Court File No.: 40348

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO)

B E T W E E N:

UMMUGULSUM YATAR

Appellant

- and -

TD INSURANCE MELOCHE MONNEX
and LICENCE APPEAL TRIBUNAL

Respondents

FACTUM OF THE APPELLANT

FILED BY THE APPELLANT UMMUGULSUM YATAR
PURSUANT TO RULE 38 OF THE RULES OF THE SUPREME COURT OF CANADA

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I. OVERVIEW AND STATEMENT OF FACTS

A. Overview

1. This is an appeal from a decision of the Court of Appeal for Ontario that restricts the availability of judicial review of decisions that are subject to limited rights of appeal. The courts below disregarded this Court's recalibration of administrative law in *Canada (Minister of Citizenship and Immigration) v Vavilov* by creating an entirely new and excessively deferential standard of review.

2. In *Vavilov*, this Court recognized the need for a "more robust" form of review of the decisions of administrative tribunals than existed at the time, and recognized that it was necessary for tribunals to "develop and strengthen a culture of justification".[1]

3. The majority and concurring reasons in *Vavilov* could not have been more strongly divided about the appropriate solution, but both recognized there was a problem. The majority observed that the *status quo* was "sometimes perceived as advancing a two-tiered justice system, in which those [who are] subject to administrative decisions are entitled only to an outcome somewhere between 'good enough' and 'not quite wrong'." The concurring reasons recognized that concerns expressed about the quality of administrative decision-making by those intervenors who represented particularly vulnerable groups, "must be taken seriously".[2]

4. In fashioning a solution, the majority recognized that limited appeal rights (*e.g.*, on questions of law alone) are not always adequate to address unjust and indefensible decisions. For this reason, the majority held that judicial review remains available in order that decisions that may be free from legal error but are nevertheless unreasonable, in the sense that they are not "defensible in respect of *the facts* and law", may be challenged.[3] Some decisions may be "so at odds with the legal *and factual* context that they could never be supported by intelligible and

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[1] *Canada (Minister of Citizenship and Immigration) v Vavilov* 2019 SCC 65 at ¶¶2, 11 to 14, 72 and 143.

[2] *Vavilov, supra* at ¶¶11 *and* 283.

[3] *Dunsmuir v New Brunswick*, 2008 SCC 9 at ¶47, *and* see *Vavilov*, *supra* at ¶52.

rational reasoning".[4] As a result of the decisions below in this case, however, decisions that are factually indefensible are close to being immune from challenge by way of judicial review in Ontario, if the legislature has curtailed appeal rights.

5. The Court of Appeal held that judicial review is only sparingly available to a specified category of litigants. It did so by disregarding the statutory scheme, which expressly provides that judicial review is available and does not include any privative clause. The Court concluded that because of the discretionary nature of judicial review, it is only available in "rare" or "unusual" cases insofar as decisions by Ontario's License Appeal Tribunal dealing with statutory accident benefits are concerned. With respect, the Court's reasoning was nonsequitous, as explained below. It did not offer any guidance about what extraordinary attributes a case would require to justify judicial intervention.

6. The decision below is also irreconcilable with this Court's decision in *Smith v Co-operators General Insurance Co.*,[5] requiring that regulations concerning accident benefits be interpreted and applied in a manner that protects consumers. The Court below wrongly concluded that the LAT adjudicator's decision was reasonable and in doing so, eroded the standards mandated by this Court for injured persons pursuing statutory accident benefits.

B. Facts

7. The appellant was injured in a motor vehicle accident on February 7, 2010.[6] She was insured under an insurance policy issued by the respondent, TD Insurance Meloche Monnex, and sought benefits under the applicable Statutory Accident Benefits Schedule.[7] TD Insurance initially paid housekeeping, home maintenance and income replacement benefits.[8]

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[4] *Vavilov, supra* at ¶86 [Emphasis added].

[5] *Smith Co-operators General Insurance Co.*, 2002 SCC 30.

[6] *Yatar v TD Insurance Meloche Monnex*, 2022 ONCA 446 at ¶3 ["Court of Appeal"].

[7] O. Reg 403/96.

[8] Court of Appeal, *supra* at ¶4.

8. On January 7, 2011, the appellant received a letter from TD Insurance, indicating that her benefits had been stopped effective January 4, 2011, because it had not received an updated disability certificate form. The letter indicated that "no benefit is payable for the period after [January 4] and before the day the insurer receives the completed disability certificate".[9]

9. The letter also advised the appellant that because of her failure to provide a disability certificate form pursuant to an earlier request, she was required to be examined by health professionals chosen by the insurer. The letter contemplated that benefits might resume after the appellant submitted a completed form and attended for medical examinations, and in fact benefits did resume. The letter did not suggest that any final decision had been made about the appellant's entitlement to benefits. The Court of Appeal correctly determined that no final decision was communicated about income replacement benefits until September 2011, but did so by misreading the decision at first instance.[10]

10. After receiving the January 7, 2011 letter, the appellant attended two medical examinations conducted by the insurer's assessors for the purpose of determining her entitlement to further benefits. On February 16, 2011, the insurer wrote the appellant and advised that her income replacement benefits were being reinstated, but that her claim for housekeeping benefits was disallowed. The letter explained that these decisions were the result of the information obtained from the medical examinations. No dispute resolution form was attached to this letter. (The significance of which is explained below.) TD Insurance also advised the appellant that it would monitor her treatment and rehabilitation to assess her entitlement to benefits moving forward.[11]

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[9] Court of Appeal, *supra* at ¶5; Affidavit of Samiya Ahmad sworn November 9, 2018 ("Ahmad affidavit") at ¶¶5-6 and Exhibit 2, Appellant's Record, Tab 12.

[10] Court of Appeal, *supra* at ¶15; Preliminary hearing decision of the License Appeal Tribunal dated April 29, 2019 ("Preliminary hearing decision") at ¶15; Ahmad affidavit at ¶7 and Exhibit 3, Appellant's Record, Tab 2.

[11] Court of Appeal, *supra*, at ¶7; Reconsideration decision of the License Appeal Tribunal dated April 23, 2020 ("Reconsideration decision") at ¶¶8, 10, Appellant's Record, Tab 3.

11. On September 19, 2011, following a further medical examination, TD Insurance wrote to the appellant, denying her claim for income replacement benefits. No dispute resolution form was attached to this letter.[12]

12. The appellant subsequently applied for mediation at the Financial Services Commission of Ontario ("FSCO") on September 13, 2012, regarding the denial of income replacement, housekeeping and home maintenance benefits. The mediation began in June 2013 and concluded on January 14, 2014, during which time, if it had begun to run, the limitation period was tolled.[13]

13. In March 2018, the appellant commenced an application before the Licence Appeal Tribunal (LAT).

14. In a decision dated April 29, 2019, a LAT adjudicator held that the two-year limitation period began to run as of January 7, 2011, when the appellant received the letter temporarily ending her benefits. The adjudicator determined that a dispute resolution form was attached to this letter, with the result that it was a valid termination of benefits. He held that the limitation period was tolled while the parties mediated, and expired on April 14, 2014. Since the appellant did not commence her application until March 2018, the adjudicator held that the appellant's claim for income replacement, housekeeping and home maintenance benefits was statute-barred.[14]

15. The appellant requested a reconsideration of the adjudicator's decision, and on April 23, 2020, the same adjudicator confirmed his earlier decision. The adjudicator held that the insurer's letters dated February 16, 2011 (reinstating income replacement benefits, but terminating housekeeping benefits) and September 19, 2011 (terminating income replacement benefits) did not include dispute resolution forms, and hence were not valid denials of benefits. He maintained his finding that the insurer's January 7, 2011 letter (which only suspended benefits but did include

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[12] Court of Appeal, *supra* at ¶9; Reconsideration decision at ¶¶8, 10.

[13] Court of Appeal, *supra* at ¶10; Preliminary hearing decision at ¶21.

[14] Court of Appeal, *supra* at ¶15; Preliminary hearing decision at ¶¶26-27.

the dispute resolution form) was a valid denial of benefits, and that the appellant's application to the Tribunal was filed after the limitation period had expired.[15]

16. The statutory scheme contemplates both appeals from, and judicial review of, LAT decisions. Specifically:

a. the *License Appeal Tribunal Act, 1999* provides that an appeal from a LAT decision relating to a matter under the *Insurance Act* may be made on a question of law only;

b. the *Insurance Act* provides that no person may bring any proceeding in court with respect to a dispute concerning statutory accident benefits other than an appeal from the LAT "or an application for judicial review"; and

c. the *Judicial Review Procedure Act* provides that judicial review is available "despite any right of appeal".[16]

17. After her reconsideration request was dismissed, the appellant concurrently pursued an appeal to the Divisional Court from the adjudicator's decision, on an issue of law, and judicial review of the decision on the basis it was not reasonable.

C. Divisional Court

18. The Divisional Court dismissed the appellant's appeal, concluding the appellant had not shown an error of law with respect to the Tribunal's decision. The Court held that the LAT decision raised only questions of fact, or mixed fact and law.[17]

19. In considering the application for judicial review, the Divisional Court observed that judicial review is a discretionary remedy and from this, concluded that only in "exceptional

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[15] Court of Appeal, *supra* at ¶¶20-21; Reconsideration decision at ¶16.

[16] *License Appeal Tribunal Act, 1999*, S.O. 1999, c. 12, Sch. G, s. 11(6), *Insurance Act*, RSO 1990, c I 9, s. 280(3), *Judicial Review Procedure Act*, RSO 1990, c. J.1, s. 2(1).

[17] *Yatar v TD Insurance Meloche Monnex*, 2021 ONSC 2507 (Div. Ct.) at ¶¶3, 26-32 ["Div. Ct. Reasons"].

circumstances" will the court exercise its discretion to consider such an application where there is a statutory right of appeal from a decision of the LAT.[18]

20. The Divisional Court held that the statutory right of appeal on a question of law was an adequate alternative remedy with respect to an alleged error of mixed fact and law and concluded that judicial review of a SABS decision is therefore "only available, if at all, in exceptional circumstances". Finally, the Court held that there were no exceptional circumstances present and declined to consider the application.[19]

D. Court of Appeal

21. The appellant obtained leave to appeal to the Court of Appeal for Ontario from the dismissal of her application for judicial review. The appeal raised two issues:

a. Did the Divisional Court err in holding that judicial review of a LAT decision concerning accident benefits is available only in exceptional circumstances, if at all, where there is a right of appeal from the decision on a question of law; and

b. was the Tribunal's reconsideration decision reasonable?

22. Before the appeal was argued, the former Chief Justice of Ontario granted leave to the Income Security Advocacy Centre and the Advocacy Centre for Tenants Ontario to intervene as *amicus*, for the following reasons:

> The issue raised on the appeal – the scope of judicial review in the context of a statutory right of appeal – is an important question of law that has implications well beyond the immediate parties to the appeal. This case, therefore, is well along the continuum between constitutional litigation on the one end, and a purely private dispute at the other end. The implications of the decision to other statutory schemes make this the kind of case in which the court would benefit from the perspectives offered by interveners.[20]

The Attorney General for Ontario also intervened.

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[18] Div. Ct. Reasons, *supra*, at ¶4.

[19] Div. Ct. Reasons, *supra*, at ¶¶41-46.

[20] *Yatar v TD Insurance Meloche Monnex*, 2022 ONCA 173 at ¶15.

23. The appeal came before Lauwers, Nordheimer and Zarnett JJ. A. The appellant conceded that there was no error of law in the reconsideration request, and hence there had never been a tenable appeal. The determination by the LAT Adjudicator that there was a valid denial of benefits is a question of mixed fact and law.

24. The appellant argued that the Divisional Court erred in concluding that judicial review of LAT decisions concerning accident benefits is only available, if at all, in exceptional circumstances. The Court of Appeal acknowledged that the lower court's use of the phrase "exceptional circumstances" was "unfortunate"; however, it agreed with the substance of the Divisional Court's decision. It attempted to clarify the Divisional Court's decision by holding that it will only be proper for a court to exercise the discretionary remedy of judicial review in "unusual" or "rare" cases insofar as LAT decisions concerning accident benefits are concerned. The Court of Appeal did not explain the distinction between 'exceptional circumstances', and 'rare' or 'unusual' cases.[21]

25. The appellant also argued that the lower court's statement that judicial review might not be available "at all" betrayed a fundamental misunderstanding of the constitutional role of courts in overseeing administrative tribunals, and that this misunderstanding informed its conclusion to erect barriers around judicial review. The Court of Appeal agreed that the phrase "if at all" was also "unfortunate" but did not address the thrust of the appellant's argument. *Vavilov* mandates more robust judicial review, whereas the court at first instance appeared to believe that an absolute restriction on judicial review might be both possible and desirable.[22]

26. The Court of Appeal held that it was not unreasonable for the adjudicator to conclude in his reconsideration decision that the appellant's income replacement benefits were denied in the letter sent on September 19, 2011, and that the notice that was given on that date was effective

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[21] Court of Appeal, *supra* at ¶42.

[22] Court of Appeal, *supra* at ¶48; *Vavilov*, *supra*, ¶¶12, 13, 67, 72 and 138.

because the dispute resolution form had been attached to the January 7, 2011 letter that temporarily suspended benefits.[23]

27. The difficulty is that this is not what the adjudicator held. Rather, he held that he could not conclude that the second and third letters "were valid denials pursuant to s. 51 [of the *SABS*] and *Smith v Cooperators*".[24] The Court of Appeal did not address the appellant's argument that it is settled law following this Court's decision in *Smith v Co-operators* that a denial of benefits is ineffective unless it is accompanied contemporaneously with a dispute resolution form, and that this is an important form of consumer protection.[25]

II. ISSUES ON APPEAL

28. This appeal raises the following questions:

a. Did the Court of Appeal err when it concluded that the Legislature's decision to limit the right of appeal from LAT decisions to pure questions of law restricted the availability of judicial review of LAT decisions for errors of mixed fact and law or errors of fact to "rare" or "unusual" cases?

b. Did the Court of Appeal err in its application of *Smith v Co-operators*, in holding that the adjudicator's reconsideration decision (that the appellant had been provided with a valid denial of benefits triggering the beginning of the limitation period) was reasonable?

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[23] Court of Appeal, *supra* at ¶50.

[24] Reconsideration decision at ¶10.

[25] Court of Appeal, *supra* at ¶¶49-52, 58.

III. STATEMENT OF ARGUMENT

A. Dicey is No Longer the Problem

29. For the first half of the 20th century, courts of inherent and plenary jurisdiction throughout the common law world were hostile to administrative tribunals and afforded them little deference. In their concurring reasons in *Vavilov*, Justices Abella and Karakatsanis referred to the 19th century chauvinism of Albert Venn Dicey:

> Dicey developed his philosophy at the end of the 19th century to encourage the House of Lords to restrain the government from implementing ameliorative social and welfare reforms administered by new regulatory agencies. Famously, Dicey asserted that administrative law was anathema to the English legal system. … Because, in his view, only the judiciary had the authority to interpret law, there was no reason for a court to defer to legal interpretations proffered by administrative bodies, since their decisions did not constitute "law".[26]

30. In the 1970s, this characterization of the common law's historic disdain for administrative tribunals, as an attempt by courts to "restrain the implementation of ameliorative social and welfare reforms", found wide academic and, eventually, judicial acceptance. In Canada, matters changed decisively with this Court's decision in *CUPE Local 963 v New Brunswick Liquor Corporation*, which ushered in an era in which courts instructed themselves to show ever-increasing levels of deference to specialized administrative tribunals.[27] In the ensuing 40 years, this Court sought to fashion the appropriate standard for reviewing decisions of administrative tribunals. The common theme was the need for courts to show greater deference to tribunals.

31. Notably, however, by the time Mr. Vavilov's case reached this Court in 2018, the intervenors who made submissions on behalf of persons who benefit (or are supposed to benefit) from ameliorative social and welfare reforms, identified a need for greater accountability on the part of administrative tribunals. Both the majority and concurring reasons acknowledged the legitimacy of these submissions.[28] The intervenors in this case made similar submissions at the

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[26] *Vavilov*, *supra*, at ¶206

[27] *CUPE Local 963 v New Brunswick Liquor Corporation,* 1979 CanLII 23 (SCC)

[28] *Vavilov*, *supra*, at ¶¶11 *and* 283.

Court of Appeal, whereas the government and the respondent insurance company earnestly championed deference, as they will no doubt do on the present appeal.

32. The modern reality is that administrative tribunals have been vested with many more responsibilities than simply "implementing ameliorative social and welfare reforms". This reality gives rise to a need for greater accountability. For one thing, tribunals do not only implement ameliorative social benefits, they also deny them, as the LAT did in this case. The depiction of courts as retrogressive defenders of property rights, thwarting legislative attempts at social reform, is, with respect, out of date. Moreover, the delegation of decision making to tribunals has proliferated in the last 50 years, and they deal with countless issues of profound significance to people's lives as diverse as employment rights, housing, pay equity, police misconduct and involuntary medical treatment.

33. These tribunals are ordinarily staffed with adjudicators, appointed by the executive branch of government for fixed terms. The resulting lack of independence is a recipe for arbitrariness. While the justice system can tolerate a lack of independence on the part of decision makers, safeguards are required to address the associated risks.[29] In the case of administrative decision-makers, that safeguard is effective judicial review.

34. In the *Report of the Royal Commission on Civil Rights*, which ushered in modern administrative law in Ontario, Chief Justice McRuer expressed the view that appeals from the decisions of administrative tribunals should be widely available, noting that "the mere existence of a right of appeal has a strong disciplinary effect on tribunals of first instance".[30] The appellant submits that the converse is also true, and that institutionalized knowledge that reviewing courts will be highly forgiving, has led to laxity in some quarters.

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[29] *R. v Lippé*, 1990 CanLII 18 (SCC), [1991] 2 SCR 114, at pp. 132e and 144g

[30] Ontario, *Report of the Royal Commission Inquiry into Civil Rights*, (Toronto: Queen's Printer, 1968) at p. 233. Chief Justice McRuer used the term 'judicial review' in a much more constrained fashion than is presently the case.

35. Chief Justice McRuer's observation about the disciplinary effect of the simple prospect of being appealed foreshadowed by a half-century the majority's reasons in *Vavilov*, which recognized "the need to develop and strengthen a culture of justification in administrative decision-making" and to develop "a more robust form of reasonableness review" focussed on the reasons that tribunals provide to justify their decisions.[31] The Court recognized that as with mathematics tests, there is inherent value in requiring decision-makers to show their work.[32]

36. In *Vavilov*, all members of this Court agreed that the case marked a dramatic turning point. The concurring reasons go so far as to criticize the majority for flouting the principles of *stare decisis*. The majority acknowledged that it was departing from the Court's existing jurisprudence and explained that it was doing so because that jurisprudence was "flawed" and "unsound in principle".[33]

37. Rather than following the course charted by *Vavilov*, the decisions in the courts below turned it on its head. If a party to administrative proceedings has full appeal rights, as is common for doctors and lawyers for example,[34] he or she has no need to resort to judicial review. Doing so would be beyond redundancy: A party with appeal rights who invokes judicial review needlessly sets the bar higher than is required. In cases where a tribunal is dealing with potential life-altering issues and there are limited appeal rights, the need for a robust form of judicial review is more, rather than less important, as the Court of Appeal and Divisional Court would have it. As set out below, this argument is fortified by the statutory scheme in issue in this case.

38. The appellant submits that the majority reasons in *Vavilov* stand for the simple proposition that there is a continuum with a mid-point. At one end there is contempt for admirative decision-

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[31] *Vavilov*, *supra*, at ¶¶2 and 79

[32] *Vavilov*, *supra*, at ¶¶79-81

[33] *Vavilov, supra*, at ¶¶18-29, 229, 254-266

[34] See, *Legal Professions Act*, SBC 1998, c. 9, s. 48, *Health Professions Act*, RSA 2000, c. P-36, ss. 90 to 92, *Legal Professions Act*, SS 1990-91, c. L-10, s. 56, *Regulated Health Professions Act*, CCSM, c. R117, s. 132(1), *Code des Professions*, CQLR, c. C-26, ss. 164 and 175, *Legal Profession Act*, RSPEI 1998, C. L-61, s. 43.

makers. At the other, there is the near-abdication of the constitutional responsibility of the independent judiciary to superintend tribunals created and staffed by the executive branch of government. *Vavilov* goes no further than recognizing that the mid-point is holding administrative tribunals to a reasonable degree of account. The majority held that judicial review must become more robust for a simple purpose: Tribunals must enhance and adopt a culture of justification which is not universally present.[35]

B. Appeals and Judicial Review Co-Exist

39. The starting point for the issue before the Court is found in *Vavilov*, in which the majority made it clear that appeals and judicial review are distinct, and that the scope of one is not determinative of the scope of the other:

> [Where] where the legislature has provided for an appeal from an administrative decision to a court, a court hearing such an appeal is to apply appellate standards of review to the decision. This means that the applicable standard is to be determined with reference to the nature of the question and to this Court's jurisprudence on appellate standards of review.
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> ...
>
> Accepting that the legislature intends an appellate standard of review to be applied when it uses the word "appeal" also helps to explain why many statutes provide for both appeal and judicial review mechanisms in different contexts, thereby indicating two roles for reviewing courts.
>
> ...
>
> The existence of a limited right of appeal, such as a right of appeal on questions of law or a right of appeal with leave of a court, does not preclude a court from considering other aspects of a decision in a judicial review proceeding.
>
> ...
>
> [We] note that statutory appeal rights are often circumscribed, as their scope might be limited with reference to the types of questions on which a party may appeal (where, for example, appeals are limited to questions of law) or the types of decisions that may be appealed ... . However, the existence of a circumscribed right of appeal in a statutory scheme does not ***on its own*** preclude applications for judicial review of decisions ... . But any such application for judicial review is distinct from an appeal, and ***the presumption of reasonableness review that applies***

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[35] *Vavilov, supra*, at ¶72.

on judicial review cannot then be rebutted by reference to the statutory appeal mechanism.[36]

40. This is, however, precisely what the Court of Appeal did when it held that "it is inconsistent with the legislature's decision to limit the right of appeal to questions of law alone to then hold that the remedy of judicial review is all-encompassing".[37] There may be other legislative *indicia* that judicial review of LAT decisions concerning matters under the *Insurance Act* are to be precluded or severely restricted, but the Court of Appeal fell into error when it inferred this legislative intention from the circumscribed rights of appeal.

41. Rather than focusing on the statutory provisions limiting appeal rights, it would have been more apt for the Court of Appeal to have focused its attention on the two statutory provisions which confirm, without any limitation or qualification, that LAT decisions *are* subject to judicial review. As noted, the *Judicial Review Procedure Act* provides that judicial review is available "despite any right of appeal". The *Insurance Act* provides that no person may bring any proceeding in court with respect to a dispute concerning statutory accident benefits clause, other than an appeal from the LAT "or an application for judicial review".

42. That is, like the majority in *Vavilov*, the legislation expressly provided that appeals and applications for judicial review could co-exist. In enacting legislation to carry out this intention, the Legislature did not include provisions suggesting judicial review was only available in 'exceptional', 'rare' or 'unusual' cases. Indeed, there is no privative clause at all.

43. The Court below held that "nothing turns" on the statutory provisions confirming the availability of judicial review, did not comment on the absence of any privative clause, and instead relied on the limitation of appeal rights to conclude that judicial review is only available in rare or unusual cases, notwithstanding this Court's clear instruction that such limitations do not 'on their own' preclude judicial review.

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[36] *Vavilov*, *supra*, at ¶¶37 to 52 [Citations omitted, emphasis added].

[37] Court of Appeal, *supra* at ¶45.

C. Nature of Discretion Misapprehended

44. In particular, the Court of Appeal replicated the Divisional Court's error, and held that the discretionary nature of judicial review signalled a legislative intention to restrict its availability. There is nothing in the relevant legislation that implies any intention to restrict the availability of judicial review.

45. The court's jurisdiction to grant *certiorari* preceded the legislation, and prevails "wherever any body of persons having legal authority to determine questions affecting the rights of subjects" adjudicates those rights improperly.[38] This Court expanded upon this jurisdiction in *Martineau v. Matsqui Institution*, but the original authority over the adjudication of individual rights has remained at the core of the remedy. Far from purporting to restrict this constitutional responsibility of the court, the legislation codifies and endorses it.

46. There is no doubt that courts have the discretion to deny relief on an application for judicial review, or prerogative writs, where the application is premature,[39] where there is an adequate alternative remedy,[40] where the issues raised are moot,[41] where the applicant delays in bringing his or her application,[42] or where the applicant is guilty of misconduct such as fraud or perjury.[43]

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[38] *R v. Electricity Commissioners*, [1924] 1 KB 171 at p 205 cited in *Martineau v Matsqui Institution*, 1979 CanLII 184 (SCC), [1980] 1 SCR 602, at p. 617

[39] *Tran v Canada (Public Safety and Emergency Preparedness)*, 2017 SCC 50 (CanLII) at ¶22, *Ackerman v Ontario* Provincial *Police*, 2010 ONSC 910 (Div. Ct.) at ¶11

[40] *Harelkin v University of Regina*, 1979 CanLII 18 (SCC), [1979] 2 SCR 561 at p. 575, *Canadian Pacific Ltd. v Matsqui Indian Band*, 1995 CanLII 145 (SCC), [1992] S SCR 3 at ¶32-38

[41] *Murugamoorthy v Canada (Citizenship and Immigration)*, 2018 FC 650 (CanLII) at ¶13, *International Union of* Operating *Engineers, Local 793 v Aecon Group Inc.*, 2023 ONSC 586 (Div. Ct.)

[42] *Friends of the* Oldman *River v Canada*, 1992 CanLII 110 (SCC), [1992] 1 SCR 3 at p. 77

[43] *Homex Realty v Wyoming*, 1980 CanLII 55 (SCC), [1980] 2 SCR 1011 at pp. 1033 to 1037, *Cock v Labour* Relations *Board*, 1960 CanLII 293 (BCCA) at p. 129

47. In any context, however, a court's exercise of its discretion is necessarily idiosyncratic. Judicial discretion allows courts to fashion flexible responses to the specific circumstances of the cases that come before them. In the case of prerogative writs, the discretion derives from "the responsibility of the court ... to match the application of the extraordinary remedy [of the prerogative writ] to the circumstances of each case".[44] The fact that prerogative writs are discretionary cannot correctly form the basis of a rule of universal application, namely that judicial review of "a LAT SABS decision is only available, if at all, exceptional circumstances" (Divisional Court), or that "it will only be a rare case where the remedy of judicial review" is available with respect to such decisions (Court of Appeal).[45]

48. In *Myers v Canada (National Parole Board)*, discretionary relief was denied to a prisoner who sought to judicially review a decision denying parole, after he escaped and remained illegally at large.[46] The case could not be properly cited for the proposition that the discretionary nature of judicial review signalled a legislative intention that judicial review of the Parole Board is only available, if at all, in exceptional circumstances. The discretionary nature of the remedy informed the treatment of the case before the Court, not the interpretation of the *Parole Act*.

49. Moreover, in the context of prerogative writs, this Court has held:

> The discretion to withhold remedies against unlawful actions may make inroads upon the rule of law, and must therefore be exercised with the greatest care. In any normal case, the remedy accompanies the right.[47]

50. Rather than exercising discretion about the case that was before them with great care, both courts below created a broad rule of general application to erect a barrier for all litigants, by concluding that a right of appeal on a question of law was an adequate alternative remedy to address a purported error of fact, or mixed fact and law. Similarly, the contention that the right to

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[44] *Homex Realty v* Wyoming, *supra*, at p. 1036

[45] Div. Ct. Reasons at ¶46, Court of Appeal, *supra*, at ¶47.

[46] *Myers v Canada (National Parole* Board*)*, 1981 CanLII 4636 (FCA)

[47] *Homex Realty v Wyoming*, *supra*, at p. 1035

request reconsideration by the original adjudicator is an adequate alternative remedy to address errors in the reconsideration decision, is untenable.

51. Professor Paul Daly correctly predicted that "those who have come of (judicial) age post-*CUPE v NB Liquor Corporation* may continue to incline towards deference".[48] The reasons in the Court of Appeal allude to the need for courts to respect legislative decisions, but in addition to disregarding the statutory provisions that confirm that judicial review *was* available in this case, the reasons ignore the fact that the reasonableness standard of review, as recast in *Vavilov*, inherently incorporates an appropriate level of curial deference.[49]

D. Correct Application of *Vavilov*

52. Even before *Vavilov*, courts recognized that a right to appeal on a question of law is not an adequate remedy if a litigant seeks judicial review of a question of fact, or a question of mixed fact and law, and recognized that the two remedies are complimentary. It is not the case that any right of appeal, however narrow, precludes judicial review of issues for which no appeal is available.[50]

53. Similarly, since *Vavilov* was handed down, courts have not encountered difficulty in dealing with appeals on issues of law being joined with applications for judicial review of issues of fact, or mixed fact and law.

54. In *Ewanek v City of Winnipeg*, an administrative decision was subject to appeal on a question of law. The appellant sought to appeal and also sought to judicially review a finding of fact. The Court of Queen's Bench held that errors other than errors of law remained amenable to review:

> The appeal provision here ... establishes the appellant's right of appeal on a question of law. This is a limited right of appeal requiring that the appellant establish that

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[48] Daly, Paul, "The Vavilov Framework and the Future of Canadian Administrative Law", 2020 CanLIIDocs 3620.

[49] *Vavilov*, *supra*, at ¶33.

[50] *St. Albert Housing Society v St Albert (City)*, 2014 ABQB 556 at ¶39, *Habtenkiel v Canada (Citizenship and Immigration)*, 2014 FCA 180 at ¶35

> his appeal involves a question of law. Where the issue is question of law, the statutory right of appeal is engaged, and the standard of correctness applies.
>
> However, the Supreme Court of Canada in *Vavilov* at para. 45 also states: "The existence of a limited right of appeal, such as a right of appeal on questions of law or a right of appeal with leave of a court, does not preclude a court from considering other aspects of a decision in a judicial review proceeding." ...[51]

In the result, the Court concluded that the decision under review was both legally correct and factually reasonable.[52]

55. Similarly, in *Neptune Wellness Solutions v Canada Border Services' Agency*, the Federal Court of Appeal held that there could be judicial review of questions of fact or mixed fact and law, where the statutory scheme provided for appeals only on questions of law.[53]

56. In *Zarroben v Workers' Compensation Board*, the Court of Queen's Bench of Alberta arrived at the same conclusion. The Court concluded that the matter before it could proceed both as a statutory appeal on a question of law and as a judicial review on other questions. The right of appeal did not preclude judicial review of those aspects of the decision in question that did not fall within the appeal provisions. In the result, the Court held that the decision, while not tainted by legal error, was unreasonable, as it "lacked rationality internal to the reasoning process". It was based on insufficient evidence, had unresolved contradictions from a key witness, and placed undue reliance on other evidence.[54]

57. The Court of Appeal of Alberta dismissed an appeal from that decision, noting but not commenting on the fact that an application for judicial review had been joined with an appeal, and two standards of review applied.[55]

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[51] *Ewanek v City of Winnipeg*, 2020 MBQB 98 at ¶¶28-*29* ["*Ewanek*"].

[52] *Ewanek* , *supra*, at ¶¶25-32.

[53] *Neptune Wellness Solutions v Canada Border Services' Agency*, 2020 FCA 151.

[54] *Zarroben v Workers' Compensation Board*, 2021 ABQB 232.

[55] *Zarroben v Workers' Compensation Board*, 2022 ABCA 50.

58. *Zarroben* was followed in *Wongkingsri v Alberta (Appeals Commission for Alberta Workers' Compensation*), in which the court held that the circumscribed right to appeal on a question of law "does not encompass all claims of error". This did not mean, however, "these types of claimed errors are insulated from review". They could be addressed by way of judicial review, for which the presumptive standard of review would be reasonableness.[56]

59. In *Simmons v Royal Newfoundland Constabulary Public Complaints Commission*, the Supreme Court of Newfoundland and Labrador permitted judicial review of a decision that did not fall within the scope of orders that were subject to appeal. Relying on *Vavilov*, the Court concluded "that although the ... decision does not, in itself, engage the statutory appeal mechanism under the ... Act, [it] can still be judicially reviewed".[57]

60. The most comprehensive treatment of the issue is found in the Federal Court of Appeal decision in *Canada (Attorney General) v Best Buy Canada Inc.* The majority held that where there was an appeal as of right on questions of law, judicial review remained available. Gleason J.A. (LeBlanc J.A. concurring) reviewed the history of judicial review and observed that this Court has consistently endorsed curial intervention with respect to serious factual errors. She noted that when the reasonableness standard of review was reformulated in *Dunsmuir v New Brunswick*[58] it required that the decisions of administrative tribunals be defensible in respect of both the facts and the law, and observed that if (as *Vavilov* requires) a decision must include an analysis tying the evidence before the tribunal to its decision, a review for reasonableness "clearly ... contemplates [consideration] of a decision-maker's treatment of factual issues".[59]

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[56] *Wongkingsri v Alberta (Appeals Commission for Alberta Workers' Compensation*), 2022 ABQB 545.

[57] *Simmons v Royal Newfoundland Constabulary Public Complaints Commission*, 2022 NLSC 27.

[58] *Dunsmuir v New Brunswick,* 2008 SCC 9 at ¶47.

[59] *Canada (Attorney General) v Best Buy Canada Ltd.*, 2021 FCA 161 at ¶22-29

61. Gleason J.A. also noted that this principle was explicitly endorsed by this Court, in the following passage in *Vavilov*:[60]

> It is trite law that the decision maker may assess and evaluate the evidence before it and that, absent exceptional circumstances, a reviewing court will not interfere with its factual findings. ...
>
> That being said, a reasonable decision is one that is justified in light of the facts: *Dunsmuir*, at para. 47. ... The reasonableness of a decision may be jeopardized where the decision maker has fundamentally misapprehended or failed to account for the evidence before it.[61]

62. Gleason J.A. quoted at length and with approval from an academic article, in which Professor Daly argued that the reasonableness standard of review articulated in *Vavilov* corresponds to the constitutional duty of courts to judicially review administrative tribunals. He highlighted the need for a reasonableness review beyond limited rights of appeal:

> For example, the harsh consequences a decision visits upon an individual as a matter of fact - perhaps leaving them homeless - would probably not fall within a limited appeal clause; this would be problematic, as it would limit the courts' ability to police the boundaries of administrative decision-makers' authority and ensure that exercises of state power are publicly justified ... .[62]

E. The Law is Unsettled

63. The decision under appeal does not stand alone. In *Best Buy Canada Ltd.,* Near J.A. delivered concurring reasons in which he disagreed with Gleason and LeBlanc JJ. A's conclusion about the availability of judicial review in cases where there are limited appeal rights. In *Democracy Watch v Canada (Attorney General)*, Stratas J.A. referred to a "serious conflict" in the jurisprudence of the Federal Court of Appeal.[63]

64. Similarly, in *Smith v Appeal Commission*, Rempel J. of the Manitoba Court of Queen's Bench, came to the opposite conclusion than that of his colleague in *Ewanek v City of Winnipeg*.

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[60] *Best Buy Canada Ltd.*, *supra*, at ¶¶77-106.

[61] *Vavilov*, *supra*, at ¶¶125-126.

[62] *Best Buy Canada*, *supra*, at ¶118

[63] *Democracy Watch v Canada (Attorney General)*, 2023 FCA 39 at ¶5.

His Honour held that a litigant who did not complain of an error of law, but who sought to judicially review a tribunal on the basis that its findings of fact were unreasonable, "was deliberately turning her back on the explicit terms of the appeal mechanism circumscribed by the Act".[64] Further, the reasoning of the Divisional Court in the case at Bar, now endorsed by the Court of Appeal for Ontario, has taken hold in Ontario.[65]

F. Need for Consumer Protection

65. In *Smith v Co-operators General Insurance Co.*, the Court of Appeal for Ontario addressed s. 71 of the Statutory Accident Benefits Schedule which at the time provided as follows:

> If an insurer refuses to pay a benefit that a person has applied for under this Regulation or reduces the amount of a benefit that a person received under this Regulation, the insurer shall inform the person in writing of the procedure for resolving disputes relating to benefits under ... the *Insurance Act*.

66. The Court held that the limitation period for commencing proceedings to claim statutory accident benefits begins to run when, among other things, the insurer has complied with this regulatory obligation. The Court characterized the requirement to provide written notice of the dispute resolution mechanism as consumer protection legislation and held that:

> In view of the nature of the required information, and in order to be meaningful, the insurer must give it at the same time benefits are refused or reduced. [66]

67. Justices Catzman and Sharpe held that on the facts of the case, the insurer had complied with its obligations more than two years before the claimant sued the insurer, and that her action was therefore statute barred. Justice Borins dissented on the issue of the adequacy of the notice and this Court granted leave to appeal.

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[64] *Smith v Appeal Commission*, 2021 MBQB 149 at ¶19

[65] *Tipping v Coseco Insurance Company*, 2021 ONSC 5295, *Peel Standard Condominium Corporation No. 779 v Rahman*, 2021 ONSC 7113 (Div. Ct.); *Friends of Simcoe Forests Inc. v Minister of Municipal Affairs and Housing*, 2021 ONSC 3813, *Ladouceur v Intact Insurance Company*, 2022 ONSC 5206 (Div. Ct.).

[66] *Smith v Co-operators General Insurance Co.*, 2000 CanLII 7138 (ON CA) at ¶9.

68. The appeal was allowed. Justice Gonthier wrote for the majority and held that the majority in the Court of Appeal had erred in concluding that the insurer had adequately fulfilled its obligation to advise its insured of the dispute resolution mechanism when it denied benefits.[67]

69. Justice Gonthier held as follows:

> There is no dispute that one of the main objectives of insurance law is consumer protection, particularly in the field of automobile and home insurance. ... In *Insurance Law in Canada* (looseleaf ed.) Vol. 1, Professor Craig Brown observed: "In one way or another, much of insurance law has as an objective of the protection of customers". I note in this vein s. 297(2) of the *Insurance Act* which provides that any restriction on a party's right to mediate, arbitrate, litigate or appeal is void except as provided in the regulations. True to that purpose of consumer protection, no refusal under s. 71 of the SABS can be said to have been given by insurer if there has not been adequate compliance with [the requirement to inform the insured in writing of the procedure for resolving disputes].[68]

70. With this in mind, he adopted the reasoning of Justice Borins, and held that the notice also had to include additional information presented in "straightforward and clear language, directed towards an unsophisticated person", including, *inter alia*, the relevant time limits that govern the entire process. As this information about time limits was missing from the notice that was provided, there was no valid denial of benefits, and the limitation period never began to run.[69]

71. There was evidence that the claimant had been informed of the limitation period subsequent to the denial of benefits. This did not change the result:

> ... To take this fact into account against the appellant would be to ignore the particular nature of the matter. As I have mentioned, insurance law is, in many respects, geared towards protection of the consumer. This approach obliges the courts to impose bright-line boundaries between the permissible and the

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[67] *Smith v Co-operators General Insurance Company*, 2002 SCC 30 (CanLII), [2002] 2 SCR 129 at ¶1.

[68] *Smith v Co-operators* (SCC), *supra*, at ¶11

[69] *Smith v Co-operators* (SCC), *supra*, at ¶15

> impermissible without undue solicitude for particular circumstances that might operate against claimants in certain cases.[70]

72. Finally, in *obiter*, Gonthier J. wrote that the language used by the insurer left "an equivocal sense of indeterminacy" about the insurer's decision, "giving the reader the impression that the insurer may very well change its stance if it [was] contacted for a discussion of the matter". He held that this might have given rise to another ground to impugn the notice.[71]

G. Regulatory Scheme

73. The Statutory Accident Benefits Schedule (SABS) is a regulation promulgated pursuant to the *Insurance Act*:

a. Section 33 of the SABS deals with information a claimant is required to provide to an insurer to obtain benefits, including information reasonably required to assist the insurer in determining the claimant's entitlement.

b. The insurer is not liable to pay benefits in respect of any period during which the claimant fails to comply with his or her obligations under s. 33, provided however that if the claimant subsequently complies, the insurer shall resume payment of any benefit that was being paid and shall pay all amounts that were withheld during the period of non-compliance if the applicant provides a reasonable explanation for the delay in complying.[72]

c. Section 42 of the SABS provides that an insurer may require an applicant to be examined by one or more health professionals for the purpose of assisting the insurer in determining if a claimant is or continues to be entitled to receive benefits.[73]

d. Section 35 of SABS deals with the insurer's obligations after an application for benefits is received. Among other things, the insurer can pay the benefits, request more

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[70] *Smith v Co-operators* (SCC), *supra* at ¶16

[71] *Smith v Co-operators* (SCC), *supra*, at ¶20

[72] Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996, O. Reg. 403/96, s. 33 ("SABS 1996"). (All references are to the SABS in effect at the material time.)

[73] SABS 1996, *supra*, s. 42

information from the applicant under s. 33 or require the applicant to attend for an examination pursuant to s. 42.

e. Within five days after receiving the report of an examination conducted under s. 42, the insurer shall advise the applicant of its determination of any benefits it agrees to pay, any benefits it refuses to pay and shall provide the reasons for its decision.[74]

H. Unreasonable Erosion of Consumer Protection

74. In the present case, as set out above, the insurer sent a letter to the appellant on January 7, 2011 advising that she was not entitled to income replacement and housekeeping benefits "as a result of [her] failure or refusal to submit a completed disability certificate within the timeframe specified in our request" dated December 8, 2010. The insurer wrote that "no benefit is payable for the period after [January 4, 2011] and before the day the insurer receives the completed disability certificate". Finally, the insurer wrote that the appellant was required to be examined by a psychologist and a physiatrist chosen by the insurer.

75. As also set out above, the appellant attended two medical examinations by the insurer's assessors in late January and early February 2011 for the purpose of determining her entitlement to income replacement benefits and housekeeping benefits.

76. On February 16, 2011, the insurer wrote to the appellant and advised that it had made a determination that she was not entitled to housekeeping benefits. As required by s. 35(9) of the SABS, it provided an explanation for its decision, with reference to the medical assessments conducted following the January 7, 2011 letter. Based on those same assessments, the insurer determined that the appellant was entitled to income replacement benefits. The appellant was told that the insurer would monitor her treatment and rehabilitation to assess her entitlement to income replacement benefits moving forward.[75]

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[74] SABS 1996, *supra*, s. 35(3), (6) and (9) [Emphasis added].

[75] Court of Appeal, *supra*, at ¶7; Reconsideration decision of the License Appeal Tribunal dated April 23, 2020 ("Reconsideration decision") at ¶¶8, 10, Appellant's Record, Tab 3.

77. On September 19, 2011, following a further medical examination, the insurer wrote to the appellant, denying further income replacement benefits.

78. No dispute resolution forms accompanied the letters sent in February and September 2011, and in his reconsideration decision, the Adjudicator correctly held that as a result, these letters could not be characterized as valid denials of benefits.[76]

79. Thus, the issue is whether it was reasonable for the Adjudicator to conclude the letter sent on January 7, 2011 was a valid denial of benefits. The Adjudicator held that upon receiving the letter, the appellant had two choices: She could provide the requested disability form and attend the medical assessments for the purpose of restarting benefits; or she could commence the dispute resolution process. By definition, this did not constitute notice in "straightforward and clear language, directed towards an unsophisticated person" that benefits would not be provided. The January 7, 2011 letter was a temporary suspension of benefits under section 33(6) of the SABS for failure to provide information and notification of the insurer's requirement that the appellant attend for examinations under s. 42 of the SABS.

80. The subsequent termination of housekeeping benefits in February was "based on the report of the examination". The payment of income replacement benefits resumed after the disability form was submitted as provided for in section 33(8) of the SABS. Those benefits were later terminated based on subsequent examinations.

81. The majority of this Court in *Smith v Co-operators* expressed serious doubt about whether a communication from the insurer which patently reflects an "equivocal sense of indeterminacy" about an insurer's decision could be said to represent a valid refusal.[77] This is precisely what occurred in the present case. The only 'denial' that was found by the LAT to meet the contemporaneity requirements concerning dispute resolution rights was not, in reality, a denial at all, but was rather a temporary suspension.

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[76] Court of Appeal, *supra* at ¶9; Reconsideration decision at ¶¶8, 10.

[77] 2002 SCC 30 at ¶20.

82. The adjudicator's conclusion that the January 7, 2011 letter constituted a valid denial of benefits, which started the clock running on the limitation period, was unreasonable for the following reasons.

83. In his original decision dated April 29, 2019, the Adjudicator held that the January 7, 2011 letter was a valid denial of benefits because of his factual conclusion that a dispute resolution form accompanied the letter. Nowhere in these reasons did the Adjudicator deal with the substance of the letter itself, as opposed to simply addressing the enclosure. He correctly instructed himself that a notice to an applicant communicating an insurer's decision must be clear and unequivocal "and permit an applicant to decide whether or not to challenge the denial", but did not deal with the fact that letter held out the promise of a resumption of benefits. There would be no point in submitting forms and attending medical examinations if there was a final decision to deny benefits. None of this is addressed in the original decision.

84. In his reconsideration decision dated April 23, 2020, the Adjudicator held that upon receipt of the January 7, 2011 letter, the appellant "had essentially two options", namely to submit to an examination and provide the form that had been requested, or commence the dispute resolution process. If one of the appellant's options was to continue to engage with the insurer, which as it turns out she did with partial success, it cannot be said that the insurer had communicated a decision to deny benefits that was clear and unequivocal, nor did it present the appellant with a clear decision to make about whether or not to challenge the denial of benefits.

85. Notably, the Adjudicator's reasons on the reconsideration request make it clear that the appellant raised the very issue of whether the January 7, 2011 letter was a suspension of benefits pending the insurer's medical examinations, or a denial of benefits. For the reasons set out above, the appellant submits the letter merely suspended benefits. The interpretation that most favours the insurer is that the letter was ambiguous, which is insufficient to validly deny benefits. As noted, the Adjudicator did not address this issue.

86. These flaws are central to the result, and are unreasonable in both senses in which the term is used in *Vavilov*. The reasons do not reveal a "rational chain of analysis" whereby the Adjudicator grappled with the issue at the heart of the case, namely, what was the nature and meaning of the January 7, 2011 letter? The Adjudicator also failed to consider the relevant legal

and factual context, including the effect of the decision on the appellant, which denied her the ability to pursue a claim for income replacement benefits on the merits. Further, because he never considered the content and specific nature of the January 7, 2011 letter, he never tied the letter to the need to extend consumer protection to the appellant.

87. To further complicate matters, the Court of Appeal held as follows:

> The adjudicator then reiterated his central point, which was that the January 7, 2011 letter had denied both the IRBs and the housekeeping and home maintenance benefits. He found that a dispute resolution form had been attached to that letter. The adjudicator therefore found that, when the IRBs were ***finally*** denied by the letter of September 19, 2011, the appellant was fully informed of the dispute resolution process. Consequently, he concluded that there was no deficiency that undermined the denial of the IRBs through the September 19, 2011 letter. Indeed, he found that the denial "is in clear language and the dispute resolution process is plainly evident from the attached Form."[78]

88. There is no doubt that the final denial of benefits did not occur until September 2011, however the Adjudicator was alive to the fact that the denials of benefits in February and September 2011 were not valid because of the failure to include the dispute resolution information. The Court of Appeal's confusion illustrates the unreasonable nature of the Adjudicator's decisions. Standing on its own, the January 7, 2011 letter was not a denial of benefits.

89. The preliminary issue that was before the LAT in this case can be determined by this Court on the record as it stands. The appellant seeks an order confirming that she is not precluded from proceeding with her application for ongoing IRB and housekeeping and home maintenance benefits, as she did not miss the statutory limitation period to dispute the insurer's denial of these benefits.

IV. COSTS

90. The appellant seeks her costs in this Court and in the courts below.

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[78] Court of Appeal, *supra* at ¶50 [emphasis added].

V. ORDER SOUGHT

91. The appellant seeks an order allowing this appeal with costs in this Court and in the courts below.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

May 23, 2023

Sean Dewart, Tim Gleason and Ian McKellar
Solicitors for the Appellant

VI. SUBMISSIONS RE: SEALING ORDER

92. Not applicable

VII. AUTHORITIES

Authority	¶
Ackerman v Ontario Provincial Police, 2010 ONSC 910 (Div. Ct.)	46
Canada (Attorney General) v Best Buy Canada Ltd., 2021 FCA 161	60, 61, 62, 63
Canada (Minister of Citizenship and Immigration v Vavilov, 2019 SCC 65	1, 2, 4, 25, 29, 30, 31, 35, 36, 38, 39, 51, 61,
Canadian Pacific Ltd. v Matsqui Indian Band, 1995 CanLII 145 (SCC), [1992] 1 SCR 3	46
Cock v Labour Relations Board, 1960 CanLII 293 (BCCA)	46
CUPE Local 963 v New Brunswick Liquor Corporation, 1979 CanLII 23 (SCC)	30
Democracy Watch v Canada (Attorney General), 2023 FCA 39	63
Dunsmuir v New Brunswick, 2008 SCC 9	4, 60
Ewanek v City of Winnipeg, 2020 MBQB 98	54
Friends of the Oldman River v Canada, 1992 CanLII 110 (SCC), [1992] 1 SCR 3	46
Friends of Simcoe Forests Inc. v Ontario, 2021 ONSC 3813	64
Habtenkiel v Canada (Citizenship and Immigration), 2014 FCA 180	52
Harelkin v University of Regina, 1979 CanLII 18 (SCC), [1979] 2 SCR 561	46
Homex Realty v Wyoming, 1980 CanLII 55 (SCC), [1980] 2 SCR 1011	46, 47, 49
International Union of Operating Engineers, Local 793 v Aecon Group Inc., 2023 ONSC 586 (Div. Ct.)	46
Ladouceur v Intact Insurance Company, 2022 ONSC 5206 (Div. Ct.)	64

Authority	¶
Martineau v Matsqui Institution, 1979 CanLII 184 (SCC), [1980] 1 SCR 602	45
Murugamoorthy v Canada (Citizenship and Immigration), 2018 FC 650 (CanLII)	46
Myers v Canada (National Parole Board), 1981 CanLII 4636 (FCA)	48
Neptune Wellness Solutions v Canada Border Services' Agency, 2020 FCA 151	55
Peel Standard Condominium Corporation No. 779 v Rahman, 2021 ONSC 7113 (Div. Ct.)	64
R. v Lippé, 1990 CanLII 18 (SCC), [1991] 2 SCR 114	33
Simmons v Royal Newfoundland Constabulary Public Complaints Commission, 2022 NLSC 27	59
Smith v Appeal Commission, 2021 MBQB 149	64
Smith v Co-operators General Insurance Co., 2000 CanLII 4138 (ON CA)	65, 66, 67
Smith v Co-operators General Insurance Co., 2002 SCC 30	6, 68, 69-72, 81
St. Albert Housing Society v St Albert (City), 2014 ABQB 556	52
Tipping v Coseco Insurance Company, 2021 ONSC 5295	64
Tran v Canada (Public Safety and Emergency Preparedness), 2017 SCC 50 (CanLII)	46
Wongkingsri v Alberta (Appeals Commission for Alberta Workers' Compensation), 2022 ABQB 545	58
Yatar v TD Insurance Meloche Monnex, 2021 ONSC 2507	18
Yatar v TD Insurance Meloche Monnex, 2022 ONCA 446	7, 9, 10-15, 20, 24-27, 76, 87
Zarroben v Workers' Compensation Board, 2021 ABQB 232	56
Zarroben v Workers' Compensation Board, 2022 ABCA 50	57

Secondary Authorities

License Appeal Tribunal Act, 1999, S.O. 1999, c. 12

11(1) Subject to subsections (2) to (6), a party to a proceeding before the Tribunal relating to a matter under any of the following Acts may appeal from its decision or order to the Divisional Court in accordance with the rules of court:

...

Insurance Act

...

(6) An appeal from a decision of the Tribunal relating to a matter under the *Insurance Act* may be made on a question of law only. 2014, c. 9, Sched. 5, s. 5 (3).

Insurance Act, R.S.O. 1990, c. I

DISPUTE RESOLUTION — STATUTORY ACCIDENT BENEFITS

RESOLUTION OF DISPUTES

280(1) This section applies with respect to the resolution of disputes in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled.

APPLICATION TO TRIBUNAL

(2) The insured person or the insurer may apply to the Licence Appeal Tribunal to resolve a dispute described in subsection (1).

LIMIT ON COURT PROCEEDINGS

(3) No person may bring a proceeding in any court with respect to a dispute described in subsection (1), other than an appeal from a decision of the Licence Appeal Tribunal or an application for judicial review.

Judicial Review Procedure Act, R.S.O. 1990, c. J.1

APPLICATIONS FOR JUDICIAL REVIEW

2(1) On an application by way of originating notice, which may be styled "Notice of Application for Judicial Review", the court may, despite any right of appeal, by order grant any relief that the applicant would be entitled to in any one or more of the following:

1. Proceedings by way of application for an order in the nature of mandamus, prohibition or certiorari.
2. Proceedings by way of an action for a declaration or for an injunction, or both, in relation to the exercise, refusal to exercise or proposed or purported exercise of a statutory power.

...

LACK OF EVIDENCE

(3) Where the findings of fact of a tribunal made in the exercise of a statutory power of decision are required by any statute or law to be based exclusively on evidence admissible before it and on facts of which it may take notice and there is no such evidence and there are no such facts to support findings of fact made by the tribunal in making a decision in the exercise of such power, the court may set aside the decision on an application for judicial review.

...

POWER TO REFUSE RELIEF

(5) The court may refuse to grant any relief on an application for judicial review.

Statutory Accident Benefits Schedule
- Accidents on or After November 1, 1996, O. Reg. 403/96,

DUTY OF APPLICANT TO PROVIDE INFORMATION

33.(1) A person applying for a benefit under this Regulation shall, within 10 business days after receiving a request from the insurer, provide the insurer with the following:

1. Any information reasonably required to assist the insurer in determining the person's entitlement to a benefit.

2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.

3. The number, street and municipality where the person ordinarily resides.

4. Proof of the person's identity.

(1.1) If requested by the insurer, a person who applies for a benefit under this Regulation as a result of an accident shall submit to an examination under oath, but is not required to,

(a) submit to more than one examination under oath in respect of matters relating to the same accident; or

(b) submit to an examination under oath during a period when the person is incapable of being examined under oath because of his or her physical, mental or psychological condition.

(1.4) The insurer shall limit the scope of the examination under oath to matters that are relevant to the person's entitlement to benefits under this Regulation.

(2) The insurer is not liable to pay a benefit in respect of any period during which the insured person failed to comply with subsection (1) or (1.1).

(3) Subsection (2) does not apply in respect of a non-compliance with subsection (1.1) if,

(a) the insurer fails to comply with subsection (1.3) or (1.4); or

(b) the insurer interferes with the insured person's right to be represented as described in subsection (1.2).

(4) If an insured person who failed to comply with subsection (1) or (1.1) subsequently complies with that subsection, the insurer,

(a) shall resume payment of the benefit, if a benefit was being paid; and

(b) shall pay all amounts that were withheld during the period of non-compliance, if the insured person provides a reasonable explanation for the delay in complying with the subsection.

...

INCOME REPLACEMENT, NON-EARNER OR CAREGIVER BENEFITS
AND HOUSEKEEPING OR HOME MAINTENANCE EXPENSES

35. (1) In this section and section 37,

"specified benefit" means an income replacement benefit, non-earner benefit, caregiver benefit or a payment for housekeeping or home maintenance services under section 22.

(2) An insured person who applies for a specified benefit shall submit with the application a disability certificate completed no earlier than 10 business days before the date the application is submitted.

(3) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,

(a) pay the specified benefit;

(b) send a request to the insured person under subsection 33(1) or (1.1); or

(c) notify the insured person that the insurer requires the insured person to be examined under section 42.

(4) If the insurer sends a request to the insured person under subsection 33 (1) or (1.1), the insurer shall, within 10 business days after the insured person complies with the request,

(a) pay the specified benefit; or

(b) notify the insured person that the insurer requires the insured person to be examined under section 42.

(5) Every income replacement benefit, non-earner benefit or caregiver benefit shall be paid at least once every second week, subject to any prepayment of the benefit by the insurer.

(6) An insurer may make a determination that an insured person is not entitled to a specified benefit if,

(a) the insured person failed or refused to submit the completed disability certificate required under subsection (2);

(b) the insurer has received the report of the examination under section 42, if the insurer has required the insured person to be examined under that section;

(c) the insurer is entitled under subsection (10) to refuse to pay the specified benefit; or

(d) the insured person is not entitled to the specified benefit for reasons unrelated to whether the insured person has an impairment that entitles the insured person to the specified benefit.

(7) If an insurer determines that an insured person is not entitled to receive a specified benefit by reason of clause (6) (a), (c) or (d), the insurer shall give the insured person a copy of its determination,

(a) within 10 business days after receiving the application, if the insured person is not entitled to the specified benefit by reason of clause (6) (a) or (d); or

(b) within 10 business days after the insured person failed or refused to comply with subsection 42 (10), if the insured person is not entitled to the specified benefit by reason of clause (6) (c).

(8) Within five business days after receiving the report of the examination of the insured person under section 42, the insurer shall give a copy of the report and of the insurer's determination to the insured person and to the health practitioner who completed the disability certificate submitted with the application.

(9) The insurer shall set out in its determination the specified benefits and expenses the insurer agrees to pay, the specified benefits and expenses the insurer refuses to pay and the reasons for the insurer's decision.

(10) If the insured person fails or refuses to comply with subsection 42 (10), the insurer,

(a) may make a determination that the insured person is not entitled to any specified benefit; and

(b) may refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with subsection 42 (10) and before the insured person submits to the examination or provides the material required by that subsection.

(11) If the insured person subsequently complies with subsection 42 (10), the insurer shall,

(a) reconsider the application and make a new determination under this section; and

(b) pay all amounts, if any, that were withheld during the period of non-compliance, if the insurer determines that the insured person is entitled to any specified benefits and the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with subsection 42 (10).

(12) If the insurer determines after receipt of the report under section 42 that the insured person is entitled to a specified benefit, the insurer shall pay the specified benefit within 10 business days after receiving the report.

(13) If an insured person fails to submit a completed disability certificate with his or her application for a specified benefit, no specified benefits are payable for the period after the day the insurer receives the application and before the day the insurer receives the completed disability certificate.

(14) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the claim by the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed, the insurer shall pay all specified benefits to which the application relates for the period commencing on that day and ending on the day the insurer gives the insured person the report or determination.

...

EXAMINATION REQUIRED BY INSURER

42. (1) For the purposes of assisting an insurer determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, an insurer may, as often as is reasonably necessary, require an insured person to be examined under this section by one or more persons chosen by the insurer who are members of a health profession or are social workers or who have expertise in vocational rehabilitation.

(2) Subsection (1) does not apply with respect to,

(a) a benefit to which section 37.1 applies, other than an amount claimed for ancillary goods or services referred to in section 37.2; or

(b) a funeral benefit or death benefit.

(3) Subject to subsection (7), each of the following examinations under this section shall be limited to an examination of material provided under subsection (10) in respect of the insured person without requiring the attendance of the insured person:

1. An examination for the purposes of section 37.2 to assist the insurer in determining whether to pay for ancillary goods or services claimed by the insured person.

2. An examination after an application is made under section 38 to assist the insurer in determining if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.

3. An examination for the purposes of section 38 to assist the insurer in determining whether to pay for goods or services contemplated by a treatment plan if the goods and services are substantially similar to goods or services the insurer previously refused to pay for when they were included in a previous treatment plan submitted to the insurer on behalf of the insured person in respect of the same accident.

4. An examination for the purposes of section 38.2 relating to an application for approval of an assessment or examination.

5. An examination for the purposes of section 40 that relates only to the issue of whether the insured person has a brain impairment that results in a score of 9 or less on the Glasgow Coma Scale referred to in subclause 2 (1.2) (e) (i).

(4) Whenever the insurer requires an insured person to be examined under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,

(a) the reasons for the examination;

(b) the type of examination that will be conducted and whether the attendance of the insured person is required during the examination;

(c) the name of the person or persons who will conduct the examination, the regulated health professions to which they belong and their titles and designations indicating their specialization, if any, in their professions; and

(d) if the attendance of the insured person is required at the examination, the day, time and location of the examination and, if the examination will require more than one day, the same information for the subsequent days.

(5) If the insurer has already notified the insured person under this Regulation that the insurer requires the insured person to be examined under this section, the insurer shall give the notice required under subsection (4),

(a) not more than two business days after the previous notice was given, if the attendance of the insured person is not required at the examination, unless the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment; or

(b) not more than five business days after the previous notice was given and, unless the insured person and the insurer mutually agree otherwise, not less than five business days before the examination, if the attendance of the insured person is required at the examination or if the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment.

(6) If the insurer is not authorized under another section of this Regulation to give the insured person notice that the insurer requires the insured person to be examined under this section, the insurer shall give the insured person the notice required under subsection (4) not less than five business days before the examination, unless the insured person and insurer mutually agree otherwise.

(7) If a notice under subsection (4) indicates that the attendance of the insured person is not required for the examination and it is subsequently determined by the person conducting the examination that the insured person should be in attendance and personally examined, the insurer

shall give a notice to the insured person within two business days after the day the notice described in subsection (4) is given and at least five business days before the examination,

(a) notifying the insured person of the change in the type of examination;

(b) requiring the attendance of the insured person at the examination; and

(c) setting out the day, time and location of the examination and, if the examination will require more than one day, setting out the same information for the subsequent days.

(8) A notice under subsection (4) or (7) may be verbal if a written confirmation is given as soon as practicable afterwards.

...

(10) For the purposes of the examination,

(a) the insured person and the insurer shall, within five business days after the day the notice of the examination under subsection (4) or (7) is received by the insured person, provide to the person or persons conducting the examination all reasonably available information and documents that are relevant or necessary for the review of the insured person's medical condition; and

(b) if the attendance of the insured person is required at the examination, the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination.

(11) Subject to subsection (12), if the insured person complies with subsection (10), the person or persons conducting the examination shall complete the examination, prepare a report of their findings and provide a copy of the report to the insurer in accordance with the following:

1. If the attendance of the insured person was not required for the examination, the examination must be completed and a copy of the report provided to the insurer,

   i. not more than 10 business days after the day the notice of the examination under subsection (4) was given to the insured person, if the examination relates to whether the insured person has a catastrophic impairment, or

   ii. not more than five business days after the day the notice of the examination under subsection (4) was given to the insured person, in any other case.

2. If the attendance of the insured person was required at the examination and the examination relates to whether the insured person has sustained a catastrophic impairment or, if the insured person has sustained a catastrophic impairment, relates to whether the insured person is entitled to medical benefits, rehabilitation benefits, specified benefits under section 35 or attendant care benefits,

i. the examination must be completed not more than 30 business days after the day the notice relating to the examination was given under subsection (4) or, if a notice was given under subsection (7), 30 business days after the day that notice was given, and

ii. a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed.

3. If the attendance of the insured person was required at the examination and paragraph 2 does not apply,

i. the examination must be completed not more than 10 business days after the day the notice relating to the examination was given under subsection (4) or, if a notice was given under subsection (7), 10 business days after the day that notice was given, and

ii. a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed. O. Reg. 546/05, s. 21.

(12) If an insured person who failed or refused to comply with subsection (10) subsequently complies, the following rules apply:

1. If the attendance of the insured person was not required for the examination, the examination must be completed and a copy of the report provided to the insurer,

i. not more than 10 business days after the day the material required under subsection (10) was provided, if the examination relates to whether the insured person has a catastrophic impairment, or

ii. not more than five business days after the day the material required under subsection (10) was provided in any other case.

2. If the attendance of the insured person was required for the examination, a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed.

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