it was not an "insurer" within the meaning of section 2 of the Regulation, because it had cancelled its policy and there was no contract of insurance in effect. The Arbitrator rejected that submission, relying on the Divisional Court's decision in *Allstate Insurance Co. of Canada v. Brown*, above. In that case, the insurer had argued that its policy had expired four months earlier and on that basis had declined to pay statutory benefits. The arbitrator found that there was "enough of a connection between the parties" to generate an obligation on the part of the insurer to respond to the application. The majority of the Divisional Court agreed with the arbitrator's decision, concluding that there was a sufficient "nexus" between the insurer and the claimant to give rise to an obligation to make the payment. While Mr. Samis on behalf of **Lombard** submits that the Divisional Court's conclusion on this issue was *obiter*, in light of its ultimate finding that the application for judicial review was premature, it is persuasive logic in light of the scheme of the *Act* and the Regulation.

45 The issue was also considered by the Court of Appeal in *Kingsway General v. Ontario* above. That decision, together with the decision of the Court of Appeal released at the same time in *Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund*, above, held that the Fund is an insurer under the Regulation.

46 In *Kingsway General v. Ontario*, the insurer, Kingsway, had cancelled the policy two days before the accident for non-payment of premiums. There were insufficient funds in the insured's bank account to pay the premium. The Fund paid the benefits and sought reimbursement from Kingsway. The arbitrator found that there was a "significant nexus" between the insured and Kingsway and ordered that it pay the accident benefits permanently because of its breach of section 2 of the Regulation. The arbitrator had based his finding on "nexus" on the fact that the insurer had apparently miscalculated the amount of the premium owing and, had it been properly calculated, there would have been sufficient funds to pay the premium. On appeal from the arbitrator's decision, Dambrot J. found that the arbitration agreement between the parties did

not authorize the arbitrator to order Kingsway to pay benefits permanently for breach of section 2 and remitted the dispute to the arbitrator to determine whether Kingsway was an insurer.

47 The requisite "nexus" has been defined in different ways. In *Allstate v. Brown*, the Divisional Court spoke of a "sufficient nexus." In the case before me, the Arbitrator found that there was a "sufficient nexus" but suggested that "any nexus at all" should trigger the payment of benefits. In *Kingsway General v. Ontario*, Mr. Justice Laskin referred to the need for "some nexus" and suggested that the nexus would vary from case to case. Although he was inclined to the view that only in the extreme case of a "totally arbitrary" connection would a refusal be justified, he declined to be more precise.

48 In my view, the Arbitrator's decision on this issue was consistent with binding authority and was also consistent with the overall purpose of the Regulation. In *Kingsway General v. Ontario*, the Court of Appeal noted the purpose of the Regulation in providing timely benefits to accident victims and approved the "nexus" test. Laskin J.A., who delivered the judgment of the Court, stated at paragraphs 19 to 21:

> Section 2 of regulation 283 is critically important in the timely delivery of benefits to victims of car accidents. The principle that underlies section 2 is that the first insurer to receive an application for benefits must pay now and dispute later. The rationale for this principle is obvious: persons injured in car accidents should receive statutorily mandated benefits promptly; they should not be prejudiced by being caught in the middle of a dispute between insurers over who should pay, or as in this case, by an insurer's claim that no policy of insurance existed at the time.
>
> Insurers cannot avoid their obligation under section 2 by claiming that another insurer should pay or that an insurance policy was cancelled shortly before the accident. If they could deny an application for accident benefits on either of these grounds, section 2 would be rendered meaningless. Thus, arbitrators and the courts have developed a nexus test for triggering an insurer's obligation under section 2. As long as there is some nexus - some connection - between the insurer receiving an application for benefits and the insured, the insurer must pay pending the determination of its obligation to do so. In addition to the arbitrator's ruling in this case, see for example *Allstate Insurance Company of Canada v. Brown* (1998), 40 O.R. (3d) 610 (Div. Ct.); and *Ontario (Minister of Finance) v. **Royal** & Sun Alliance* (January 2003, Arbitrator M. Guy Jones).

49 Mr. Justice Laskin agreed with the arbitrator's conclusion that the purpose of the legislation would be undermined if an insurer could refuse to pay benefits simply because it decides that it is not an insurer, in spite of some connection between the insurer and the injured claimant.

50 The statutory scheme of "pay first, arbitrate later if necessary" would be frustrated if an insurer could dispute its liability at the outset, no matter how well-founded its dispute may ultimately prove to be. In this case, there was a delay of some 15 months in the payment of benefits as a result of the position taken by the insurer. In the meantime, the Claimant received no benefits. In my view, the Arbitrator's decision was correct.

Third Issue: Notice and Saving Provision

51 The third issue is whether the Arbitrator was wrong in finding that **Lombard** was required to comply with the notice provision of section 3 of the Regulation and that the "saving provision" of subsection 3(2) was not applicable. The Arbitrator referred to the recent decisions of the Court of Appeal in *Allstate v. MVACF* and *Kingsway General v. Ontario*, both of which have been referred to earlier, holding that the Fund is an insurer for the purposes of the Regulation. He therefore found that the 90 day notice provision applied and that **Lombard** did not give notice to either RSA or to the Fund within the 90 day period. Again, in my view, his decision was correct.

52 The question, then, is whether the Arbitrator erred in refusing to invoke the saving provision of subsection 3(2). In so doing, he precluded **Lombard** from continuing with the arbitration and it was obliged to pay accident benefits without recourse to RSA, which admittedly had a policy of insurance that would have provided benefits coverage to the Claimant.

53 The Arbitrator's reasons on this issue are set out at pages 8 to 10 of his decision. The Arbitrator pointed out that

because **Lombard** was taking the position that it was not an insurer, and had no liability, it essentially conducted no investigation of whether another insurer might be liable for benefits. Once it did undertake the investigation, some nine months after receiving notice of the claim, it took less than a week to identify the RSA policy. He therefore found that **Lombard's** failure to give notice to RSA was not saved by subsection 3(2).

54 In *Liberty Mutual Insurance Co. v. Zurich Insurance Co.* (2007), 88 O.R. (3d) 629 (Ont. S.C.J.) Mr. Justice Perell set out a very useful summary, at paras. 14 to 23, of the principles established in the judicial and arbitral case law surrounding subsection 3(2) of the Regulation. He extracted the following principles, which are set out without footnotes below:

> • subsection 3(2) is to operate strictly, because an insurer is entitled to know at an early stage that it will be managing and be responsible for the payment of benefits;
>
> • subsection 3(2) is designed to immediately engage the provision of benefits for the insured and to encourage the insurer who is providing the benefits to promptly exercise due diligence to make a determination whether another insurer should be responsible to pay;
>
> • it is desirable to interpret subsection 3(2) in such a way as to discourage insurers from issuing notices indiscriminately in the off chance that a priority insurer will be identified;
>
> • the insurer is required to make a reasonable investigation, but perfection is not required and there should be recognition that adjusters are extremely busy handling more than one complex matter at the same time;
>
> • the onus is on the party relying on the late notice provisions of subsection 3(2) to show that 90 days was not a sufficient time for the determination;
>
> • the inquiry is fact-specific and the circumstances of each case must be examined to determine whether 90 days was not a sufficient time for the determination;
>
> • if the insurer shows that it actually was impossible to make a determination within 90 days, then it will have satisfied the onus of showing that 90 days was not a sufficient time for a determination;
>
> • something less than proving that a determination was impossible within 90 days will suffice to satisfy the onus; and
>
> • an insurer seeking to deliver a notice after 90 days must show both that it exercised due diligence and also that there was something in all the circumstances that would justify requiring more than 90 days to make a determination about whether to issue a notice to a particular insurer.

55 In *Kingsway General v. Ontario*, above, the Court of Appeal dealt with the issue of whether an insurer was entitled to dispute its liability to pay accident benefits, having failed to give appropriate notice under subsection 3(2). Mr. Justice Sharpe, who gave the judgment of the Court, commented on the need for certainty in the application of the section and the absence of room for exceptions based on the equities of particular cases. He stated at paragraph 10:

> The Regulation sets out in precise and specific terms a scheme for resolving disputes between insurers. Insurers are entitled to assume and rely upon the requirement for compliance with those provisions. Insurers subject to this Regulation are sophisticated litigants who deal with these disputes on a daily basis. The scheme applies to a specific type of dispute involving a limited number of parties who find themselves regularly involved in disputes with each other. In this context, it seems to me that clarity and certainty of application are of primary concern. Insurers need to make appropriate decisions with respect to conducting investigations, establishing reserves and maintaining records. Given this regulatory setting, there is little room for creative interpretations or for carving out judicial exceptions designed to deal with the equities of particular cases.

56 In light of the language of the Regulation, the principles of interpretation set out in the foregoing authorities, and the

circumstances of this particular case, in which no effort was made by **Lombard** to investigate the existence of another insurer within the 90 day period, I agree with the decision of the Arbitrator.

Fourth Issue: The Consequences

57 The result of the Arbitrator's decision on the preceding issues was that **Lombard** was prevented from continuing with the arbitration. This meant that it was required to pay accident benefits indefinitely and without recourse to RSA, the "rightful" insurer.

58 **Lombard** submits that the result of the Arbitrator's decision is to punish it for its non-compliance with the Regulation and to give RSA a windfall. It says that there are other provisions of the *Act* that are designed to sanction infringements of the *Act* or its regulations. Counsel submits in his factum that, "The arbitrator's decision effectively sets a precedent whereby an insurer that breaches section 2 will become permanently responsible for paying the claimant's claims, regardless of the size of the claims, meaning in some cases the penalty would be nominal while in others it would be extraordinary."

59 In *Kingsway General v. Ontario*, the Court of Appeal remitted to the arbitrator the determination of whether Kingsway was an insurer at the time of the accident. If he found that it was not an insurer, the Court of Appeal said, at paragraph 24, that he could then consider the appropriate order in light of that finding. It continued, "His consideration should then include not only the effect of Kingsway's breach of section 2 of regulation 283, but as well the effect of Kingsway's failure to give timely notice of its intent to dispute its obligation to pay in accordance with section 3 of the regulation." By implication, the Court of Appeal did not conclude that the insurer's breach of section 2 would automatically give rise to an obligation to pay benefits indefinitely.

60 In the case before me, the Arbitrator did not directly address the effect of **Lombard's** breach of section 2 or the effect of the failure to give timely notice under section 3. He simply found that **Lombard** was foreclosed from continuing with the arbitration, with the consequence that it was obliged to permanently pay accident benefits. This was the same result as in *Kingsway General v. Ontario*, above, in which the Court of Appeal held that the insurer's failure to give proper notice under subsection 3(2) prevented the continuation of the arbitration. The Court of Appeal also agreed with the decision of the motions judge, Nordheimer J., that there was no general discretion in the Court to provide relief from forfeiture on equitable grounds.

61 In this case, the obvious consequence of **Lombard's** breach of section 2 was to leave the Claimant without benefits, at a time when those benefits were most needed, for a substantial time, a result that offends the very purpose of the legislation. The obvious effect of the failure to give prompt notice to RSA was to deprive that insurer of any opportunity to make timely investigation of the claim and to take appropriate and early claim management measures. While we have no specific evidence of the direct results of these breaches, it is a reasonable inference that it was highly prejudicial to the Claimant and caused at least some prejudice to RSA. Indeed, as **Lombard** did not take ownership of the claim, no insurer was taking steps, in the crucial early stages, to come to grips with, investigate and manage the claim.

62 In my view, there is much to be said for an inflexible rule that an insurer who fails to pay benefits and fails to put other insurers on notice on receipt of an application, with which there is some nexus, should be found permanently responsible for the claimant's benefits. This promotes compliance with the statutory scheme. It is no more inequitable than fixing permanent responsibility on the first insurer, who initially pays the claim but fails to give timely notice to the other insurer under subsection 3(2). It is not necessary, in this case, to decide whether the rule should be inflexible. It is sufficient to say that I agree with the Arbitrator's decision on the facts of this particular case.

63 Counsel for **Lombard** also submits that the Arbitrator erred in applying section 3 of the Regulation with respect to the Fund, based on *Allstate v. Brown*, because other decisions of the court have held that the decision does not apply retrospectively: see *Ontario (Minister of Finance) v. Pilot Insurance Co.* (2008), 60 C.C.L.I. (4th) 98, [2008] O.J. No. 860 (Ont. S.C.J.). He says that **Lombard** was therefore entitled to give notice to the Fund after the expiry of the 90 day period. He submits that the Fund was "culpable" in the matter in not paying benefits to the Claimant after **Lombard** failed to do so. It is well established that the Fund is an insurer of last resort: *Allstate Insurance Co. of Canada v. Motor Vehicle Accident Claims Fund*, above; *Young v. Ontario (Minister of Finance)* (2003), 68 O.R. (3d) 321, [2003] O.J. No. 4832 (Ont. C.A.). In my view, the Fund was entitled to look to **Lombard** to discharge its statutory obligations and **Lombard** was not entitled to

shift responsibility for the claim to the Fund.

Conclusion

64 The appeal is therefore dismissed. If counsel are unable to agree on costs, written submissions may be addressed to me within 15 days of this date. The submissions are to be no more than three pages in length, excluding the costs outline.

Appeal dismissed.

Footnotes

* Additional reasons at ***Lombard*** *Canada Ltd. v.* ***Royal*** *&* ***SunAlliance*** *Insurance Co.* (2009), 2009 CarswellOnt 406, 70 C.C.L.I. (4th) 209 (Ont. S.C.J.).