Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A12-007924

BETWEEN:

MICHAELA VANDERGAAG

Applicant

and

AVIVA CANADA INC.

Insurer

REASONS FOR DECISION

Before: Arbitrator Irvin H. Sherman, Q.C.

Heard: In person at Kitchener, Ontario on June 1-5, 2015 and by written submissions completed on October 22, 2015

Appearances: Mr. Robert Deutschmann participated on behalf of Ms. Michaela Vandergaag
Ms. Tara Lemke, assisted by Ms. Alessia Petricone-Westwood, Student-at-Law, participated on behalf of Aviva Canada Inc.

Issues:

The Applicant, Ms. Michaela Vandergaag, was injured in an automobile accident that occurred on January 4, 2007 and sought accident benefits from Aviva Canada Inc. ("Aviva") payable under the *Schedule*.[1] The Parties were unable to resolve their disputes through mediation, and Ms. Vandergaag applied, through her representative, for arbitration of her claims at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

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[1] *The Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

The issues in this Hearing are:

1. Did Ms. Vandergaag sustain a catastrophic impairment as a result of the accident within the meaning of the *Schedule*?
2. Is Ms. Vandergaag entitled to receive a rehabilitation (medical) benefit in the amount of $7,770.68 for a Treatment and Assessment Plan (OCF-18) for therapy support services provided by Joanne Nunn?
3. Is Aviva liable to pay Ms. Vandergaag's expenses in respect of the Arbitration?
4. Is Ms. Vandergaag liable to pay Aviva's expenses in respect of the Arbitration?
5. Is Ms. Vandergaag entitled to interest for the overdue payment of benefits?

Result:

1. Michaela Vandergaag sustained a catastrophic impairment as a result of the accident within the meaning of the *Schedule*.
2. Michaela Vandergaag is entitled to receive a rehabilitation (medical) benefit in the amount of $7,770.68 for a Treatment and Assessment Plan (OCF-18) for therapy support services provided by Joanne Nunn.
3. Michaela Vandergaag is entitled to interest for the overdue payment of benefits.
4. The parties made no submissions as to expenses. If they are unable to resolve this issue, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code*.

EVIDENCE AND ANALYSIS:

On January 4, 2007, Michaela Vandergaag ("Michaela"), then 8 years of age, was a passenger in the car seat of an automobile driven by her mother, Tammy Vandergaag ("Tammy"), at 80 km per hour, that was involved in a serious single car accident. Michaela's two brothers were also passengers in the car. All suffered injuries in the accident. Tammy was off work for three years as a result of the accident. The two brothers recovered from their injuries and resumed their education.

Michaela was taken to the Stratford Hospital by ambulance 15 minutes following the accident. Her Glasgow Coma Scale reading was noted as being 15/15 at the accident scene. She remained at the Stratford Hospital for an hour-and-a-half before being airlifted to a hospital in London, Ontario. She arrived in London two-and-a-half hours after the accident. Michaela reported to two of the neuropsychologists who have treated her since the accident that she has a memory of being transported by air to the London hospital.

It is undisputed that Michaela suffered significant and severe injuries in the car accident.

Michaela was using a lap belt at the time of the accident during which time she hit her head on the console. She suffered from a fracture of her lower spine, a fracture of her left elbow, bruising to her lower pelvis and a large laceration on her forehead extending along her eyebrows that required 45 stitches to repair. A CT scan taken three days post-accident did not reveal any fractures or inter-cranial bleeding. The CT scan noted frontal subcutaneous emphysema that may have been caused by trauma. Michaela also suffered from a facial contusion (bruising) and swelling. She has been left with a facial scar that is usually covered by makeup. She also has ongoing muscle paralysis in her forehead.

Michaela had two surgeries to repair her elbow. She was in a body cast for four months because of her lower back fracture. She experienced bruising around her eyes and that remained swollen and discoloured, and her upper lip was bruised and swollen one week after the accident.

While in the London Hospital, Michaela was transferred uneventfully to the Acquired Brain Injury ("ABI") team. There is no evidence that anything significant regarding Michaela's presentation arose from the transfer to the ABI team.

Michaela spent one week in hospital before she returned home. She remained home for four months following the accident where she was home schooled. She attended school for the final month of the school year. Michaela was then in grade three.

MICHAELA – BEFORE THE ACCIDENT

Prior to the accident Michaela had a happy and bubbly personality. She played with her friends, enjoyed ballet, and was confident and self-assured. She enjoyed going to school.

Dr. Ted DeYoung, a school board educational psychologist, in a report written about three months before the car accident, stated that Michaela's working memory was assessed as being at the high end of the borderline range. Her working memory was adequate for problem solving with one or two-step problems. More complex problem solving overwhelmed her. Michaela's processing speed was assessed as being at the low range of average.

Michaela had prior to Dr. DeYoung's psychological assessment completed a speech and language assessment. Since she attended Junior Kindergarten she had difficulties with change. She also lacked independence as a learner.

Michaela appeared easily discouraged when encountering change in Senior Kindergarten. She required adult assistance to help her learn new tasks. She was placed in the Strong Start Program that permitted her to have one on one educational support (Assessment – Joint Brief, Volume 3, Tab 38, pp.897-907, dated October 10/07).

In Grade One, Michaela required teacher support in order to help her complete learning tasks. She also received special education resource withdrawal support. Her progress varied such that by the third term of Grade One, Michaela had an Individual Education Plan ("IEP") for English and Math. She experienced borderline mild language impairment.

In Grade Two, Michaela was subject to an IEP as well as a host of accommodations that involved the use of several teaching strategies. She received speech and language instructions.

Dr. DeYoung noted that Michaela had since Grade One "made slow progress as a learner in spite of special education support" and "In summary, Michaela did demonstrate the intellectual potential for future academic success in the low average range compared to others her age.

Assuming that her conceptual thinking and her phonemic awareness continue to develop and that she is able to access needed remedial support as those abilities come on line. Her working memory weaknesses likely will continue to limit the completing of problem solving tasks that Michaela can manage."

Dr. DeYoung concluded his psychological assessment report by making a series of recommendations while noting that:

> Michaela's strength with social skills should continue to be encouraged through opportunities for leadership within the school. She clearly can be a model for others for friendliness and enthusiasm.

MICHAELA – AFTER THE ACCIDENT

When asked by her counsel what her life was like after the accident, Michaela accurately responded: "It went downhill for me."

Following her accident, Michaela experienced bullying and teasing from her peers (especially the female students) over her scar and her subsequent weight gain. She was sometimes looked upon by her peers as being the victim in a prank. As a result of one school prank, Michaela became lost, which raised concerns for her safety.

Michaela would sometimes phone home and tell her mother that she was ill when in fact she was not ill. She was tormented by the bullying, which diminished the enjoyment she earlier experienced in attending school.

Michaela's parents, Tammy and Jeffrey Vandergaag, gave credible evidence at this Hearing. She is fortunate to have these caring and devoted people as her parents.

The parents corroborated the evidence relating to the bullying and teasing. They stated that Michaela had difficulty following more than one step commands. She required daily reminders

about basic activities like taking a shower or brushing her teeth. She possessed poor organizational skills. She had difficulty setting a table or in putting her clothes away when she returned home from school. Michaela did not pursue ballet after her accident because of her back surgery and because of her inability to remember the ballet steps.

Tammy stated that Michaela was often depressed and lacked self-confidence. Michaela considered herself ugly and had few friends. She was fearful of seeing her doctor and of needles.

Michaela's parents acknowledged her pre-existing learning disability. They stated that Michaela became frustrated when she tried to learn new things. Michaela's father helped her with her homework. It was more of a struggle for Michaela to complete her homework after the accident than it was before the accident. She was struggling to read books she had read before her accident. She also had difficulty turning door locks which caused her parents concern for Michaela's safety, especially in potentially emergent situations. Michaela was afraid her parents would leave without her.

Jon Yorty, an education counsellor, corroborated the evidence relating to Michaela's fear of driving, her having nightmares and her desire to get rid of scary thoughts. There was a change in Michaela's relationship with her friends following the accident. She felt sad, disappointed and became concerned about losing her friends.

Michaela stopped going to the gym in Grade 9.

Michaela, at the time of the Hearing, was in high school. She participated in the Fast Forward Special Education Program that consisted of Michaela attending a smaller size class, one teacher and three teaching assistants. Michaela takes academic courses and courses in life study. She is participating in a Co-Op Work Program at a location near her high school. She chose this particular work program because if she went to work at a different and unfamiliar location she may get lost because of her inability to take a bus.

Michaela still requires reminders and cueing regarding certain aspects of daily living such as applying makeup and brushing her hair. She has the assistance of Ms. Jessica Helms, a support worker, once a week.

Michaela has to be reminded about dressing according to weather conditions. She remains forgetful. She sometimes forgets to take her lunch to school. In such cases, she is provided food at her high school.

Michael now has two girlfriends and a boyfriend.

Michaela relies on and trusts the advice she receives from Ms. Helms. Michaela stated she is doing well in English but math remains a struggle for her. She still requires help for her high school curriculum. She is no longer on medication.

Michaela remains frustrated when trying to solve problems. She often cries and she does not understand the concepts regarding making change. She has difficulty telling time on an analog clock. She no longer has sleepovers with friends.

By the time Michaela was in Grade 8, she was no longer bullied by her peers.

Michaela likes to be alone, playing her guitar or being on her computer.

Michaela enjoys going to modelling school where she communicates with her peers.

Michaela's father and Al Tordjman, a special education resource teacher, each stated that notwithstanding Michaela's attending Grade 11, she functions at a Grade 3 level for reading where she could complete 75% of the curriculum. She is at a Grade 4 – 5 level for math where she can complete 50% of the curriculum. She is at a Grade 7 level for science and geography where she could complete 50% of the curriculum.

Michaela attended the Kumon School in the Fall of 2010. This school offers an after school program to assist students in mathematics. She attended this program weekly. She did not complete the program because of her inability to complete assignments on time. She became upset on learning new matters.

Mr. Tordjman began interacting professionally with Michaela when she was in Grade 6 and more extensively when she was in Grade 7. By Grade 7, Michaela had issues with auditory processing and memory. She had six modified learning plans and was accommodated on another learning issue. She had difficulty retaining information and was accommodated on that issue. Mr. Tordjman knew of the teasing issue and how Michaela's peers arranged to meet her at a specific location but deliberately did not show up causing Michaela to become lost which, in time, raised the safety concerns.

Michaela struggled with modified learning programs. By Grade 7, her struggles increased.

In Grade 8, Michaela received three R's or marks lower than 50%. There was insufficient data to obtain marks for her in algebra, geometry, patterning and spatial sense.

Mr. Tordjman noted Michaela's willingness to be a compliant pupil. He stated that Michaela was "one of the neediest students in the school in Grade 7." She became upset at any challenging school work.

When asked during cross-examination to look at the accommodation Michaela received in Grade 3 and to compare that with the accommodation Michaela received in Grade 7, Mr. Tordjman stated, "Overall the levels of accommodation have not changed much." Michaela is able to learn slowly. She does not hold on to information over a period of time and was a challenging student to teach. There was 9 or 10 differences between the Grade 3 and Grade 7 lists of accommodations.

Angela Jaeger is a behavioural educational assistant who first met Michaela who was then in Grade 9. She described Michaela as being quiet, a follower who did not know what to do, and a

person who was desirous of keeping to herself. Sometimes Michaela was not feeling well. She sometimes failed to take her lunch. By mid-term, Michaela began to do better at school.

Ms. Jaeger referred to Michaela's inability to remember instructions given to her at gym class. Michaela forgot what team she was on, got disillusioned and felt lost.

Ms. Jaeger connected this evidence relating to Michaela's difficulty in remembering as her being in the Fast Forward Program.

Ms. Jaeger worked with Michaela in Grade 11. She noted that Michaela functions better in a small class, that Michaela functions below grade level and that she struggles with math.

Ms. Helms is now a social worker who works as a support worker for Michaela. She helps Michaela with aspects of daily living. She took Michaela to the Kumon class which Michaela did not like and where she felt overwhelmed.

Ms. Helms corroborated Michaela's difficulty in telling time and of her continuing need for prompts at home. Michaela appeared younger than her age. She is learning to cope. Michaela appears happy with her boyfriend which helps boost her self-esteem.

Ms. Helms had no knowledge regarding Michaela before her accident. She knew of Michaela's pre-existing learning disability. She was unaware of issues regarding Michaela's IQ or working memory.

CATASTROPHIC IMPAIRMENT

Michaela submitted that she meets the definition of catastrophic impairment under ss. 2(1.2)(e) and 2(1.2)(g) of Ontario Regulation 403/96 – *Statutory Accident Benefits Schedule* – Accidents on or after November 1, 1996, which reads as follows:

2 (1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,

(e) subject to subsection (1.4), brain impairment that, in respect of an accident, results in,

...

(ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose:

...

(g) subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder. O. Reg. 281/03, s. 1(5).

(1.3) Subsection (1.4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (1.2) (e), (f) or (g), can be applied by reason of the age of the insured person. O. Reg. 281/03, s. 1(5).

(1.4) For the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in subsection (1.3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment.

(2.1) Clauses (1.2) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless,

(a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or

(b) two years have elapsed since the accident. O. Reg. 281/03, s. 1(7).

(3) For the purpose of clauses (1.1) (f) and (g) and (1.2) (f) and (g), an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person. O. Reg. 403/96, s. 2(3) (e); O. Reg. 281/03, s. 1 (8).

The evidence submitted by Michaela in support of her claim for catastrophic impairment includes, but is not limited to, the psychological assessment and subsequent report prepared by Dr. Andy Cancelliere, The Catastrophic Impairment Determination documentation and addendum that includes the report of Drs. Anne Pignot and Ronald D. Kaplan. The evidence submitted by the Insurer who denies catastrophic impairment includes the Catastrophic Impairment Assessment Report prepared by Life Mate Assessments that includes the Neuropsychological Assessment prepared by Dr. Elaine MacNiven.

The Insurer submitted that Michaela was not catastrophically impaired as a result of the injuries and effects that she suffered in the car accident. The Insurer acknowledged that Michaela suffered severe injuries in the accident. The Insurer further submitted that the mental and behavioural issues identified by Drs. Kaplan and Andy Cancelliere arising from the car accident have now been resolved such that Michaela's presentation arises from her learning disability which predated the accident. Michaela is in the trajectory that she could expect for a person her age who suffers from this learning disability.

The Insurer acknowledges that the determination of the catastrophic assessment will govern whether Michaela is entitled to the medical benefit she claims.

MARKED IMPAIRMENT

To determine whether Michaela suffered a marked impairment and thereby falls under s. 2(2.1)(g) of the *Schedule*, it is necessary to follow the three-step approach outlined by the Ontario Court of Appeal in *Pastore v. Aviva Canada Inc.* 2012 ONCA 642:

> An assessment under s. 2(1.1)(g) is carried out by reference to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the *Guides*). Chapter 14 of the *Guides* sets out a three-stage process for evaluating catastrophic impairment based on mental disorder using four categories of functional limitation and five levels of dysfunction. The first stage is diagnosis of any mental disorders, followed by the second stage where the impact on daily life is identified. The third stage is assessing the severity of limitations by assigning them into the four categories and determining their levels of impairment. The *Guides* direct the assessment in the following "four categories of functional limitation."

In the case of *Mujku and State Farm Mutual Automobile Insurance Company*, FSCO A10-002979 (2013), Arbitrator Rogers stated that an Applicant is not required to prove that the accident was the only cause of her mental or behavioural disorder. An Applicant must prove that the accident materially contributed to it. In the *Pastore* case, *supra*, the Court of Appeal held that if pain due to physical injuries cannot be factored out, an Applicant is not required to show that her impairment is due solely to her mental or behavioural disorder. The Court held, "there was no statutory requirement to dissect the mental disorder into its constituent parts."

CAUSATION

The Applicant submitted that in determining whether she was catastrophically impaired, the evidence must be accessible under the "material contribution" test for causation. The Applicant relied on the decision of the Ontario Court of Appeal in the case of *Monks v. ING Insurance Co. of Canada*, (2008) 90 O.R. (3d) 689, as well as on the following arbitration cases: *Ghabu and Dominion of Canada General Insurance Company* (FSCO A12-002238); *D.M. and Portuges la*

Prairie Mutual Insurance Company (FSCO A12-005533) and *Mujku and State Farm Mutual Automobile Insurance Company* (FSCO A10-002979).

The Insurer submitted that the *Monks* case never stated that the material contribution test is the test to be used in statutory accident benefits cases. When the *Monks* case came before the trial judge, the Insurer's counsel submitted that the appropriate test for causation was the material contribution test. Even if the "but for" test was used, the Insurer could still have been liable for the payment of accident benefits. There has been no definitive opinion by the Court of Appeal that clearly states that the only test for causation is the material benefit test.

With respect to those Arbitration cases which applied the material contribution test, the Insurer, relying on *Domtar Inc. c. Quebec*, 1993 2 S.C.R. 756, submitted that members of an administrative tribunal are not bound by *stare decisis*.

The Insurer submitted that the appropriate test for determining causation was that found in the recent decision of the Ontario Court of Appeal in *Blake v. Dominion of Canada General Insurance Company*, 2015 ONCA 165, where the Court found no error in the trial judge's applying the "but for" causation test to the facts of that case. The Applicant in the *Blake* case did not ask the trial judge to depart from applying the "but for" test for causation which the Supreme Court of Canada in *Clements (Litigation Guardian) v. Clements*, [2012] 2 S.C.R. 181, held was the appropriate test for determining causation in negligence cases.

In the *Clements* case, the defendant was found to have negligently driven an overloaded motorcycle at excessive speeds. The issue was whether the "but for" or the "material contribution" test should be applied. The Supreme Court of Canada held that the appropriate test to determine causation was the "but for" test. The Court held that the material contribution test may be applied only in rare circumstances such as in cases involving multiple tortfeasors. This test has never been applied by the Supreme Court.

The *Clements* case applies to negligence cases. A statutory accident benefits case involves contract law. The insured person claims accident benefits under a policy of

automobile insurance that he or she has contracted with the insurance company. In *Smith v. Co-operators General Insurance Co.*, [2002] 2 S.C.R. 129, the Supreme Court of Canada held that one of the main objectives of insurance law is consumer protection, particularly in the field of automobile insurance.

In the *Ghabu* case, *supra*, Arbitrator Alan G. Smith referred to the case *Greenleigh v. Douro-Dummer Township*, 99 O.R. (3d) 632, affirmed on appeal 2012, ONCA 299, where Mr. Justice Lauwers (as he then was) stated:

> The task of the court in construing statutory and contractual language in a SABS [Statutory Accident Benefit Schedule] case is radically different from its task in determining credibility in a negligence case … legal causation for SABS purposes can be quite different than "legal causation" for torts purposes.

While I may not be bound to follow Arbitrator Smith's decision as a matter of *stare decisis*, I nevertheless find his analysis on the causation issue to be correct.

Subsection 64(1) of the *Legislation Act* reads:

> An Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects.

In *Monks, supra*, the Court of Appeal held that, in the circumstances of that case, the trial judge did not err in applying the material contribution test rather than the more onerous but for test. Having regard to the purpose of the statutory accident benefits legislation, which is to provide persons who have sustained injury in an automobile accident with accident benefits on a no-fault basis, the material contribution test best complies with the purpose behind the statutory accident benefits legislation.

The issue thus becomes, whether the car accident materially contributed to the Applicant's impairments.

DID MICHAELA SUFFER FROM A MENTAL OR BEHAVIOURAL DISABILITY?

Prior to her accident on January 4, 2007, there is no persuasive evidence to show that Michaela suffered from a mental or behavioural disability. She had a learning disability. There is nothing in Dr. DeYoung's report that was valid for "predictive purposes for two years following the date of his assessment," that would indicate a future decline in Michaela's functioning.

The only evidence of a behavioural concern pre accident was that Michaela had some conflicts with her brothers. I find that these conflicts are not significant based on the totality of the evidence.

The brothers offered help to Michaela when she was anxious, fearful and upset while driving in a car. There was no post-accident evidence of any conflict between Michaela and her brothers.

Dr. DeYoung is an educational psychologist who wrote a report on Michaela's educational functioning three and one-half months prior to her accident. Dr. DeYoung's report is not a neuropsychological assessment. Dr. DeYoung did not raise any concern about Michaela subsequently developing a mental or behavioural disability because of her learning disability.

No issue was raised regarding the worsening of Michaela's working memory or an expected decline of neurological testing because of her learning disability. Dr. MacNiven acknowledged that the trajectory of worsening symptoms was speculative.

Michaela's demeanour changed following the accident. She went from being friendly and outgoing to quick to anger, moody, crying, anxious and desirous of getting rid of many thoughts following her accident.

DR. CANCELLIERE'S REPORT, DATED FEBRUARY 1, 2010

Dr. Cancelliere referred to Dr. DeYoung's report wherein Dr. DeYoung noted Michaela suffered from borderline language impairment, weakness in function words, grammar and short term vocabulary. Michaela's strongest asset was her determination and ability to learn by rote. She was a socially confident and outgoing person who had many friends.

Dr. Cancelliere found that Michaela's intellectual abilities were borderline impaired. Verbal comprehension and perceptual organization indices fell within the low average range. Working memory and speech processing indices fell into the impaired and borderline impaired ranges respectively.

Dr. Cancelliere stated that Michaela's mother reported that since the car accident Michaela required specific, one-on-one direction to help her to complete tasks and chores (Joint Brief, Vol. 1, Tab 14, pp. 256-278).

Dr. Cancelliere stated at p. 199 of his report:

> Unfortunately, Michaela has demonstrated very little learning/progress with respect to academic abilities (reading, spelling and written arithmetic) since the previous assessment some three years previously. This is compelling evidence of a decline in her learning ability as a result of the subject head injury. She was at the beginning of Grade 3 at the time of this assessment. She was found to be spelling at the early grade 2 level. Thus, she had acquired grade 2 spelling abilities in her kindergarten and grade 1 and 2 years at school and was close to operating at grade level in this area. That is, she was performing within normal limits in this area.
>
> Currently, Michaela continues to function, in spelling, at an early grade 2 level. Her abilities are now well below the average range. She demonstrated good learning prior to the subject MVA but little or no learning after her head injury.

> Michaela's ability to maintain a pace of learning/development commensurate with that of her peers premorbidly was objectively observable since speech pathology and psychoeducational testing featured some overlap. These two assessments were separated by approximately 1.5 years. The overlap involved receptive vocabulary and she was average on both occasions in this capacity. That is, premorbidly her vocabulary knowledge was developing at an age-appropriate level.
>
> The deterioration noted in working memory and processing speed indices is consistent with a traumatic brain injury as the latter is most susceptible, of the intellectual indices, to traumatic brain injury. Working memory is also at risk following traumatic brain injury (particularly where there is frontal lobe involvement). Performance on the memory battery indicated problems isolated to the attention/concentration index (although the learning index was low average).
>
> Michaela's poor performance correctly relative to her neurocognitive test performance three years earlier is likely the result of the subject traumatic brain injury and its impact upon the neurodevelopmental process (i.e. negative impact upon her ability to learn and continued neuronal/brain development). The subject traumatic brain injury has compromised her ability to learn as well as her peers post-MVA. This is an example of a child growing into cognitive deficits over time . That is, the traumatic brain injury altered her neurodevelopmental trajectory.

Dr. Cancelliere noted (a) the "significant decline" in Michaela's marks when he compared her Grade 2 (pre-accident) with her Grade 4 (post-accident) results and (b) that her learning skills "declined dramatically" in that two-year period.

Dr. Cancelliere found that there are multiple points of evidence to show that Michaela sustained a traumatic brain injury with "predominant involvement of the frontal lobes as a result of the back injuries she suffered in the car accident."

Dr. Cancelliere stated that it has been noted that children with learning disabilities are at greater risk for neurocognitive losses following even mild brain injury. He also found that Michaela is experiencing difficulties in the emotional, personality and social spheres as a result of the injuries she sustained in the car accident. He found that Michaela suffered from Post-Traumatic Stress Disorder ("PTSD") issues and that Michaela is likely lacking in insight.

Dr. Cancelliere concluded his report by finding that Michaela suffers from a severe disability currently.

In his follow-up report dated February 2, 2015, Dr. Cancelliere found that Michaela's academic progress was very poor. Michaela moved from being approximately 1.3 grade levels behind her peers pre accident to being 3.6 grades behind her peers post-accident. (Joint Brief, Vol. 2, Tab 25, p. 596.)

DR. KAPLAN'S REPORT – IDENTIFYING CATASTROPHIC IMPAIRMENT DETERMINATION, DATED FEBRUARY 3, 2011

Dr. Kaplan's report and findings are predicated upon the reports of Dr. Judy Trotter – physical medicine, Dr. Trotter – physiology, Dr. Robert Kaplan and Dr. Anna Pignot – pediatric psychologists and Dr. Scott Garner – medical quality assurance. Dr. Pignot interviewed Michaela's parents and attended a school meeting regarding Michaela. Michaela completed a battery of psychological tests.

With reference to ss. 2(1.2)(g) of the *Schedule*, Dr. Kaplan provided ratings of functioning according to the domains described in chapter 14 of the *AMA Guides*, Fourth Edition, which are used in the *Schedule* to evaluate the degree of functional limitation due to mental or behavioural impairment or disorder.

Upon analysis of Michaela's present conditions, Dr. Kaplan concluded, both verbally and in writing that with respect to each domain, Michaela presented the corresponding degree of impairment as follows:

DOMAIN	IMPAIMENT RATING
ACTIVITIES OF DAILY LIVING	MARKED
SOCIAL FUNCTIONING	MODERATE TO MARKED
CONCENTRATION, PERSISTENCE, PACE	MODERATE TO MARKED
ADAPTION TO WORK OR WORKLIKE SETTING	MARKED

GLASGOW OUTCOME SCALE

Dr. Kaplan stated that assuming that behavioural changes reflect Traumatic Brain Injury ("TBI"), the GOS may be used in assessing catastrophic impairment. There is a wealth of psychological evidence that indicated that Michaela now has greater dependence on adults than she did pre-accident. She still required extraordinary assistance both at home and at school. As such she has a severe disability satisfying the criteria for catastrophic impairment.

With respect to ss. 2(1.2)(g) of the *Schedule* and the *AMA Guides,* Fourth Edition, Dr. Kaplan opined:

> Our impairment analysis yields a marked impairment with respect to two domains of functioning (activities of daily life and adaption) according to Chapter 14 of the AMA Guides, 4th edition. Thus Ms. Vandergaag satisfies the criteria for catastrophic impairment according to SABS....
>
> We believe there is a reasonable likelihood of deterioration and failure of normal development and that in the future she would likely have four domains of marked impairment.

…

> She had documented pre-MVA learning disabilities; however the record supports very serious behavioural, functional and academic changes and greatly increased dependence on adults post MVA. The injuries suffered in the MVA are the most reasonable explanation for the reported deterioration.

In an addendum report, dated April 29, 2015, Dr. Kaplan repeated and confirmed his findings and opinion in his February 3, 2011 report.

Dr. Kaplan referred to the reports written by Marlene Morse, OT, which report forms part of the Insurer's documentation relating to catastrophic impairment.

Ms. Morse wrote:

> She has medical documentation indicating that she sustained a traumatic brain injury during the MVA …
>
> Based upon the clinical interview, functional testing results, discussion with Miss Vandergaag and her mother, and a review of the available file documentation, it is apparent that she is experiencing cognitive behavioural symptoms that are impacting areas of her daily functions.

Ms. Morse also wrote:

> … throughout both days of testing, Miss Vandergaag's cognitive performance was decreased and there were times that the claimant required guidance with respect to the social context and environmental demands. During the in-school assessment there were noticeable changes with respect to her concentration, persistence and pace (task completion) and signs of decompensation were also observed during the in-home assessment.

Dr. Kaplan stated that Ms. Morse's reports were consistent with his observations and findings. (Joint brief, Vol. 2, Tab 21C and 27, pp 379,599-607; *Ibid.* p. 606.)

DR. MACNIVEN'S NEUROPSYCHOLOGICAL ASSESSMENT, DATED JUNE 24, 2011

The thrust of Dr. MacNiven's opinion is found at pp. 68 and 69 of the Insurer's Catastrophic Impairment Assessment Report where Dr. MacNiven in her comprehensive report opined as follows:

> It is my opinion that Michaela's condition stabilized at some point between the assessment completed by Dr. Cancelliere and that completed by Dr. Kaplan. This is based on neuropsychologic test data. It is impossible to determine exactly when her neuropsychological condition stabilized, especially given her premorbid condition.

With respect to ss. 2(1.2) (g) of the *Schedule* and the four domains:

> There is no doubt Michaela has difficulties in all of these areas, but with respect specifically to the results of the motor vehicle accident, there is no neurocognitive impairment. There is no indication that there are any psychoemotional issues at this point that could impact on her day-to-day functioning. Although I concur with the fact that there are severe impairments in functioning compared to her peers, I do not believe they can be attributed in any way to the effects of the index accident. (Joint brief, Vol. 2, Tab 22C, pp. 441-488)

Dr. MacNiven wrote that under the *Schedule* "an individual must meet the criteria for catastrophic impairment with respect specifically to the results of the motor vehicle accident" which review is contrary to the holistic approach pronounced by the Ontario Court of Appeal in the *Pastore* case, *supra*.

Dr. MacNiven concluded that Michaela has not suffered from a catastrophic impairment.

In cross-examination, Dr. MacNiven admitted that at the time of her assessment, Michaela was still exhibiting mental and behavioural issues attributable to the accident such as bullying and her fear of needles and doctors.

Dr. MacNiven admitted that her concept of trajectory is speculative on her part. She would not say for certain when Michaela's current presentation could be attributable to her learning disability and not her accident.

Drs. Kaplan and Cancelliere did not support the MacNiven trajectory theory. These neuropsychologists attributed Michaela's presentation as being attributable to the car accident.

Michaela required more educational support following the accident than she did before the accident. She continues to struggle socially and with certain aspects of daily living.

Dr. Kaplan diagnosed Michaela with a cognitive disorder not otherwise specified, PTSD in partial remission and with having specific phobias (needles and doctors). These conditions were not present pre-accident.

Dr. MacNiven suggested that it would be desirable to get collateral information when a person such as Michaela showed lack of insight into learning disabilities. In this regard, Dr. MacNiven interviewed Michaela's mother even though the information she received from family members is such that the mother may lack objectivity. Dr. MacNiven did not interview school officials. Dr. Pignot interviewed school officials regarding Michaela. Dr. Pignot's report forms part of Dr. Kaplan's report. Dr. MacNiven also did not discuss with Ms. Morse, OT, the latter's opinion regarding Michaela's areas of functioning.

I find that Michaela's parents, who have a deep and caring affection for their daughter, gave their evidence in a realistic and credible manner. They were not prone to exaggeration. Their evidence is credible.

Dr. Cancelliere diagnosed Michaela as suffering from PTSD which Dr. Kaplan found sometime later was in remission.

Michaela has significant support structures in place in school where she is functioning well below grade level. She also has the assistance weekly of a rehabilitation specialist. More supporting structures remain in place eight years following the date of the car accident than there were pre-accident.

I find on the balance of probabilities that the car accident materially contributed to Michaela's current presentation. I also find, adopting the holistic approach mandated by the Court of Appeal in the *Pastore* case, *supra*, that Michaela suffers from a marked impairment in at least one domain of functioning and she merits the definition of catastrophic impairment under ss. 2(1.2)(g) of the *Schedule*.

GLASGOW OUTCOME SCALE – s. 2(2.1)(e) of the *Schedule*

The Glasgow Outcome Scale must be administered more than six months following the date of the car accident. Dr. Kaplan considered the application of the Glasgow Outcome Scale in his report, dated February 3, 2011, which is more than six months after the car accident (January 4, 2007).

The next issue to be decided is whether Michaela suffers from a brain injury. The Insurer denies Michaela suffered a brain injury in the accident.

Michaela suffered a significant gash to the forehead in the car accident that required at least 45 stitches to close. She also suffered from facial bruising, swelling, lacerations and contusions.

Michaela's parents noted significant changes post-accident with respect to Michaela's ability to learn and with respect to some aspects of daily living. Michaela dropped ballet because she could not remember the steps. She needs cueing and reminding. Michaela dropped out of the Kumon Learning Program because of her inability to cope with that learning program. Ms. Helms, the

rehabilitation therapist, noted the effects of the bullying of Michaela, helped Michaela with her homework, took her to the Kumon program, and helped Michaela with the preparation of meals and in the selection of appropriate clothing.

Michaela's teachers, Mr. Tordjman and Ms. Jaeger, referred to the accommodations she was receiving post-accident. Michaela was functioning significantly below grade level. She had difficulty retaining information.

Dr. Cancelliere diagnosed Michaela as suffering from a brain injury resulting from a moderate head injury. He also noted Michaela suffered from post-traumatic amnesia.

Dr. MacNiven did not place significant weight on the report cards given Michaela by her teachers because of the subjective nature of report cards. Dr. MacNiven stated that the decline in Michaela's educational attainments post-accident was significant. Dr. MacNiven did not know that Michaela received home schooling post-accident.

Dr. Cancelliere, on the other hand, stated that Michaela's accident and head injury significantly contributed to her learning problems. He stated that children with learning problems are at greater risk of neurocognitive losses following even a relatively mild brain injury.

Dr. Kaplan tested Michaela more than one year after Dr. Cancelliere tested her. Dr. Kaplan noted an improvement in Michaela's working memory since the date of Dr. Cancelliere's report. Michaela's working memory is nonetheless still below her pre-accident level. Dr. Kaplan concluded that Michaela suffered from brain trauma that contributed to her severe post-accident functional limitations.

The Insurer submitted that the results of Michaela's CT scan post-accident did not reveal apparent brain injury. She was referred to the Acquired Brain Injury section of the hospital without apparent result. Her Glasgow Coma Score was 15 and thereby not indicative of catastrophic impairment.

Dr. MacNiven stated that a GCS score of 15 does not suggest a brain injury. This opinion is not shared by Drs. Cancelliere and Kaplan. Dr. MacNiven stated that the negative CT results are not indicative of a brain injury. Drs. Cancelliere and Kaplan each stated that there may have been undetected damage to the axial neurons of the brain post-accident. The medical records revealed that Michaela suffered from a minor subcutaneous emphysema which, in Dr. Cancelliere's view, is indicative of brain trauma.

Dr. MacNiven stated that the assessment of brain injury based on post traumatic amnesia well after the accident is inappropriate. Michaela's counsel submits otherwise. Counsel referred to an article entitled, Assessment of Post-Traumatic Amnesia After Severe Closed Head Injury: Retrospective or Prospective? The abstract of the article indicates that retrospective measurement of post traumatic amnesia is a valid method. The author stated, at p. 426 of the article, that, "This reconfirms the view that post-traumatic amnesia is currently the Gold standard with respect to prediction of outcome after traumatic head injury"(Exhibit A-11).

Dr. MacNiven noted that while it is possible that Michaela suffered from a brain injury in the accident, she should have recovered from that injury by now. I agree with the submissions made by Michaela's counsel that there is no evidence as to when or how the recovery occurred.

Michaela's counsel filed as Exhibit A9 an article entitled, "Mild Brain Injury in Children: Ringing the Alert Bell," where the following may be found:

> Mild traumatic brain injury (TBI) is a common occurrence around the world, and in the United States its estimated incidence exceeding 1 million injuries per year, with cognitive, emotional, behavioural and physical impairments as common *sequelae*. (p1 – abstract)
>
> **Summary**

Predicting clinical outcomes in children after TBI is highly variable and needs to combine different complex aspects of each case such as the child's pre-injury global psychological state and support after the injury, behavior, family support and even their economical status. The presence of comorbid psychiatric problems such as a major depressive episode, anxiety disorders (including post-traumatic stress disorder), or substance abuse, whether or not these are regarded as etiologically related to the mind TBI, should be treated aggressively using appropriate psychotherapeutic and pharmacologic interventions. Education early after a mild TBI includes the symptoms it produces, the usual time course for resolution of these symptoms, and the potential for long-term difficulties, which may decrease the likelihood of developing persistent post concussive symptoms. Clinicians should offer validation of the person's experience of symptoms, regardless of their cause, without fostering illness behaviors. This validation is best coupled with the development of individualized and realistic goals for return to major activities. Unfortunately, the majority of treating clinicians have few tools available to help determine when it is appropriate for the individual to return to activities. This, added to the fact that many mild head injuries never come to medical attention, should lead health care professionals to conclude that the incidence of mild head injury is quite likely to be underestimated rather than overestimated, and that is critically important to accurately identify those children that may develop complex neurological symptoms after mild head trauma and by this focus the needed interventions on them. There are relatively few randomized controlled trials of treatments in the TBI population, there is evidence suggesting that when properly applied they may be of benefit for the treatment of memory, attention, executive function, and communication deficits among reasonably high-functioning and well motivated persons with TBI. When pharmacologic therapies are used, the indications and need for ongoing prescriptions should be reviewed, and efforts should be made to eliminate those not affording clear benefits or that are potentially worsening post concussive symptoms. More studies are required to evaluate the overall quality of life, health care utilization, influence of the family and the effect of school and school performance after a child has a closed head

> injury. Research utilizing advances in neuroimaging is necessary to understand the underlying neuropathology of mild closed injury and to attempt to correlate these studies with neuropsychological outcome. Prospective longitudinal studies following children post mild TBI over a period of years will be most helpful, allowing movement beyond group characterization. The aim will then be to provide better treatment and adequate support to children recovering from a mild closed head injury.

Dr. Cancelliere, in his oral testimony, disagreed with Dr. MacNiven's opinion that Michaela is in her expected trajectory, given her pre accident learning disabilities. Dr. Cancelliere stated: "She has not got the skills cognitively that she once had. The losses that she has are specific to traumatic brain injury."

Dr. Cancelliere noted that Michaela's naming ability was higher pre accident than it is post-accident.

Marlene Morse, OT, who was part of the Insurer's assessment team, stated in her report from her review of the documents in the file that, "Michaela Vandergaag does appear to have a significant brain injury which is affecting her school work and normal activities."

It is agreed by all neuropsychologists that working memory is a function of the frontal lobes of the brain (Joint brief, Vol. 1, Tab 19, p. 330).

Michaela's working memory, as tested by Dr. DeYoung, was given a score of 77. When tested by Dr. Cancelliere 34 months later, her working memory score was 54. When tested 15 months later her working memory score was 65, which was the same result Dr. MacNiven recorded six-and-a-half months after Dr. Kaplan tested Michaela.

Michaela's working memory function has not returned to its pre-accident level.

Dr. MacNiven's opinion on brain injury is not supported by any meaningful evidence.

Upon consideration of the totality of the evidence relating to brain injury and on the balance of probabilities, I find that Michaela suffered a brain injury as a result of the accident and that she continues to suffer from the effects of the brain injury. The accident materially contributed to the brain injury.

It is now necessary to determine if Michaela rates a score of two (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale as published in Jemott, B. and Bond, M., "Assessment of Outcome after Severe Brain Injury."

The Glasgow Outcome Scale has five categories of outcome that have "proven practicable." Two of these five categories are relevant to this matter. They are:

> (3) Severe Disability (conscious but disabled). "This is used to describe patients who are dependent for daily support by reason of mental or physical disability usually a combination of both."
> (4) Moderate Disability (disabled but independent). It is noted "such patients can travel by public transport and can work in a sheltered environment and are therefore independent in so far as daily life is concerned."

Michaela's parents, Mr. Tordjman, the special resources teacher, and Ms. Helms each referred to safety concerns in their evidence, especially if Michaela is left alone – at home, lost at a bus stop or victimized by bullying at school. On one occasion, Michaela was told by her school friends to meet them at a certain place and time. Michaela appeared at the appointed place and time only to learn that her friends deliberately did not show up at the designated location and time.

In this case we have, as Dr. Kaplan noted, a vulnerable child with a learning disability. Michaela remains dependent upon her parents and her rehabilitation therapist. To some extent she needs assistance with instructions for food preparation, clothing selection, understanding concepts of time, forgetting to bring food with her to school, help at school and with certain aspects of daily

living. Michaela still requires prompting and even to assist her with the various tasks she faces daily. She is unable to keep pace with her peers.

I find on the totality of the evidence and on the balance of probabilities that the car accident materially contributed to Michaela's brain impairment that results in a severe disability. She meets the definition of catastrophic impairment under ss. 2(1.2)(e) of the *Schedule*.

ENTITLEMENT TO A MEDICAL BENEFIT

It is agreed by the parties that if Michaela is found to have suffered a catastrophic impairment then she is entitled to receive a rehabilitation (medical) benefit in the amount of $7,770.68 for a treatment and assessment plan (OCF-18) for therapy services provided by Joanne Nunn. It is so ordered. She is also entitled to interest on this amount at the rate of 2% per month compounded monthly.

CONCLUSION

I wish to acknowledge the professional, co-operative and courteous manner each counsel exhibited during this Hearing.

EXPENSES:

The parties made no submissions on expenses. If they are unable to resolve this issue, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code*.

Irvin H. Sherman, Q.C.
Arbitrator

February 1, 2016
Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A12-007924

BETWEEN:

MICHAELA VANDERGAAG

Applicant

and

AVIVA CANADA INC.

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended, it is ordered that:

1. Michaela Vandergaag sustained a catastrophic impairment as a result of the accident within the meaning of the *Schedule*.
2. Michaela Vandergaag is entitled to receive a rehabilitation (medical) benefit for a treatment and assessment plan (OCF-18) for therapy support services provided by Joanne Nunn in the amount of $7,770.68.
3. Michaela Vandergaag is entitled to interest for the overdue payment of benefits.
4. The parties made no submissions as to expenses. If they are unable to resolve this issue, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code.*

February 1, 2016

Irvin H. Sherman, Q.C.
Arbitrator

Date