File No. A-001005

ONTARIO INSURANCE COMMISSION

BETWEEN:

LAWRENCE WHITNEY

Applicant

and

CO-OPERATORS GENERAL INSURANCE COMPANY

Insurer

DECISION

Issues:

The Applicant, Lawrence Whitney, was injured in an automobile accident on February 14, 1991 while riding his snowmobile. He applied for and received disability benefits and other benefits under an insurance policy issued by the Insurer. Every automobile policy includes the no-fault benefits set out in the No-Fault Benefits Schedule, Ontario Regulation R.R.O. 1990, Reg. 672, (the Schedule), enacted under the Insurance Act, R.S.O. 1990, c. I.8.

The issues in dispute in the arbitration are as follows:

1. Is the Applicant entitled to continuing disability benefits from July 23, 1992 and thereafter, under section 13 of the Schedule?

2. Is the Applicant entitled to a special award under section 282(10) of the Insurance Act?

3. Is the Applicant entitled to recover payments for care he received from his common-law spouse, Catherine Halls, under section 7 of the Schedule?

4. Is the Applicant entitled to additional benefits in respect of his dependant children under section 13(4) of the Schedule?

5. Is the Applicant entitled to recover the cost of certain goods and services, claimed to be required for the Applicant's treatment or rehabilitation, under section 6 of the Schedule?

The Applicant also claimed interest and his expenses incurred in participating in the arbitration.

At the hearing, a number of items in dispute were settled by the parties. These included a claim for interest and penalties against the Insurer for the period prior to July 23, 1992.

Decision:

The decision is:

1. The Applicant is not entitled to continuing disability benefits from July 23, 1992, under section 13 of the Schedule.

2. The Applicant is not entitled to a special award under section 282(10) of the Insurance

Act.

3. The Applicant is not entitled to payments for care he received from his common-law spouse, Catherine Halls, under section 7 of the Schedule.

4. The Applicant is not entitled to additional benefits in respect of his dependant children under section 13(4) of the Schedule.

5. The Applicant is entitled to recover the cost of transportation expenses incurred by Ms. Halls in consulting with Mitchell Hewson, a registered horticultural therapist, together with interest. The Applicant is not entitled to payment of other goods and services claimed under section 6 of the Schedule.

Hearing:

An arbitration hearing was held in North Bay, Ontario, on October 13, 14 and 15, 1992, and was continued in Huntsville, Ontario, on November 30, 1992, before me, Susan Naylor, Senior Arbitrator.

Present at the hearing were:

Applicant:	Lawrence Whitney
Applicant's Representative:	Ms. Catherine Halls

Insurer's Representative:	Stephen Malach Barrister and Solicitor

Witnesses:

The following persons gave sworn oral testimony at the hearing:

Lawrence Whitney, Applicant

Catherine Halls, Applicant's spouse

Fran Nault, Analyst, Northern Regional Ministry of Health

Paul Larmond, Private Investigator

Constable John Phillips, Burks Falls Police Division

Ron Devost, Eligibility Review Officer, Ministry of Community and Social Services

Mac Rettie, Income Maintenance Officer, Ministry of Community and Social Services

Arlene Jan Newstead, Insurance Broker

Constable John Newstead, Burks Falls Police Division

Dr. C. Kwiatkowski

Documents before the arbitrator:

The following documents were marked as exhibits at the hearing:

1. OHIP Summary for the Applicant, dated October 7, 1992

2. Records of Huntsville District Memorial Hospital with regards to the accident

3. Report of Dr. C. Kwiatkowski, dated March 18, 1992

4. "How to Manage" Manual for Families of Chronic Pain Patients, Dennis Todd, Ph.D., Editor

5. Videotape

6. Letter from Mr. Mac Rettie, Income Maintenance Supervisor, Ministry of Community and Social Services, dated September 28, 1992, (enclosing Medical Report Form 4 under the General Welfare Assistance Act, dated May 30, 1985, and Medical Summary, dated August 22, 1988)

7. Letter from Mr. Lawrence Whitney, dated May 21, 1992

8. List of claims for expenses incurred in respect to rehabilitation and invoices

9. Letter from Mitchell L. Hewson, Horticultural Therapist, enclosing articles relating to horticultural therapy

10. Invoice for dental expenses from Murdy Management & X-Ray Centre Inc., dated September 3, 1992

11. Application for Additional Accident Benefits (Form 2) and invoices

12. Letter from Dr. Deane A. Murdy, dated July 23, 1992

13. Letter from Mr. Wilfred C. Butler, Claims Representative, The Co-Operators, dated March 6, 1992

14. Letter from Mr. Michael Sheridan, President, Northern Rehabilitation & Consulting Services Inc., dated April 6, 1992

15. Report of Dr. M.P. Yadav, dated September 10, 1992

16. Report from Dr. C. Kwiatkowski, dated September 8, 1992, including his clinical notes

17. Report from Dr. C. Kwiatkowski, dated October 17, 1991

18. Consultation Report from Gamma Nuclear Medicine Imaging Services Inc., dated October 5, 1992

19. Letter from Mr. J.H. Pride, Director, Income Maintenance, Ministry of Community and Social Services, dated November 12, 1992

20. Medical Report in Form 4, from Dr. C. Kwiatkowski, dated March 25, 1992

Documents before the arbitrator, but not marked as exhibits:

Application for Appointment of an Arbitrator, dated April 15, 1992

Amended Response by Insurer, dated June 19, 1992

Amended Reply and attachments, dated June 26, 1992

Pre-hearing Letter, dated July 6, 1992

Second Pre-hearing Letter, dated July 30, 1992

Evidentiary Issues:

(a) Medical reports and medical testimony:

The Applicant filed a number of reports from his family physician, Dr. C. Kwiatkowski, and also called the doctor to testify at the hearing. Counsel for the Insurer objected to the admission of the medical reports in addition to having the doctor testify. He submitted that medical reports should only be filed in lieu of expert oral testimony. He cited in support the decision of the Ontario Court of Appeal in Ferraro v. Lee, (1974) 2 O.R.(2d) 214.

Ferraro concerned the scope of s. 52 of the Evidence Act, which provides that a medical report is admissible in an action, with leave of the court and on notice. The Court of Appeal held that, in the ordinary course, a party cannot both file a medical report and call the doctor. The court reasoned that, if the doctor was needed to explain his or her report, the report would be incomplete, and might mislead the trier of fact. It concluded that admission of the report in addition to viva voce testimony required the careful exercise of judicial discretion.

Pursuant to section 15 of the Statutory Powers Procedure Act, as restated in section 18 of the Dispute Resolution Practice Code, enacted under section 21 of the Insurance Act, an arbitrator is not bound by the strict rules of evidence that apply to court proceedings and has the discretion to admit evidence that would otherwise be inadmissible, for example on grounds of hearsay.

The establishment of a general principle that requires parties to elect whether to file a medical report or call the doctor to testify may inject a degree of formality into the arbitration system that impairs its objectives of simplicity and accessibility.

Section 18(2) and (3) of the Dispute Resolution Practice Code require parties to give notice of any intention to introduce expert evidence, and to disclose the nature and substance of such evidence. These provisions preclude surprise at the hearing.

The substance of an expert witness' testimony may be reflected in medical-legal reports that the expert has prepared at the request of a party, supplemented as necessary by any new or revised findings or opinion to which the expert will testify. Admission of the reports in circumstances in which the doctor is also called to testify avoids the necessity of preparing a duplicative summary of the evidence, and enables the parties and the arbitrator to be more fully informed of the previously expressed findings of the expert, upon which to evaluate the testimony. It also allows the parties to dispense with testimony that is set out in the report, and is not in dispute. Parties can and should be discouraged from calling expert witnesses to testify where the filing of a report is sufficient. This can be accomplished through the arbitrator's general discretion to control the proceedings, and through the power to award an applicant his or her expenses.

I find, therefore, that in the specific context of arbitration proceedings, an applicant may file a medical report in addition to calling the doctor to testify.

(b) Disclosure of medical reports, prepared under section 23(2) of the Schedule:

Prior to the arbitration hearing, the Applicant was required by the Insurer to undergo a medical examination by an orthopaedic specialist, Dr. Yadav, under section 23(2) of the Schedule.

The examination took place on September 10, 1992. Afterwards, Dr. Yadav prepared a report of his findings and recommendations, which he provided to the Insurer, and to the Applicant's family physician. However, the Insurer refused to produce a copy of the report to the Applicant and objected to its admission at the hearing on the grounds that the report was prepared in contemplation of adjudication, and was therefore privileged. The Applicant requested an order

for the disclosure of the report.

After hearing the submissions of both parties on October 14, 1992, I ruled that no privilege attached to the report, and that it must be disclosed to the Applicant. I held that adjudication was not the dominant or a substantial purpose for preparation of the report. Instead, it was prepared under statutory authority in furtherance of a first party insurer's right and, indeed, obligation to fairly assess an insured's ongoing medical condition in connection with a claim for periodic disability benefits. I further held that, in the circumstances of this case, any privilege had been waived. A copy of my oral reasons are attached as Appendix A to this decision.

Counsel for the Insurer sought judicial review of this order, and a stay of the order and arbitration hearing pending final determination of the application. A motion to stay the arbitration order and arbitration was heard by Judge S. D. Loukidelis, Regional Senior Justice, North East Region, on November 13, 1992. Judge Loukidelis dismissed the motion for a stay. His reasons are attached as Appendix B to this decision. The arbitration hearing was resumed on November 30, 1992, and the report of Dr. Yadav was marked as Exhibit 15 to this hearing.

Findings on the substantive issues:

1. Weekly benefits:

(a) The Regulations:

The Applicant claims weekly benefits under section 13 of the No-Fault Benefits Schedule. Section 13(1) provides as follows:

> (1) The insurer will pay with respect to each insured person who sustains physical, psychological or mental injury as a result of an accident, a weekly benefit during the period in which the insured person suffers substantial inability to perform the essential tasks in which he or she would normally engage if he or she meets the qualifications set out in subsection (2).

Under section 13(1), the onus is on an applicant to establish disability to the extent required. The Applicant must first establish the essential tasks in which he would normally engage. Second, he must establish that he suffers substantial inability to perform those essential tasks, as a result of the accident.

(b) The snowmobiling accident:

The Applicant was injured in a snowmobiling accident on February 14, 1991 when he was knocked off his snowmobile by a rope strung across the path. He went to the Emergency Department at Huntsville District Memorial Hospital on the following day, complaining of neck pain, nausea and headaches, and was discharged that day. He was given a neck collar and medication, and was told to take precautions for closed head injury. Some months later, on April 30, he went to see a family doctor, Dr. Kwiatkowski, who has been treating him since then.

The Applicant was paid weekly disability benefits until July 23, 1992. He claims that chronic neck and back pain have prevented him from resuming his normal and essential tasks since that time. He states that he continues to experience headaches, and that he is confused and has difficulty remembering things as a result of the accident. He claims that his ongoing pain, and subsequent problems resulting from the conduct of the Insurer, have resulted in depression and insomnia.

(c) The Applicant's essential tasks:

At the time of the accident, the Applicant was aged thirty-nine, and had not worked for many years. He was receiving a monthly allowance of $781.00 from the Ministry of Community and Social Services ("COMSOC") under the Family Benefits Act. The evidence indicates that the Applicant was granted the allowance because he was deemed to be permanently unemployable due to a combination of health reasons and social factors. The Applicant had a Grade 7 education and, according to his spouse's testimony, could not read or write.

COMSOC records, dated August 22, 1988, filed as Exhibit 6, indicate that the Applicant suffered from painful feet and a two or three year history of low back pain secondary to degenerative disc disease in his lumber spine. The Applicant acknowledged that, prior to the accident, he had problems with his hands and feet, and could not walk or stand for very long. He was also restricted in lifting objects and in bending.

There was no evidence that the Applicant experienced neck and upper back problems before the accident, nor was there any indication that the Applicant had been treated for depression or other psychological problems. Although the Applicant has complained of low back pain, this condition apparently pre-existed the accident and there is no medical evidence that his condition was aggravated by it. However, I accept the testimony of Dr. Kwiatkowski that the Applicant's problems, for the most part, have been in relation to his neck and upper back, rather than his lower back.

The Applicant has a common-law spouse, Catherine Halls, and three children by her, the youngest of whom was born after the accident. At the time of the accident, the Applicant was not living

with his family, apparently for reasons having to do with the family's eligibility for social assistance. He lived alone, some four or five miles away from his family, in a small cabin in a township north of Huntsville, Ontario.

The Applicant testified that he spent his time gardening, chopping wood, and fishing. He owned and maintained a motor boat and two or three canoes. He had a two-acre garden, and supplemented his income by growing vegetables and chopping his own wood. He snowmobiled in winter and drove an all-terrain vehicle in summer. He travelled frequently between his and his spouse's home by these means. Ms. Halls owned both vehicles, which he borrowed. Ms. Halls also owned a car that he drove. The Applicant testified that he took care of himself at the cabin, but kept in close contact with his family, playing with the children and helping with babysitting.

The Applicant's testimony as to his pre-accident activities was confirmed by the oral testimony of Ms. Halls.

I accept that these activities of the Applicant - taking care of his domestic and personal needs, occasional childcare, gardening, fishing, ice-fishing, maintaining his boats, chopping wood, and travelling by a variety of seasonal vehicles - represented the Applicant's essential and normal tasks before the accident.

(d) The effects of the accident:

(i) The medical evidence, and findings:

The Applicant's family doctor, Dr. Kwiatkowski, testified at the hearing. His clinical notes and records, and three reports were filed in evidence.

Dr. Kwiatkowski concluded that the Applicant had suffered from a musculotendinous whiplash injury from the snowmobile accident, resulting in chronic pain and depression. He has prescribed anti-inflammatory medication, and increasing dosages of an anti-depressant, amitriptyline (Elavil), for the Applicant's chronic pain and depression. On his recommendation, the Applicant went to physiotherapy in the summer of 1991; however, the Applicant stopped going because of transportation problems, and because the therapy did not help.

Dr. Kwiatkowski has been unable to find any objective physical etiology to explain the Applicant's continued chronic pain. However, he concluded that the Applicant would likely be left with a permanent disability, and reported on a standard Form 4, dated March 25, 1992, marked Exhibit 20:

> This patient cannot fish, hike, carry wood, ride on an A.T.V. or snowmobile 2d. to his back pain.

At the hearing, Dr. Kwiatkowski acknowledged that, in recording what functions the Applicant could and could not do, he was simply reporting what the Applicant told him. He also conceded that his findings of depression were based on the subjective reports of the Applicant. He agreed that a number of stressors could have contributed to the Applicant's depression, including the Applicant's financial difficulties, an assault charge, and problems in connection with his family benefits.

On September 10, 1992, the Applicant was examined by Dr. Yadav, an orthopaedic specialist, at the request of the Insurer. His report is marked Exhibit 15.

Dr. Yadav concluded that the Applicant was suffering from "subjective pain and disability" in regards to his soft-tissue injuries. He felt that psychiatric help would be more beneficial than treatment for physical injuries. He thought that the Applicant's associated psychosomatic problems and financial problems associated with anxiety neurosis likely prevented him from returning to his former activities, and that a psychiatric assessment was required before the degree of disability could be opined on.

I find that the Applicant continues to suffer from chronic pain in his neck and upper back, from headaches, and from depression and anxiety as a result of his unresolved pain. The Applicant's psychological status was markedly exacerbated by his financial concerns, and his difficulties with the police and COMSOC. However, I am satisfied that the effects of the accident triggered the Applicant's depression and anxiety, and that they continue to play a significant contributory role in the Applicant's psychological condition.

In order to qualify for continuing disability benefits, it must be established not merely that the Applicant's physical or psychological injuries related to the accident, but furthermore, that those injuries rendered the Applicant substantially unable to perform his essential tasks. To qualify for benefits under this test, it is not sufficient to show that Applicant has been prevented from returning to his full pre-accident level of activities, or that he suffers from some remaining limitations. As stated in Lily Steele and Zurich Insurance Company, O.I.C. File No. A-001024, dated December 3, 1992, at page 32:

> …it is not **some** inability to perform key tasks, but a **sizeable** inability which is

compensable.

The medical opinions of both Dr. Kwiatkowski and Dr. Yadav as to the Applicant's disability rely exclusively on the subjective reports of the Applicant. To that extent, those reports constitute little more than hearsay evidence, and present all the inherent problems of reliability that generally characterize such evidence. Because the reports reflect what the Applicant told the doctors he could and could not do, I chose to rely instead on the direct testimony of the Applicant.

(ii) The testimony of the Applicant and his spouse, and findings:

The Applicant testified that he could not do the tasks that he did before the accident - snowmobiling, gardening, maintaining his boats, fishing, and cutting wood. On cross-examination, however, he admitted that he performed most of these activities since the accident, but experienced pain and difficulty doing so.

The Applicant has gardened since the accident, although he has not been able to do so to the extent he would like, in part, because of his discomfort and in part because the garden at his present residence is smaller than at his cabin.

The Applicant acknowledged that he has painted his boats, and that he has used them to go fishing since the accident. He testified that painting caused him discomfort, which he reported afterwards to his family doctor. He testified that being in the boat made him uncomfortable, and he had

trouble loading and unloading the boat. However, it cannot be said that the Applicant is unable to maintain his boats or to use them, when the evidence is that he does so.

The Applicant has fished since the accident in both summer and winter. He estimated that he had been ice-fishing at least six times. In January 1992, he purchased a new diesel ice-auger, to make cutting the ice easier.

The Applicant acknowledged that he has continued to drive Ms. Halls' car since the accident and that he has driven an all-terrain vehicle. He testified that he was not able to drive a snowmobile, although it was not clear whether he had done so. His testimony was that he could drive a snowmobile if he was provided with a new model. There was no corroborative evidence that the Applicant's injuries prevented him from driving one model of snowmobile but not another.

The Applicant testified that he could not hike. However, given the Applicant's prior foot problems, there is no evidence that the Applicant hiked for any length of time before the accident.

The Applicant testified that he could not split wood because of his injuries. He said that he had made an effort to do so about seven months ago in preparation for the winter.

In my view, however, an inability to cut wood or ride a snowmobile does not represent substantial inability to perform essential tasks when these represent the only significant activities that the Applicant cannot do.

The evidence is that the Applicant is very dependent upon his spouse. Because the Applicant is functionally illiterate, Ms. Halls handles all his affairs, including communications with the

Insurer. Ms. Halls ensures that the Applicant takes his medication daily, and helps him use hot packs and the TENS machine. The Applicant depends on Ms. Halls to take him to medical appointments and to pick up his prescriptions. Ms. Halls testified that she has to force the Applicant to do things in order to structure his day. She stated that the Applicant suffers from memory lapses and is confused and depressed.

Ms. Halls' commitment to the Applicant's rehabilitation, and the care and support that she provides to him, are manifest. I recognize the vital importance of this caring environment to the Applicant. However, there is no evidence that the Applicant's depression or confusion prevent him from doing the above activities. I accept that the Applicant requires and receives the support and encouragement of Ms. Halls in order to be able to participate in activities; nonetheless, I find that the Applicant is able to do his essential tasks, with such support and encouragement.

The Applicant relied on Ms. Halls to take him to medical appointments, to pick up prescriptions, and to manage his affairs before the accident. The only change after the accident is in respect to the frequency of the activities. Moreover, the Applicant acknowledged that he could manage his own medication and equipment if he had to. He could also drive himself to appointments.

(iii) Decision:

I find therefore that the Applicant does not suffer from substantial inability to perform the essential tasks in which he would normally engage, either as a result of physical or psychological injuries sustained in the automobile accident. Therefore, I find that the Applicant is not entitled to benefits under section 13 of the No-Fault Benefits Schedule, for the period from July 23, 1992, when benefits were terminated, and thereafter.

I am satisfied that the Applicant continues to experience chronic pain, depression and anxiety as a consequence of the accident, and may require treatment for his psychological problems. Dr. Yadav is of the view that the Applicant requires a professional psychiatric assessment and that he may benefit from referral to a pain management program to help him cope with his pain. The Applicant is entitled to the cost of any such treatment as is needed.

The Applicant's entitlement to medical and rehabilitative treatment does not rest on a finding that the Applicant is entitled to benefits under section 13. As Arbitrator Palmer states in Surbir Singh Gaba and Allstate Insurance Company, A-000624, dated August 21, 1992:

> I stress that the test of eligibility under s. 6 and s. 12 [or 13] of the Schedule are completely different. There may well be occasions when insured persons will be entitled to supplementary medical and rehabilitation benefits, although they are not substantially unable to perform their essential tasks.. and thereby qualify for weekly income benefits.

I firmly adopt Ms. Palmer's views of the need for a co-operative partnership between the insured person, the insurer and treating health professional, in working towards the goal of rehabilitating the insured person to his or her pre-accident level of functioning.

Regrettably, the Insurer, through its counsel, has taken an adversarial and confrontational approach in these arbitration proceedings. It refused to provide the Applicant with a copy of Dr. Yadav's report or to advise the Applicant of Dr. Yadav's recommendations. It took no steps to ensure that the recommendation to pursue a psychiatric evaluation was followed. In so doing, the Insurer improperly placed defence of its case above the Applicant's right to effective and timely rehabilitation.

On this basis, I would have found that the Insurer acted unreasonably for the purpose of section 282(10) of the Insurance Act. However, since I find that no benefits are owing to the Applicant, I have no authority to make a special award under this section.

I would note that the Applicant was distressed and very bitter about his experience following the accident. He blamed the Insurer for the suspension of his family benefits, for his subsequent financial difficulties, and for assault charges that were brought against him and of which he was ultimately convicted. The Insurer, in turn, relied on these events to challenge the general credibility of the Applicant.

I heard a great deal of evidence from witnesses in relation to these events. In my view, that evidence is not germane to the issue before me - namely, whether the Insurer is required to pay ongoing no-fault benefits. In any event, the parties settled a claim by the Applicant for a special award and interest against the Insurer for the period prior to July 23, 1992.

2. Care benefits:

The Applicant claimed $3,000 per month for care-services provided by his spouse, Ms. Halls. Section 7(1) of the Schedule states:

> (1) The insurer will pay with respect to each insured person who sustains physical, psychological or mental injury as a result of an accident, for the care, if any, required by the insured person.
>
> (a) the reasonable cost of a professional care-giver or the amount of gross income reasonably lost by a person other than the insured person as a result of the accident in caring for the insured person;

and

(b) all reasonable expenses resulting from the accident in caring for the insured person after the accident.

Under section 7(2), the maximum monthly payment under section 7 is $3,000. In order to qualify for care benefits, the Applicant must establish that:

1. He required and received care from Ms. Halls as a result of the accident.

2. Ms. Halls lost income as a result of caring for the Applicant.

3. The amount claimed represents the gross income reasonably lost by Ms. Halls in caring for the Applicant.

Ms. Halls testified that she was disabled from employment for health reasons and was a homemaker in receipt of a mother's allowance under the Family Benefits Act. She acknowledged in her testimony that she had not lost any income from employment in caring for the Applicant, because she was not employed before the accident. Although she submitted that it could not be determined what future income she would lose as a result of caring for the Applicant, there was no evidence that Ms. Halls intended to obtain employment during any period prior to the hearing. However, it is Ms. Halls' position that she lost social benefits as a result of caring for the Applicant, because he was forced to move in with her.

Section 7(1) is designed to provide compensation to cover the cost of a professional caregiver, or to allow reasonable recompense where a person loses income in providing care required by an insured. The usual situation contemplated is where a person, customarily a spouse or other close relative, has to take time off work in order to nurse the insured. Care provided by relatives or

friends, for which no loss is incurred or payments made, is not compensable under section 7.

The wording of section 7(1) refers to "gross income" and is not limited to reimbursement of lost income from employment sources. The purpose of section 7 is to ensure that the insured can receive necessary care from a spouse or other relative, without fear of financial loss on either part. The wording of the section should be given a broad and liberal interpretation, that best accomplishes this purpose. I accept that proof of income lost from other sources in providing care is compensable under section 7.

While the Applicant's claim raises an interesting and novel question, the evidence before me does not establish, on the facts, that Ms. Halls suffered a loss of income as a result of caring for the Applicant.

The evidence is that, in this case, the Applicant and Ms. Halls structured their living arrangements in order to maintain their separate eligibility for family benefits. Because the Applicant moved in with her, Ms. Halls ceased to be assessed as a single claimant, but was assessed as part of a larger family unit that included the Applicant. Ms. Halls did not thereby lose eligibility for benefits. However, the income, expenses and needs of the family unit of which she is a member are considered collectively for the purpose of determining the benefits payable. It is impossible, on the basis of the meagre evidence before me, to establish that Ms. Halls suffered a loss of income solely by virtue of this change in status.

I find therefore that the Applicant is not entitled to payments under section 7 because it has not been established that Ms. Halls lost income in caring for the Applicant.

Child care benefits:

Very shortly before the accident in early February, Ms. Halls fell and broke her hip. She was nine months pregnant with their third child at the time. Subsequently (it is not clear when), the Applicant moved in with his family. The Applicant and his spouse testified that this was in order that they could provide mutual support to each other, to help each cope with the effects of the accidents. The Applicant testified that, because of his spouse's injuries, he had to assume primary responsibility for looking after the children. It was not argued that these additional child-care functions represented the Applicant's normal pre-accident tasks. However, the Applicant submitted that they entitled him to further no-fault benefits in respect of the children under section 13(4) of the Schedule. This section states:

> (4) The insurer will pay to an insured person who is receiving a weekly benefit under subsection (1), or who but for section 17 would be entitled to the weekly benefit, a benefit of $50 per week if Optional Benefit 3 has not been purchased, or $100 per week if it has been purchased, for each person who at the time of the accident was residing with the insured person and in respect of whom the insured person was the primary caregiver if the person receiving the care was less than sixteen years of age or if the person required the care because of physical or mental incapacity.

In order to establish entitlement to benefits under section 13(4), it must be established that the Applicant:

1. was residing with the child at the time of the accident.

2. was the primary caregiver of the child.

The Applicant testified that he was not residing with his children at the time of the accident, but lived in his own separate residence several miles away. Since it is not disputed that the Applicant was not residing with his children at the time of the accident, he cannot meet the requirements of section 13(4). Therefore, I find that the Applicant is not entitled to benefits in respect of his children under section 13(4).

Rehabilitation:

The Applicant claimed payment of certain goods and services under section 6(1)(f) of the No-Fault Benefits Schedule. The items claimed are listed in Exhibit 8. Certain of these claims were settled in the course of the hearing. The items remaining in dispute, together with their estimated or actual cost, including relevant taxes, are as follows:

1993 W50 Dodge Diesel Club Cab
- estimated cost: $28,929.05

992 ski-doo, Formula MXXTC-R, with heater and cover options, and 94 inch Tip Type Snowmobile HD Trailer
- estimated cost: $9,148

1992 Honda TRX 3000 4 by 4 trike
- estimated cost: $6,894.25

1991 B1750 H5JD Tractor, with loader, backhoe, bucket, snowblower, tiller and log splitter
- estimated cost: $39,794.00

Diesel 10 inch ice auger
- cost: $408.37

Two way communication device for a snow mobile helmet
- estimated cost: $169.95

Snow Suit
- cost: $235.39

Dental account for work performed on July 22, 1992 and September 3, 1992
- cost: $388.33 and $119, respectively (under section 6(1)(a))

Weight Scales
- estimated cost :$400

Ms. Halls' travelling expenses incurred in consulting with Mr. Mitchell L. Hewson, Registered Horticultural Therapist
- cost: $149.60

The applicable provisions of section 6 of the No-Fault Benefits Schedule state as follows:

> (1) The insurer will pay with respect to each insured person who sustains physical, psychological or mental injury as a result of an accident all reasonable expenses resulting from the accident within the benefit period set out in subsection (3) for,
>
> (f) other goods and services, whether medical or non-medical in nature, which the insured person requires because of the accident;

In Richard Mark Plows and Jevco Insurance Company, O.I.C. File Nos. A-000175 and A-000588, dated January 16, 1992, the arbitrator set out three criteria that must be met before an expense is recoverable under section 6(1)(f):

1. it must be a reasonable expense resulting from the accident.

2. it must be required because of the accident.

3. a medical practitioner must provide a signed statement that the expenses is necessary for the insured's treatment or rehabilitation, if the insurer so requires.

The Insurer requested a signed statement from the Applicant's treating physician that the items claimed were required for the Applicant's treatment or rehabilitation. The request is contained in a letter dated March 6, 1992, marked as Exhibit 13. The Applicant did not comply with the request, and the Insurer has never been provided with such a statement. I note that Dr. Kwiatkowski, the Applicant's family physician, testified at the hearing, but was not questioned about the necessity of the items claimed. The Applicant provided no excuse for failing to provide the statement required by the Insurer.

There was no medical evidence of any kind that the items claimed were required for the Applicant's treatment or rehabilitation. I have only the testimony of the Applicant and his spouse as to their requirements. In my view, this evidence is completely inadequate.

The Applicant submitted invoices for dental work. Dr. Murdy, who performed the dental work, wrote a letter, dated July 23, 1992, filed at Exhibit 12, which stated: "the treatment currently under way for (the Applicant) is not related to the automobile accident."
Since it is clear that the dental bills do not relate to treatment of injuries sustained in the automobile accident, I have no jurisdiction to order the Insurer to pay for such services.

The Applicant claimed the cost of a club cab truck, and an automatic trailer. The total cost of the vehicle was $28,429.05. At the hearing, the Applicant stated that the truck had been purchased in the name of Ms. Halls under a conditional sales agreement on September 9, 1992. The sales invoice was marked at Exhibit 8.

In Plows, the arbitrator considered whether the cost of a modified van was recoverable under section 6(1)(f). The Applicant had been rendered a paraplegic in an motorcycle accident. The arbitrator held that a modified van was required as a result of the accident. The Applicant had

extraordinary requirements for transportation as a result of his catastrophic injuries, and could no longer rely upon on his former means of transportation. Furthermore, there was extensive medical evidence as to the Applicant's needs for independent transportation from a psychological as well as physical dimension.

The Applicant testified that he required the vehicle for transportation to doctors' appointments, rehabilitation treatment and to pick up prescriptions. No medical evidence was filed in support of his claim. The Applicant has no special or extraordinary needs for transportation, due to his physical condition, and there was no reason given why he could not rely on his former means of transportation. I find that the vehicle is not required for the Applicant's treatment or rehabilitation. I further find that the expense claimed is unreasonable.

The Applicant also claimed the cost of a tractor with optional features, including loader, tiller, backhoe, bucket and log splitting feature, snowblower and lawnmower. The value of the package was $39,794.00. The Applicant submitted that the tractor and accessories were required to help restore the Applicant to his pre-accident level of gardening. Ms. Halls submitted an article by Mitchell L. Hewson, Registered Horticultural Therapist, at Exhibit 9, in support of the claim. The article endorsed the therapeutic benefits of horticulture.

The Applicant also claimed the cost of an all-terrain trike, a snowmobile, snowmobiling equipment and gas-powered ice auger for ice-fishing. The Applicant stated that these items were necessary to restore the Applicant to his pre-accident level of activities.

There was no evidence that the Applicant's condition warranted these unrealistic claims. The medical evidence in this case supports the need for professional psychological help, not physical

solutions to the Applicant's continuing complaints. I find that the items are not required for the Applicant's treatment or rehabilitation. I further find that the expenses claimed are unreasonable.

The Applicant requested a set of professional scales to weigh himself accurately, at an estimated cost of $400. Dr. Kwiatkowski had recommended that the Applicant lose weight in order to relieve his back pain. There was no evidence why the Applicant required a set of professional scales, appropriate for a doctor's office for the purpose.

I find that the professional set of scales is not required because of the accident, and is not a reasonable expense.

The Applicant also claimed the cost of travelling expenses incurred by Ms. Halls in visiting Mitchell L. Hewson, a registered horticultural therapist in Guelph, Ontario. Mr. Hewson endorses the use of horticultural activities as a medium to enhance and rehabilitate physical and emotional well-being. The Applicant filed articles on the benefits of horticultural therapy, written by Mr. Hewson, as Exhibit 9.

Ms. Halls testified that she consulted with Mr. Hewson in order to benefit the Applicant's rehabilitation through the use of gardening activities. The Applicant had not apparently benefited from the treatment he had received to that time. In exploring alternative means of rehabilitation treatment, Ms. Halls acted in good faith with a view to furthering the Applicant's rehabilitation through increased activity, as suggested by the Applicant's family physician. In the particular circumstances, I find that the Applicant is entitled to transportation expenses that Ms. Halls incurred in visiting Mr. Hewson, as a reasonable expense required for the Applicant's rehabilitation.

Expenses:

The Applicant is entitled to his reasonable expenses incurred in respect of the arbitration in accordance with section 282(11) of the Insurance Act, and Ontario Regulation R.R.O. 1990, Reg. 664.

Order:

1. The Applicant is not entitled to continuing disability benefits from July 23, 1992, under section 13 of the Schedule.

2. The Applicant is not entitled to a special award under section 282(10) of the Insurance Act on the basis that the Insurer has unreasonably withheld or delayed benefits.

3. The Applicant is not entitled to recover payments of $3,000 each month for care he received from Ms. Halls, under section 7 of the Schedule.

4. The Applicant is not entitled to additional benefits in respect to his dependant children under section 13(4) of the Schedule.

5. The Applicant is entitled to recover the cost of transportation expenses incurred by Ms. Halls in consulting with Mitchell Hewson, a registered horticultural therapist, together with interest. The Applicant is not entitled to payment of other goods and services claimed under section 6 of the Schedule.

March 31, 1993

Susan Naylor
Senior Arbitrator

Date