IN THE MATTER OF The *Insurance Act*, R.S.O. 1990, c. 1.8, as amended

AND IN THE MATTER OF the *Arbitration Act*, S.O. 1991, c. 17, as amended

AND IN THE MATTER OF an Arbitration

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO,
As represented by THE MINISTER OF FINANCE
("THE MOTOR VEHICLE ACCIDENT CLAIMS FUND")

Applicant

and

ECHELON INSURANCE
(formerly ECHELON GENERAL INSURANCE COMPANY)

Respondent

AWARD

Heard: June 28 and July 19, 2016

Counsel:

Marie Sydney for the Applicant, Her Majesty the Queen. ("HMQ")

Jamie R. Pollack and Jason H. Goodman for the Respondent, Echelon Insurance ("Echelon")

SCOTT W. DENSEM: ARBITRATOR

Introduction[1]

This Award relates to a priority dispute arbitration commenced pursuant to Ontario Regulation 283/95 – Disputes between Insurers, in connection with an accident occurring January 3, 2012. On that date one Frazer Bird was operating a snowmobile owned by him on which his girlfriend, Anne Louise Barnes, was a passenger. Ms. Barnes was injured as a result of being ejected from the snowmobile while it was being driven by Mr. Bird.

At the time of the accident, the Respondent ("Echelon") insured a Mazda vehicle owned by Mr. Bird under a standard owner's (OAP 1) policy of motor vehicle liability insurance which was in effect between September 7, 2011 and March 7, 2012 (hence covering the date of the accident) issued as policy number A20291941.

Ms. Barnes, through her counsel, Sokoloff Lawyers, applied to Echelon for Statutory Accident Benefits ("SABS"). Crawford Adjusters ("Crawford") was retained by Echelon as its agent to deal with Ms. Barnes' SABS claim and the related priority dispute matters. Shortly after it commenced handling Ms. Barnes' SABS claim, Crawford served a Notice of Dispute between Insurers ("NDBI") on the Applicant ("HMQ"). The NDBI was served for the purpose of transferring responsibility to HMQ for the payment of SABS to Ms. Barnes. The NDBI asserted that the snowmobile owned and driven on the date of the accident by Mr. Bird was uninsured.

[1] The facts in this introduction are detailed in the Partial Agreed Statement of Facts and Documents, Exhibit 2.

Claimspro/SCM Adjusters Canada ("Claimspro") was retained by HMQ as its agent to deal with the priority dispute and related investigation in respect of Ms. Barnes' SABS claim.

A series of events, and communications between Crawford and Claimspro followed. These will be described in detail in the Analysis part of this Award. Ultimately, Claimspro communicated to Crawford that HMQ would accept priority for the payment of SABS to Ms. Barnes. Approximately 18 months later counsel retained by HMQ wrote to Crawford requesting that Echelon reassume responsibility for the payment of SABS to Ms. Barnes.

Counsel for HMQ indicated in this correspondence that relevant provisions of the OAP 1 policy issued by Echelon to Mr. Bird had been "*mistakenly overlooked or not considered by both Echelon and the Fund at the time that Echelon sought that the Fund accept priority*". The effect of these provisions was that the snowmobile being driven by Mr. Bird at the time of the accident was insured for, *inter alia*, SABS, pursuant to the OAP 1 policy issued by Echelon to Mr. Bird.

Echelon declined to reassume responsibility for the payment of SABS to Ms. Barnes. Consequently, HMQ commenced this arbitration seeking to have the priority issue determined.

The Issues

The issues the parties have placed before me according to the Arbitration Agreement[2] are as follows:

(a) Which insurer is higher in priority to pay statutory accident benefits to and on behalf of Anne Louise Barnes following a motor vehicle accident on or about January 3, 2012 which includes the issue of what is the effect of the Applicant's acceptance of priority?

(b) What amount, if any, is the Respondent required to pay to the Applicant, including interest?

(c) The quantum of costs and the burden of payment.

The Evidence

The arbitration hearing was conducted over two days. Evidence was introduced both in document format, and *viva voce*. The following documents were marked as exhibits:

Exhibit 1: Arbitration Agreement executed in counterpart, April 13, 2016 – HMQ, April 21, 2016, Echelon.

Exhibit 2: Partial Agreed Statement of Facts and Documents, Tabs 1 – 15.

Exhibit 3: Claimspro Claims Notes, pp. 1 – 4, February 15, 2012 to August 13, 2012.

[2] Exhibit 1.

Exhibit 4: Claimspro Claims Notes, pp. 1 – 63, March 21, 2012 to May 27 2014.

Exhibit 5: Letter from Miller Thomson LLP to Crawford & Company (Natalie Creith), dated March 15, 2012.

The following witnesses testified at the arbitration hearing:

HMQ witnesses: Victor Lam – Claimpro Claims Adjuster.

Anne Kerr – Claimspro Accident Benefits Examiner.

Kees Van Brink – HMQ Claims Administrator (retired).

Echelon witnesses: Natalie Creith – Crawford Claims Adjuster.

Susan Verghase – Crawford Claims Adjuster.

I do not intend to summarize the entirety of the evidence of the witnesses who testified at the arbitration hearing. I will make reference to their evidence, as necessary, in addressing the various issues which I must decide.

Analysis

An issue central to the determination of which insurer is in priority is whether HMQ's agreement to accept priority from Echelon for Ms. Barnes' SABS claim should be set aside. Echelon phrases the issue it in its submissions slightly differently. It puts the question as: should HMQ be permitted to resile from its agreement to accept priority? I do not think that the phrasing of the question matters in the result. In order for me to find that Echelon is the priority insurer, I must conclude that HMQ's agreement to

accept priority can be set aside, or, to put it in Echelon's terms, HMQ should be permitted to resile from the agreement.

The issue is framed in this manner since is not disputed that HMQ agreed to accept priority from Echelon. The parties differ on the issue of whether that agreement should remain binding on HMQ.

HMQ's position is rather complex, and involves a number of alternative submissions. HMQ's initial submission is that Echelon failed to comply with the terms of Regulation 283/95 3.1. Since that section is important to the analysis I will reproduce it here:

> 3.1 (1) This section applies to disputes relating to accidents occurring on or after September 1, 2010.
>
> (2) Before giving a notice to the Fund[3] under section 3, an insurer must,
>
> (a) complete a reasonable investigation to determine if any other insurer or insurers are liable to pay benefits in priority to the Fund; and
>
> (b) provide particulars to the Fund of the investigation and the results of the investigation.

HMQ submits that the evidence establishes Echelon did not complete a reasonable priority investigation, and did not provide HMQ with either the particulars of, or the results of any investigation it did conduct before serving HMQ with its NDBI.

[3] "Fund" is defined in Regulation 283/95 as meaning the Motor Vehicle Accident Claims Fund in respect to the Fund's obligations to pay SABS pursuant to the *Motor Vehicle Accident Claims Act*. For clarity, in my Award where I refer to HMQ, the term "Fund" could be used interchangeably.

HMQ submits that the consequence of this failure to comply with 3.1 of Regulation 283/95 should be that it is entitled to a "special award" pursuant to subsection 7 (6) of the Regulation. That section reads as follows:

> 7 (6) If the (priority) dispute relates to an accident that occurred on or after September 1, 2010 the failure of an insurer other than the Fund to comply with section 2.1 or 3.1 may be the subject of a special award made by the arbitrator.

HMQ submits that an appropriate special award in the circumstances would be for me to exercise the equitable jurisdiction I possess pursuant to section 31 of the *Arbitration Act* to order restitution by Echelon to HMQ of the SABS paid by HMQ to the claimant (as well as expenses associated with adjusting the claim), and that Echelon be deemed to the priority insurer in this case.

HMQ submits (at paragraph 51 of its factum), *"Where an insurer's failure to comply with section 3.1 leads or contributes to a failure to determine the priority insurer, the special award should be one that undoes the damage caused by the noncompliance. Such an award would achieve a regulatory goal sought to be achieved by that subsection."*

HMQ cites other grounds, both as part of its section 3.1 argument, and as independent, legal bases, to justify setting aside its agreement to accept priority and have Echelon declared the priority insurer.

Mistake of fact or law, and unjust enrichment, are two such grounds advanced by HMQ as appropriate to the circumstances of this case in which courts and arbitrators may apply the law of restitution as an equitable remedy.

HMQ submits that the evidence in this case satisfies the requirements for restitution either on the basis of mistake of fact or law, or unjust enrichment. In support of this argument, HMQ cites a line of judicial authority, including authorities relating to the SABS indemnification scheme established by section 275 of the *Insurance Act* referred to in the insurance world as loss transfer. I will deal with this submission and the others described in the following paragraphs in more detail further on in my Award. My purpose here is to simply set out in general terms the arguments advanced by the parties.

HMQ argues that there was no contract or settlement agreement between it and Echelon. Even if I were to find that there was a contract or settlement agreement however, HMQ submits that the contract is *void ab initio* on the grounds that it was entered into with both parties being mistaken about a fundamental term – the insurance status of the snowmobile involved in the accident.

If there was a contract between HMQ and Echelon, HMQ argues further that HMQ was induced to enter into the contract by misrepresentation on the part of Echelon with respect to the status of the snowmobile involved in the accident. HMQ cites authority for the proposition that it is irrelevant whether a representation is fraudulent or innocent, and whether the contracting party relying upon the misrepresentation was negligent. If a misrepresentation was material, there is a presumption that it induced the misrepresentee to enter into the transaction. This is a presumption that may be rebutted by proof of no reliance on the misrepresentation.[4]

[4] *Barclays Bank v. Metcalfe & Mansfield* 2011 ONSC 5008 (CanLII), paragraph 156 and ff.

The appropriate relief in such a case is, HMQ submits, rescission of the contract.

If there was a contract between HMQ and Echelon, there are questions as to whether the doctrines of waiver and/or promissory estoppel apply in the circumstances to preclude HMQ from being able to set aside its agreement to assume responsibility from Echelon for the payment of SABS to the claimant.

Echelon submits that HMQ unequivocally agreed to assume responsibility (i.e. accept priority) from Echelon for the claimant's SABS claim. Echelon submits that the grounds upon which an insurer who, like HMQ in this case, should be permitted to resile from a clear agreement to accept section 268 priority for the payment of SABS are extremely limited. Based upon an interpretation of a line of arbitral authority, Echelon submits that it is only where the insurer seeking to transfer SABS priority acts in bad faith, or deliberately misleads the insurer it seeks to have accept priority with respect to facts or law relevant to the priority decision that the accepting insurer should be allowed to rescind its agreement.

The priority dispute system, argues Echelon, has been repeatedly described by the courts as requiring expeditious and efficient action on the part of the participants – the insurers, in making their decisions with respect to the management of claims, and disputes connected with those claims.

Echelon emphasizes that the courts have repeatedly identified insurers as sophisticated litigants. Not only do they have extensive specialized knowledge of the priority dispute system, but they have a professional level of knowledge of the insurance legislation which underlies the system. As has also been pointed out by the courts, to

the extent there is any gap in the insurers' own knowledge and they require assistance, they have ready access to legal advice of the best quality with respect to insurance matters.

Echelon submits that all of this supports the theme in the line of authority it relies upon which justifies allowing insurers to "change their mind" about accepting SABS priority in only in the very rare circumstances cited.

In this case, Echelon acknowledges neither it nor HMQ adverted to the insurance coverage for the snowmobile involved in the accident based on the correct interpretation of its policy wording before HMQ accepted SABS priority. Echelon argues however, that at no time did it act in bad faith or intentionally mislead HMQ about the facts and law relevant to the priority decision. Echelon further submits that HMQ did not rely on any representation made by it about the insurance status of the snowmobile. HMQ conducted its own priority investigation and when HMQ made the decision to accept priority for the SABS claim, it had all the necessary facts and documents available to it to determine that there was coverage available for the snowmobile involved in the accident under Echelon's policy. The fact that HMQ failed to recognize this and accepted priority for the claim is not the fault of Echelon and, based on the authorities, is not a sufficient justification to allow HMQ to resile from its agreement to accept SABS priority.

Echelon submits that to allow insurers to "second guess" their priority acceptance decisions – especially where, as here, the attempt to withdraw the acceptance occurs 18 months later, because they finally correctly interpreted the same facts and law that

were there to be considered when the decision was originally made would introduce huge uncertainty into the priority dispute system, and undermine the predictability of its operation.

I will first address the issue of whether Echelon has failed to satisfy the requirements of section 3.1 of the priority dispute regulation, and if so, the consequences of any such failure.

Subsection 3 (1) of Regulation 283/95 establishes the requirements for an insurer to serve a valid NDBI on any other insurer except for HMQ. In summary, to be valid a section 3 NDBI must be served by an insurer on another insurer who it claims is in priority within 90 days from that insurer's receipt of a completed SABS application. Failure to do so renders the NDBI invalid unless the insurer can demonstrate that 90 days was not a sufficient period of time to determine whether another insurer is in priority, and within the 90 days the insurer made reasonable investigations to determine if another insurer was liable.[5]

Section 3 was amended in the September, 2010 *Insurance Act* amendments to exclude HMQ from the 90 day NDBI service requirement. For accidents occurring after September 1, 2010, HMQ may serve an NDBI later than 90 days, and it is not required to demonstrate that 90 days was not a sufficient time to determine whether another insurer may be in priority, or that it conducted reasonable investigations to so determine.

[5] See section 3 (1), and (2) of Regulation 283/95.

The important point to note about section 3.1 is that it imposes more stringent requirements in addition to those set out in section 3 (1) upon an insurer wishing to serve an NDBI on HMQ. Not only must that insurer meet the timing requirements (or satisfy the relieving provisions) in subsections 3 (1) and (2), but it now has a positive obligation to conduct a reasonable priority investigation, and to provide the results of that investigation to HMQ before it serves an NDBI on HMQ.

In my view section 3.1 must be read in conjunction with section 3, they are not mutually exclusive. They must be read together to determine the requirements for proper service of an NDBI where that NDBI is being served upon HMQ.

Reading the sections together I conclude that to properly serve a NDBI on HMQ, an insurer must take the following steps in the order set out after it receives a completed SABS application:

1. Within 90 days of the receipt of the completed SABS application, conduct a reasonable priority investigation to determine if any other insurer – apart from HMQ, is liable to pay SABS; and

2. If the insurer's reasonable investigation does not identify another insurer apart from HMQ as being liable to pay SABS, provide particulars to HMQ of the investigation and the results of the investigation; and

3. Subsequent to taking the steps outlined in paragraph 2, and within 90 days of the receipt of the completed application, serve HMQ with a NDBI.

The first question to be decided is whether Echelon conducted a reasonable priority investigation after receiving the claimant's SABS application before serving its NDBI on HMQ.

Some of the evidence on this issue comes from Echelon's underwriting notes.[6] Other evidence comes from the testimony of Natalie Creith of Crawford. As previously indicated, Crawford was retained by Echelon to adjust the SABS claim of the claimant Barnes after she submitted her SABS application to Echelon on January 30, 2012.

It is unclear when Echelon first made contact after the accident with its insured, Frazer Bird. The earliest indication available to me which suggests that there had been some contact between Echelon and Mr. Bird – or at least someone with knowledge of the January 3, 2012 accident, is found in an underwriting note of January 31, 2012. I pause to note here that according to the evidence the accident was not reported to the police.

A January 31, 2012 underwriting note confirming a communication to Echelon's broker indicates that Echelon intended to cancel Mr. Bird's policy in accordance with underwriting rule #25 A, on the grounds that Mr. Bird – the named insured and primary driver of the Mazda automobile listed on the policy, had two "at fault" claims within the last six years, the second of these being noted as January 3, 2012. I think it is a reasonable inference to draw that the January 3, 2012 accident was the accident involving Ms. Barnes and the snowmobile.

[6] Exhibit 2, Tab 12.

The significance of this note is that it indicates that Echelon understood Mr. Bird to have been driving the snowmobile on the January 3, 2012 accident date. I am supported in this conclusion by a subsequent underwriting note of February 14, 2012. Although this note is made a week after Echelon (through Crawford) served its NDBI on February 7, 2012, the content of the note relates to a telephone call from the insurance broker who was inquiring about the January 3, 2012 snowmobile accident claim. The note goes on to indicate that Echelon had retracted its earlier position designating this as an "at fault" accident until, "*liability can be determined*", and it was reinstating the policy. The note states, "*insured owns snowmobile with no insurance on it and was operating it on a public roadway*".

In my view this note, when read together with the January 31, 2012 note, supports the conclusion that before Echelon served its February 7 NDBI, through whatever investigation it, or its agents, Crawford, had conducted up to that time, it was aware that its insured, Frazer Bird, was driving the snowmobile on the January 3, 2012 accident date when Ms. Barnes was injured.

Ms. Creith's evidence was that she obtained the information she included in the NDBI from Frazer Bird, and from conversations with the claimant Barnes' mother. She could not recall whether she had performed an Auto Plus search to see if the snowmobile involved in the accident was insured elsewhere (I understood this to mean as a vehicle listed on an insurance policy as it was not listed on Echelon's policy), or to determine (independent of which he was told by Ms. Barnes' mother) whether Ms. Barnes had her own insurance.

She stated that her reference in the NDBI to "*uninsured snowmobile*" was based on Frazer Bird telling her that it was not insured in addition to her understanding that it was not a described automobile on the Echelon policy.

Based on my review of the evidence this was the extent of investigation that had been completed by or on behalf of Echelon before it served its NDBI on HMQ.

The NDBI prepared by Ms. Creith and served on HMQ on behalf of Echelon reads in Part 3: Reasons (Why Notice Is Given to Other Insurers) as follows:

> Ms. Barnes was a passenger on an uninsured snowmobile when she was involved in an accident. Ms. Barnes is not listed as a driver on anyone's insurance policy and has only been living with her boyfriend for the last 1.5 years and is thereby not considered his spouse.

There were no supporting documents such as a statutory declaration from Ms. Barnes, or copies of any insurance searches to substantiate the reasons given for serving the NDBI. Nevertheless, the NDBI did provide information which later proved to be accurate concerning the results of Echelon's priority investigation to that point insofar as the fact that Ms. Barnes did not have insurance coverage of her own and that she was not a spouse of Mr. Bird for SABS purposes.

Unfortunately, the NDBI did not include the critical piece of information relevant to "other automobile" coverage under Echelon's policy for the snowmobile – the fact that Echelon's named insured was driving the snowmobile at the time of the accident.

HMQ argues that the investigation conducted by Echelon or its agents prior to the service of its NDBI was not reasonable. This argument is based in part on the fact that it had not obtained a statutory declaration from the claimant to properly evidence

the verbal information it had apparently obtained from her mother. HMQ also points out that there is no evidence that any insurance searches were conducted to confirm the lack of insurance coverage elsewhere (other than potentially the Echelon policy), Echelon's agents appeared to simply be taking the word of Ms. Barnes' mother and possibly their own insured for this conclusion.

The main thrust of HMQ's argument that Echelon's priority investigation was not reasonable is that it failed to properly consider the coverage under its own policy. As a result it started a priority dispute proceeding when it ought to have known it was without merit.

HMQ submits that the evidence indicates that very early on after learning of the accident, Echelon began looking into coverage under its policy and determined that the snowmobile was not a described automobile in its policy. Its policy investigation essentially stopped there. Consequently, HMQ argues, Echelon failed to complete a reasonable coverage investigation by not thoroughly considering other provisions in its policy.

Had such a reasonable investigation been done in this case, HMQ argues, Echelon would have realized it had coverage for Ms. Barnes SABS claim and a priority dispute would never have been commenced.

I agree with this submission.

The first step for an insurer when presented with any type of claim is to determine whether its policy provides coverage. That is especially the case where an insurer is presented with a claim for SABS. Apart from complying with its section 2 "pay

first and dispute later" obligation, one of the first things the insurer wants to determine is whether it has any contractual responsibility to pay, and then secondly, whether another insurer has a higher responsibility to pay under section 268 of the *Insurance Act*.

A proper coverage investigation by a knowledgeable insurer should not end where Echelon's ended. An insurer such as Echelon should know that there is potential for coverage in an OAP 1 for automobiles other than described automobiles. To address this possibility, a logical line of inquiry for an insurer such as Echelon with a professional knowledge of the OAP 1 would be to first consider the definition of "automobile" in section 1.3 of the policy to see if a snowmobile came within the definition. Then if so, to consider the various coverages outlined in section 2 – "What Automobiles Are Covered? to determine if any of those coverages applied.

I do not believe it would be too onerous a standard to require that, in the circumstances of this case, a reasonable priority investigation by a sophisticated insurer with an extensive knowledge of the OAP 1 standard automobile policy should include the kind of analysis of its own policy described in the preceding paragraph.

I believe my finding on this issue is especially relevant for priority dispute cases involving HMQ. Section 3 of the priority dispute regulation was amended in 2010 to place a specific statutory onus to complete a reasonable priority investigation on an insurer before it starts a priority dispute involving HMQ which has repeatedly been noted in the case law to be a publicly funded payor of last resort. In my view, the main reason this amendment was put in place was to reduce or eliminate the possibility that

insurers would either conduct no or inadequate priority investigation before "dumping" that responsibility on HMQ by simply serving a NDBI on HMQ.[7]

In support of my conclusion, I would also reference the foundation of Echelon's own argument in this case to resist HMQ's resiling from its agreement to accept priority. The basis of this argument is that insurers are sophisticated litigants who not only have expert knowledge of the priority dispute system and the underlying insurance legislation, they also have access to the best legal advice. They should be held to a very high standard in respect of their decision-making given this expertise and the expeditious, predictable manner in which the priority dispute system is intended to operate. The essence of the position is that in light of the foregoing, insurers should be permitted to avoid the consequences of priority decisions they have made only when the insurer who has served them with a NDBI has acted in bad faith or intentionally misled them in the decision-making process.

In my opinion, and especially considering the amendment to section 3 of the dispute regulation for cases involving HMQ, if the above standard is appropriate for insurers making priority decisions after being presented with an NDBI, there is no reason not to impose the same stringent standard on insurers who wish to initiate the priority dispute process.

In conducting a priority investigation, an insurer should be required to exercise the diligence, and employ the analytical skills which could reasonably be expected of professionals with extensive knowledge of the regulation and legislation with which they

[7] There is a discussion of this issue in *Cooperators General Insurance Company v. Ontario (Minister of Finance)* 214 ONSC 515 (CanLII) at paragraph 24, a case interpreting section 3 before it was amended by section 3.1.

regularly deal. A priority dispute is often a time-consuming, expensive exercise for all involved, and depending on the result may lead to significant consequences with respect to the payment of SABS. In my view this is another reason why a thorough priority investigation should be undertaken – especially as mandated by statute in the case of HMQ, to minimize or eliminate the occurrence of proceedings which may not be meritorious in fact, in law, or both.

I also accept HMQ's position that Echelon's has failed to satisfy the requirements of section 3.1 on the basis that before Echelon served HMQ with its NDBI, it had not provided HMQ with the particulars and the results of its priority investigation.

With respect to "particulars", Echelon did not provide HMQ with details of the inquiries it had made to obtain the information contained in its NDBI before it was served. HMQ did not know whether any insurance searches had been conducted. It did not know whether a statutory declaration or even a statement had been obtained from the SABS claimant and/or Echelon's insured. Echelon did not provide evidence such as the declarations page of its policy to confirm that the snowmobile was not a described vehicle. It was only months later that underwriting notes were provided along with a notification that, "*Echelon does not insure snowmobiles*", this latter comment being in itself misleading as there is no dispute that the snowmobile was covered under Echelon's policy for the reasons previously discussed.

As far as the results of the investigation were concerned, although it could be argued that Echelon provided concurrently with the service of the NDBI the results it had obtained to that point, as I have indicated, one critical piece of information central to

coverage in this case that was known to Echelon but not included in the NDBI was a statement confirming that Echelon's named insured, Fraser Bird, was driving the snowmobile when the accident happened. From my review of the evidence, HMQ was not able to confirm this important fact until it obtained in April, 2012 through its own efforts a copy of the statutory declaration of the claimant Barnes which had been provided to Echelon a month earlier.

From HMQ's perspective, when it received the NDBI it was not provided with any substantive evidence to support the assertions contained therein. It was put in the position of having to write several letters which in effect sought supporting documentation for the assertion contained in Part 3 of the NDBI that the snowmobile was uninsured. Ultimately, getting no response from Echelon's agent Crawford, HMQ's agent Claimspro sought more substantial proof on the insurance issue directly from counsel for the claimant Barnes.

It was only after the NDBI was served on February 7, 2012 that Echelon's agent, Crawford, obtained appropriate supporting documentation for the "*uninsured snowmobile*" assertion in the NDBI. It requested and obtained a legal opinion authored March 15, 2012 on the issue of SABS coverage for the snowmobile, which unfortunately was incorrect.[8] It requested and obtained on or about March 8, 2012 a statutory declaration sworn by the claimant Barnes providing under oath confirmation of the information relevant to the insurance coverage issue previously obtained informally from her mother.[9]

[8] Exhibit 5.
[9] Exhibit 2, Tab 9.

It is most relevant to the section 3.1 issue that the evidence discloses Echelon's agent never did provide to HMQ the statutory declaration it obtained from Ms. Barnes. HMQ obtained that directly from claimant's counsel.

The second part of section 3.1 requiring an insurer in Echelon's position to provide the particulars and the results of its priority investigation to HMQ received limited attention in HMQ's argument which focused mostly on the lack of reasonableness of Echelon's investigation because it failed to review its policy and conclude it covered the snowmobile.

I want to be clear that I realize HMQ was not conceding that the second part of the section 3.1 requirements had been satisfied by Echelon. In fact, as will be clear from my comments on the evidence above, Echelon had not satisfied the second half of the section 3.1 requirements prior to Echelon serving its NDBI on HMQ. The corroborating investigations had not been conducted at the time Echelon served its NDBI, and as I have pointed out the results of the corroborating investigations were either not provided to HMQ or HMQ was required to obtain them through its own efforts.

For the foregoing reasons I accept HMQ's submission that Echelon has failed to comply with the requirements of section 3.1 of the priority dispute regulation. The critical question is: What is the appropriate sanction upon Echelon, and remedy for HMQ, as a result of this failure?

As I have discussed, one of HMQ's submissions is that I should apply the terms of section 7 (6) of the priority dispute regulation. By way of "special award", it is submitted that I should set aside HMQ's acceptance of priority and using the equitable

remedy of restitution, require Echelon to indemnify HMQ for the SABS (a related expenses) paid to date, and require Echelon to assume responsibility for the claim henceforth.

Echelon did not argue strenuously that it had not technically breached the terms of section 3.1, although it did not agree that it had failed to conduct a reasonable priority investigation because it did not determine its policy actually covered the SABS claim it was seeking to transfer to HMQ. The essence of Echelon's position on this issue is that if there was a breach of the requirements of section 3.1 because particulars and/or results of its investigation were not provided to HMQ before service of the NDBI, it was inconsequential in the result and should have no bearing on my disposition of the matter.

Echelon emphasizes that the critical time to be considered insofar as what priority information HMQ had is the point at which HMQ made the decision to accept priority.

Echelon stresses that the key piece of information that provided confirmation of everything HMQ needed to know to be able to come to the correct conclusion – that Echelon's policy provided coverage for Ms. Barnes SABS claim in the circumstances, was in HMQ's hands on or about April 10, 2012. On that date Ms. Barnes' counsel faxed a copy of the statutory declaration sworn by Ms. Barnes on March 8, 2012 to HMQ.[10]

[10] Exhibit 2, tab 9.

It is undisputed that the statutory declaration contains confirmation of the following facts: that Echelon insured Fraser Bird under policy number A20291941 at the material time, that a Mazda B3000 was a described vehicle on the policy and owned by Mr. Bird, and most importantly, that Ms. Barnes was a passenger on a snowmobile owned and driven by Fraser Bird at the time of the accident.

Echelon points out that subsequent to HMQ receiving the statutory declaration, and before HMQ decided to accept priority, on or about May 18 2012, Crawford provided Echelon's underwriting file/notes to HMQ which confirmed the essential details contained in the statutory declaration.

At this point, Echelon emphasizes, with one exception HMQ had all of the same information Echelon had and so HMQ should have been able to come to the correct coverage conclusion (even though Echelon could not – using the same information). The only document HMQ did not have was the legal opinion requested by Echelon's agent back in March, 2012. This, Echelon submits, would undoubtedly not have been of assistance to HMQ. Reading the opinion would have only drawn HMQ further away from making an accurate conclusion about coverage because the opinion given to Echelon concluded Echelon's policy did not provide SABS coverage.

Echelon submits that when HMQ wrote to Crawford on June 19, 2012[11] advising that it would accept priority it had been in possession of all relevant facts and documents to enable it to make a correct conclusion about coverage under Echelon's policy since as early as April 10, 2012, and no later than May 30, 2012. This fact, and

[11] Exhibit 2, tab 13.

the comment in HMQ's June 19, 2012 letter, argues Echelon, makes it clear that if there was a technical breach of the requirements of section 3.1, it had absolutely no impact on HMQ's ability to make a correct decision about accepting priority.

The June 19, 2012 letter from HMQ's agent to Crawford states in part, "*…We have completed our investigation and would like to advise that the Fund will accept priority on this claim…*"

On this point, Echelon stresses that this evidence is important not just to its argument on the section 3.1 submission by HMQ, but for its position generally that HMQ did not rely upon the information and/or representations provided to it by Echelon, HMQ arrived at its priority decision based on its own investigation and analysis.

Echelon cites the arbitration testimony of Victor Lam who was the "frontline" file handler with Claimspro on behalf of HMQ. It was Mr. Lam's job to obtain information relevant to the priority issue and make a recommendation to his supervisor, Anne Kerr, and ultimately to the decision making authority at HMQ, Kees Van Brink (both of whom testified at the arbitration).

Echelon's counsel emphasized the evidence given by Mr. Lam confirmed that he made his decision to recommend acceptance of priority based on the information he obtained. With respect to handling these types of claims, Mr. Lam stated that as a general rule one does not rely on what the other insurer says without conducting one's own "due diligence". Mr. Lam was satisfied that by the time he made his recommendation he had the information he deemed necessary to properly make the recommendation to accept priority.

Based on this interpretation of the evidence, Echelon's counsel urged me to conclude that if there was any technical breach of the section 3.1 by Echelon in failing to provide particulars and results of its investigation to HMQ before serving its NDBI, it had absolutely no influence on HMQ's decision to accept priority.

I do not agree that the evidence on this issue was as clear cut as submitted, and compels the conclusion sought by Echelon's counsel. I take a different view particularly of the evidence respecting the misrepresentations by Echelon in the NDBI that the snowmobile was "*uninsured*", and later in the underwriting notes accompanied by the specific notification to the effect of: "*Echelon does not insure snowmobiles in Ontario*". I do not agree that these misrepresentations (even though they were innocent) had no influence on HMQ's decision making, and were not relied upon at all by HMQ.

I will address this evidence in more detail later in my Award in my discussion of the potential remedy of rescission.

There is no authority directly on point of which I am aware, or to which I was directed by counsel which addresses the appropriate remedy for a breach of section 3.1 of the priority dispute regulation, or whether using the "special award" provisions in section 7 (6) would be proper grounds for the result sought by HMQ.

With respect to the meaning of special award, although the September, 2010 amendments to section 3.1 the priority dispute regulation introduced the concept of special award, there is no definition of the term or even a description of what is intended by it in the regulation.

For the reasons which follow, I am **not** inclined to conclude that what is intended by "special award" in section 7 (6) for a breach of section 2.1 or 3.1 is the extensive remedy proposed by HMQ.

First, to try to develop a frame of reference for what might be meant by "special award", I believe it is appropriate to look at a previous version of insurance legislation which incorporated the special award concept.

In a previous version of the *Insurance Act,* section 282 (10) followed a bold heading entitled, "**Special award**". This section authorized an arbitrator who found that an insurer had unreasonably withheld or delayed SABS payments to a claimant to award the claimant up to an additional 50% of the amount to which the claimant was found entitled in the claim. In effect this was a punishment for insurer bad behaviour and a deterrent against future bad behaviour. Obviously though, to be entitled to a special award the claimant had to be successful on the underlying merits of the dispute and found entitled to recover benefits. The section has now gone by the wayside and an entirely new regime exists under the Licensing Appeal Tribunal system.[12]

The concept of what is meant by special award (in the context of the aforementioned legislation) has been discussed in court decisions. The context appears to characterize a special award as I have suggested – a punishment and deterrent for bad claims handling behaviour on the part of the insurer. Again, this assumes that the claimant has been successful on the merits of the benefits claim in the first place.

[12] Section 282 (10) was repealed in 2014.

For example, it has been held that an insurer does not have to have exhibited bad faith or malice for such an award to be made. The standard required to justify an arbitrator making a special award is less than what is required to establish a cause of action for bad faith, or to be entitled to aggravated damages. It has also been held that a special award is a "creature of statute" the jurisdiction to award same being conferred only on an arbitrator, not on a judge.[13]

I conclude from this that the historical application and judicial treatment of "special award" has been to allow an arbitrator to impose an added penalty type of sanction upon an insurer where the facts warranted it, and after a claimant has been found successful on the merits of the claim.

Second, section 7 (6) makes reference to a special award in circumstances where there has been a breach of either section 3.1 or section 2.1. Section 2.1 deals with what an insurer must do when notified that someone wishes to apply to the insurer for SABS. Amongst other things, it specifically forbids the first insurer from taking any action to prevent a person from applying for SABS, or redirecting the application to another insurer – an occurrence referred to in priority dispute parlance as "deflection".

Before the addition of section 2.1 to the post-September 2010 version of the dispute resolution regulation, the deflection cases were dealt with by arbitrators and courts without any specific statutory direction as to what should happen in the event it occurred, and there is appellate authority (referenced *infra*) on the proper disposition of such cases.

[13] See *Monks v. ING Insurance Company of Canada*, 2005 CanLII 21688 (ONSC).

A violation of section 2.1 carries with it not only the potential consequences of a section 7 (6) special award, but a specific provision in section 2 (7) also provides costs penalties for noncompliance. I do note that while section 2.1 provides for cost consequences for its violation separate and apart from a special award, section 3.1 does not.

My overall reading of the provisions in their legislative context, and their historical application, leads me to conclude that in the absence of explicit statutory direction, a section 7 (6) "special award" is not intended to provide a remedy which essentially determines the merits of the priority dispute.

I believe I am supported in this opinion by the reasoning outlined in *State Farm Mutual Automobile Insurance Company v. TD Home & Auto Insurance Company et al.*[14]

The important part of the case for this issue relates to a finding by the arbitrator at first instance that the TD had improperly deflected the claimant's SABS application. State Farm was next to receive the SABS application which it processed and commenced a priority dispute involving TD and HMQ (The Motor Vehicle Accident Claims Fund).

The arbitrator determined preliminary issues as to whether State Farm had priority (on the basis of a dependency argument), and whether TD had improperly deflected the claim. The arbitrator decided that State Farm did not have priority as there was no dependency, and that TD had improperly deflected the claim. TDs defence on

[14] 2016 (ONSC) 6229 (CanLII).

the merits was that it had canceled its policy prior to the accident. This issue was deferred pending the determination on the first two issues.

HMQ argued before the arbitrator that TDs deflection of the SABS claim should result in TD being fixed with permanent responsibility to pay the claimant SABS. This argument was rejected by the arbitrator who instead determined that the appropriate sanction was to order TD to pay the costs of all involved up to and including the decision on the preliminary issues, and then determine on the merits the issue of whether TDs policy had been properly canceled before the accident. It is important to note that this case was decided after the section 2.1 and 3.1 amendments to the priority dispute regulation.

There was an issue as to whether TD should be found to have priority because not only did it deflect the claim, it did not serve a section 3 NDBI notice on HMQ within 90 days. The arbitrator rejected that argument because after State Farm received the SABS application, it did serve an NDBI on both TD and HMQ. The arbitrator held that TD was entitled to rely on this NDBI involving HMQ in the dispute similar to the effect of a crossclaim in court litigation so that a determination of all issues on the merits could be made.

On appeal by HMQ, Justice Stinson upheld the arbitrator's decision on all issues, including his finding that the proper sanction for TD's deflection of the claim was a costs penalty, not permanent responsibility to pay SABS. He cited with approval the arbitrator's analysis of why a costs sanction, and not permanent responsibility to pay

SABS was the appropriate remedy. He stated the following (at paragraph 22, 29, and 31):

> [22]…the Arbitrator considered *Wawanesa Mutual Insurance Co. v. Lombard Canada*, 2010 ONCA 383. In that case, the arbitrator had held (following the decision of the Court Of Appeal in *Kingsway General Insurance Co. v. Ontario (Minister of Finance)* (2007), 84 OR (3d) 507) that 'a breach of sections 2 and 3 (of the *DBI Reg*.), while a serious matter that deserves sanction, does not result in an insurer automatically being required to pay benefits to the claimant forever.' On appeal in the first instance, that conclusion was expressly approved by Belobaba J.: see 2009 CarswellOnt 9124 at para 1. On further appeal, the Court Of Appeal quoted the same language and found no error in the reasoning and results below.
>
> [29] Based upon *Lombard Canada v. Wawanesa Mutual Insurance Company* and *Kingsway General Insurance Company v. Ontario* (both discussed above and considered by the arbitrator), there is appellate authority for the proposition that a breach of ss. 2 and 3 of the *DBI Reg.* does not result in an insurer automatically being required to pay benefits to the claimant forever. To this extent, the arbitrator's decision "falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law."
>
> [31] In my view, in all respects the arbitrator's decision was justified, transparent and intelligible. It follows that it meets the standard of reasonableness.

Although this decision deals with a breach of section 2.1, and not 3.1, the case law it refers to as referenced by the arbitrator, whose reasoning was approved of by the appeal judge in my opinion all supports my conclusion that the "special award" remedy referred to in section 7 (6) ought not to be used by itself to essentially determine the merits of the priority dispute before me.

Instead, in my view a special award under section 7 (6) is to be considered in the form of a costs type of sanction if I deem it appropriate for Echelon's failure to comply with the terms of section 3.1, and provided I find HMQ otherwise successful on the merits of its claim.

Having dealt with the issues of whether there has been a breach of section 3.1 of the priority dispute regulation, and the consequence of that breach, I will now examine the merits of HMQ's and Echelon's other legal arguments on whether HMQ's agreement to accept priority should be set aside/whether HMQ should be permitted to resile from its agreement to accept priority.

The central question which must be answered in deciding whether HMQ's agreement to accept priority can be set aside/it should be permitted to resile from the agreement is: what is the appropriate test in law to be applied to determine the issue?

HMQ submits that the priority dispute regulation is silent on the circumstance of insurers accepting priority after receipt of a NDBI, then seeking to retract that acceptance. There is no provision in the priority dispute regulation even mentioning this, let alone discussing the grounds upon which this should be permitted, if at all. Therefore, argues HMQ, since the statute has not occupied the field, the principles of equity or contract law can and should be applied to the circumstances of the case.

Echelon does not contest the fact that the priority dispute regulation is silent on the circumstance of an insurer seeking to resile from an agreement to accept priority. Its position however, is that for the purposes of this specific issue the court and arbitral authorities have clearly indicated that expediency and certainty in the priority dispute

system requires that insurers not be permitted to resile from agreements to accept priority except in situations where the first insurer has induced such agreement through bad faith or deliberate misrepresentation.

HMQ disagrees with Echelon's position as stated in the foregoing paragraph. HMQ submits that the arbitral decisions relied upon by Echelon have effectively over-extended the intended scope of the comments in the one court decision which has formed the basis for their interpretation, and the approach advocated by Echelon – *Kingsway General Insurance v. West Wawanosh Insurance*.[15]

HMQ submits that to the extent that arbitrators have interpreted *Kingsway v. West Wawanosh* to stand for the proposition that bad faith or deliberate misrepresentation on the part of the first insurer is required before the insurer accepting priority after receiving a NDBI should be allowed to retract an agreement, they are incorrect in should not be followed.

For the reasons which follow, I agree with HMQ's position on the issue.

I will begin my analysis with a discussion of the *Kingsway v. West Wawanosh* case. The first point that I think is important to observe is that this was essentially a limitation period case. The opening sentence of Justice Sharpe's judgment confirms this: "*This appeal concerns the time limits that apply to an insurer who wishes to dispute with another insurer liability for the payment of no-fault benefits to an injured motorist*."

Courts have always taken a very restrictive view of the circumstances in which parties to a dispute may avoid the consequences of a statutory or contractual limitation

[15] [2002] O.J. No. 528, 2002 CanLII 14202 (ONCA) ("*Kingsway v. West Wawanosh*").

period. *Kingsway v. West Wawanosh* is a prime example in the priority dispute field, but the case law is replete with other examples. I will cite one which is specific to the similarly statutorily governed loss transfer system – *Intact Insurance Company of Canada v. Lombard General Insurance Company of Canada.*[16]

The Court of Appeal in this case held that the equitable defence of laches was not available to resist a loss transfer claim under section 275 of the *Insurance Act.* In analyzing the issue the court stated (at paragraph 37) that the limitation periods provided for in the *Limitations Act*[17]*,* "…*apply to all claims – whether legal or equitable, arising under statute or common law…*".

The facts and the specific section of the priority dispute regulation under consideration in *Kingsway v. West Wawanosh* are, I believe, very important to the conclusion of the court. The claimant presented a SABS application first to West Wawanosh, then to Kingsway. West Wawanosh obtained a legal opinion and concluded that it was the higher priority insurer. West Wawanosh did not serve a Notice of Dispute Between Insurers (NDBI) within 90 days of having received the claimant's SABS application, as required by subsection 3 (1) of the priority regulation. About 6 ½ months after receiving the claimant's SABS application however, West Wawanosh was alerted to some unreported decisions which suggested that the law was different than it had been previously advised. Consequently, it served Kingsway with a NDBI, and commenced arbitration.

[16] 2015 ONCA 764 (CanLII).
[17] S.O. 2002 c. 24.

The central issue in the case for the purposes of this discussion was whether West Wawanosh satisfied the subsection 3 (2) test to permit it to serve a valid NDBI beyond the 90 days required by subsection 3 (1). The question was – whether 90 days was a sufficient time for West Wawanosh to determine that another insurer had section 268 liability to pay SABS.

The arbitrator accepted West Wawanosh's argument that 90 days was not a sufficient time, and allowed the extension of time for service of the NDBI, focusing on the fact that the priority law in question was unclear during the 90 day period and indeed after that for some time.

On appeal to the Superior Court, Justice Nordheimer reversed the arbitrator's decision. He concluded that the arbitrator appeared to have improperly read in to subsection 3 (2) the word "correctly" in respect of the priority determination required of West Wawanosh. The judge pointed out that for subsection 3 (2) purposes, the correct priority determination was not essential, just that the insurer have sufficient means/information for a priority determination to be possible. The fact that West Wawanosh was able to make a determination to accept priority based on a legal opinion (which, like the opinion here, apparently turned out to be incorrect) within the 90 day period was evidence in itself that 90 days was a sufficient time to make a priority determination.

Justice Nordheimer also emphasized that concluding 90 days was not a sufficient time to make a priority decision because the law was unclear would give subsection 3 (2) virtually unlimited application. As the judge put it (at paragraph 34), "*The law is*

frequently in a state of flux…(The arbitrator's decision) raises the thorny question as to when it can be said the law is clear."

Justice Nordheimer also dealt with an argument advanced by West Wawanosh concerning arbitral or judicial power to relieve against forfeiture – in this case, against the finality of West Wawanosh failing to satisfy the 90 day time limit or the prescribed grounds to extend it.

I will quote Justice Nordheimer's analysis on this issue because in my opinion it has a direct bearing on the *ratio* of the case and how it should be applied.

> [36] The other issue is the reliance by West Wawanoosh (*sic*) on the equitable jurisdiction to grant relief from forfeiture. This issue did not need to be addressed by Arbitrator Malach in light of his conclusion regarding the application of s. 3(2).
> [37] I am prepared for the purposes of this appeal to assume that arbitrators under the Arbitration Act, 1991 have jurisdiction to grant equitable relief. In my view, however, that jurisdiction in the circumstances of this case has been ousted by the provisions of s. 3(2) of the Regulation. The government has "occupied the field" by including a provision which allows for relief from the imposition of the 90-day notice period in the particular circumstances set out in s.3(2). Having done so, there is no jurisdiction to invoke other grounds for granting such relief.
> [38] In any event, it is questionable whether the court has any jurisdiction to relieve against a penalty or forfeiture that is decreed by statute. This principle is stated in Story on Equity, 3d ed., (1920) at para. 1326:
> When any penalty or forfeiture is imposed by statute upon the doing or omission of a certain act, then courts of equity will not interfere to mitigate the penalty or forfeiture, if incurred, for it would be in contravention of the direct expression of the legislative will.
> [39] The same principle is set forth in the Court of Appeal's decision in McBride v. Comfort Living Housing Co-operative Inc. (1992), 7 O.R. (3d) 394, 89 D.L.R. (4th) 76, where Finlayson J.A. said, at p. 402: Section 111 (now s. 98) of the CJA now sets out the equitable power of the court in much the same fashion: 111. A court may grant relief against penalties and forfeitures, on such terms as to compensation or otherwise as are considered just. This section apparently does not empower a court to relieve against penalties and forfeitures imposed by statute: Webb v. Box (1909), 19 O.L.R. 540 (Div. Ct.) (leave to appeal refused (1909), 20 O.L.R. 220 (C.A.)).
> [40] However, even assuming there is some residual jurisdiction in the court to relieve against penalties and forfeitures imposed by statute, I cannot see how the jurisdiction could arise in a situation where, as here, the statute has already stipulated for relief to be

> given in certain defined conditions and the party seeking the relief has been unable to bring itself within those defined conditions.

On appeal to the Court Of Appeal, Justice Sharpe agreed with Justice Nordheimer's reasoning as set out above, and essentially adopted it. The appeal by West Wawanosh was dismissed.

In my opinion, the reasoning in the *Kingsway v. West Wawanosh* decision cannot properly be exported beyond the section of the priority dispute regulation with which it was concerned. The court clearly focuses on the fact that section 3 of the priority dispute regulation sets out a specific time within which insurers must take certain steps, and further, sets out specific conditions for the extension of the time. It is in that context that both the Superior Court and the Court Of Appeal are speaking when they are making reference to the premium to be placed on certainty and predictability in the operation of the regulation.

The fact that the section of the regulation prescribes a specific time for a certain action, and a specific basis for determining whether the time can be extended is the entire reason for the courts stating that they have no discretion to change what the legislature has clearly mandated. Otherwise, as the judgments indicate, it would be open to the court to apply the principles of equity and common law in interpreting the section.

The case does not, in my view, purport to make a general statement about how other sections of the priority dispute regulation are to be interpreted. Even accepting that the insurers are sophisticated litigants, and that it is desirable for any statutory scheme like the priority dispute system to operate expeditiously, there is no statement anywhere in either the Superior Court or Court of Appeal decision which could be

construed as finding that the legislature intended to oust the principles of equity and contract law from consideration, if appropriate, in interpreting other sections of the priority dispute regulation.

It is even more certain, in my opinion, that there is no basis to extrapolate from the *ratio* of the *Kingsway v. West Wawanosh* case judicial approval for the theory that an insurer who has accepted priority following receipt of a NDBI may only be permitted to retract that agreement if the insurer serving the NDBI has induced the agreement through bad faith or deliberate misrepresentation. There is simply no discussion whatsoever of these concepts or even the circumstances of the withdrawal of an agreement to accept priority in the *Kingsway v. West Wawanosh* case.

Having set out the facts and analysis of the *Kingsway v. West Wawanosh* decision, I will now review the arbitration decisions which purport to follow it and which are germane to the issue before me. I will endeavour to demonstrate why, in my view, they are not persuasive in foreclosing a consideration of the principles of equity and common law to resolve the issue before me.

Echelon in its brief of authorities submitted five arbitration decisions in support of its position in the matter. In my opinion only three of those decisions are specifically relevant to the issue before me. I will comment briefly on the two decisions I do not believe to be relevant.

The first of these decisions is *AXA Insurance Company of Canada v. Her Majesty the Queen in Right of Ontario As Represented by the Minister of Finance*.[18] In this case the issue of "resilement" came up only obliquely in that AXA sought to amend the arbitration agreement to add it as an issue for the arbitration hearing. Consequently, the

[18] Arbitrator Guy Jones, February 7, 2008 ("AXA v. HMQ").

law considered here dealt with the circumstances under which a priority dispute litigant should be permitted to add an issue to arbitration which had not initially been raised. In my view it does not bear on the issue of the appropriate legal test for whether an insurer should be permitted to resile from an agreement to accept priority.

The second decision I do not consider relevant is *Erie Insurance Company v. Progressive Casualty Insurance Company.*[19] This case dealt with the question of whether the parties were jointly mistaken as to whether they had reached a full and final settlement of their priority dispute, or whether the mistake rested only with Erie and possible miscommunications between Erie and its previous counsel. The latter is what the arbitrator concluded and held that because Erie's former counsel had agreed to a full and final settlement, Erie was bound by that agreement. The arbitrator founded her decision on the law of agency, and the fact that a lawyer could bind the lawyer's client, especially in the case where the other side was unaware of any lack of authority to bind on the lawyer's part.

The first arbitration decision relied upon by Echelon which, in my opinion, is relevant to the issue I am considering is *Motors Insurance Co. v. Co-operators Insurance Co.*[20] The first important point to make here, is that Arbitrator Jones was not dealing with a case involving HMQ, and he was dealing with an entirely different version of the priority dispute regulation than the post-September, 2010 version which I must consider.

[19] Arbitrator Shari Novick, November 2009.
[20] Arbitrator Guy Jones, August, 2004 ("*Motors v. Cooperators*").

The facts were that following an accident the claimant submitted a SABS application to Cooperators. Cooperators, in accordance with its section 2 obligations, commenced paying SABS to the claimant. Cooperators took the position however, that the claimant was not principally dependent for financial support upon their insured (the only basis upon which Cooperators would have section 268 responsibility to pay SABS).

Cooperators served a NDBI on Motors Insurance, the insurer of the vehicle in which the claimant was an occupant at the time of the accident.

In this case, both Motors and Cooperators had a section 268 obligation to pay SABS. Cooperators had the highest section 268 priority, provided the claimant was determined to be a dependant of their insured. Motors had a section 268 obligation to pay SABS because of the claimant's occupancy in their vehicle, but this was indisputably a lower section 268 priority than the Cooperators if the claimant was a dependant.

Both insurers conducted investigations on the issue of whether the claimant was a dependant of the Cooperators insured. The Motors' adjuster ultimately wrote to counsel for Cooperators stating, "*please be advised that we accept priority of (the claimant's) accident benefits claim*."

About a month later Motors received a letter from the claimant's lawyer advising that it was his opinion the claimant was a dependent of the Cooperators insured. This prompted the Motors adjuster to write to Cooperators stating:

> …the information we received on the above-noted claim was not complete and incorrect. If we had been provided with all of the information that

> we now have, we would not have accepted priority…Please be advised that we are withdrawing our acceptance…

Motors argued that it should be entitled to withdraw from its agreement to accept priority based on:

> (i) new information received or,
>
> (ii) that Cooperators had acted in bad faith and had failed to provide Motors with information which Cooperators possessed with regard to the dependency issue.

Consequently, it is understandable that Arbitrator Jones phrased the issue to be decided as:

> …the right of an insurer to withdraw from an agreement to take over an accident benefit file based simply on new facts coming to light, absent any bad faith or misleading by the other insurer.

I pause to note here that the facts of the case before me, and the framing of the issue to be decided, are very different than those before Arbitrator Jones in *Motors v. Cooperators.*

The evidence in the case before me discloses that this is not a "new facts coming to light" situation. Very shortly after having been presented with the claimant's SABS application Echelon had the necessary information not only to make a priority determination within 90 days (as *Kingsway v. West Wawanosh* states should be done within 90 days if sufficient information is available to do so, even if the determination is not correct), but it had all of the necessary information to make the correct priority determination. HMQ later had that same information (except for Echelon's legal opinion).

Unlike *Motors v. Cooperators*, the case before me does not involve a situation where the section 268 order of priority between Echelon and HMQ was dependent upon gathering and evaluating information on an issue such as dependency. That was a live issue, and if it had been arbitrated, the priority order between Motors and Cooperators would have been decided by the arbitrator's decision as to whether, on the facts, a dependency existed.

In this case however, there was never any question on the facts, as far the section 268 priority tiers are concerned, that Echelon was the priority insurer. Its insured, Frazer Bird, was driving a snowmobile that by policy definition was covered for SABS. It had a statutory obligation in priority to HMQ from the outset to pay SABS to the claimant. Apart from the consequence of mistakenly accepting priority, HMQ could never have had, on the facts of this case, a statutory obligation to pay SABS to the claimant.

In this case, Echelon and HMQ had the same factual information that should have led both of them to conclude, albeit at different times, that Echelon's policy provided coverage for SABS in the circumstances. Section 268 is clear that there is never any SABS coverage responsibility for HMQ if another insurer has any level of section 268 responsibility to pay SABS to a claimant.

I find that the essence of the evidence of all the witnesses who testified at the arbitration for both sides indicated that neither Echelon nor HMQ directed their minds to the possibility of coverage for the snowmobile as an "other automobile" by operation of sections 1.3, and 2.2.3 of the policy. "*I did not consider this possibility… I believe it is*

just an oversight." (Victor Lam – Claimspro). "*I did not consider the "other automobile" provisions before recommending HMQ accept priority*" (Anne Kerr – Claimspro). "*It never occurred to me*" (Kees Van Brink – HMQ). "*I did not consider the "other automobile" provisions and the definition of automobile* (in the policy)*. I got a legal opinion to cover things off. I was not aware of the "other automobile" provisions under the OAP 1. In my opinion this was not applicable. Throughout my involvement I believed Echelon was not in priority*" (Natalie Creith – Crawford). "*I was not aware of the "other automobile" provisions in April, 2012*."[21] (Susan Verghase – Crawford).

The evidence demonstrates that both Echelon's and HMQ's agents focused on whether the snowmobile was a described vehicle in the Echelon policy, whether the claimant was a specified driver on the Echelon policy, whether the claimant was a spouse of Echelon's named insured, and whether the claimant had available to her SABS coverage under some policy other than Echelon's policy. All of these were proper priority factors to consider, but none of them turned up any coverage for the claimant.

What happened in this case was not that HMQ accepted priority, subsequently obtained further and better details on an issue that could determine priority, and then wanted to "change its mind", as Motors sought to do in *Motors v. Cooperators*. In this case, HMQ finally realized the mistake that both HMQ and Echelon had made in not noticing that there was coverage on the snowmobile from the outset under Echelon's policy and therefore, by the terms of section 268, not with HMQ.

[21] Ms.Verghase assumed carriage of this claim from Natalie Creith in April, 2012, when Ms. Creith moved to Ottawa.

Arbitrator Jones in *Motors v. Cooperators* unquestionably invokes the "*certainty, simplicity, and efficiency*" language of *Kingsway v. West Wawanosh* to support his decision not to allow Motors to retract its priority acceptance agreement. As I have opined earlier however, I do not accept that *Kingsway v. West Wawanosh* supports a general statement of law that an insurer should only be permitted to withdraw an acceptance of priority in extreme circumstances involving bad faith or deliberate misrepresentation on the part of the other insurer.

The following excerpt from the decision of Arbitrator Jones illustrates, in my view, that like *Kingsway v. West Wananosh*, the result in *Motors v. Cooperators* should also be confined to its own facts.[22]

> While I accept that in proper circumstances an arbitrator can exercise his equitable powers to intervene and allow a party to withdraw from an agreement, this should only occur in the most extreme cases. In a scheme where certainty, simplicity and efficiency are important, allowing one party to revoke a previous agreement simply because they may later become aware of new facts is not desirable. To allow such an approach would be to encourage parties to change their positions each time they obtained new facts…

Given the manner in which Motors argued its case, a good part of Arbitrator Jones' analysis in *Motors v. Cooperators* was taken up with whether Cooperators had deliberately withheld information (statements) from Motors, and thus had either acted in bad faith or had deliberately misled Motors. Ultimately Arbitrator Jones decided that Cooperators had not done so. Some of his comments in this area again raise an

[22] Arbitrator Densem's emphasis.

important point of distinction between the priority dispute regulation as Arbitrator Jones was interpreting it at that time, and as it exists in the case before me. He stated:[23]

> While I accept that it is desirable that the parties in a priority dispute provide information and documentation to each other, I do not accept that there is an obligation to provide the documentation even if it is not requested…there is an obligation on both sides to investigate the claims and to do what is necessary to advance their positions. They cannot simply take the position that it is up to the other insurer to do the investigation and provide the documentation even if not requested.

Arbitrator Jones made these comments with respect to priority dispute regulation procedure as it was in 2004. That is not however, the version of the priority dispute regulation that I must consider. As I have emphasized, the September, 2010 amendments to the priority dispute regulation place a positive obligation on an insurer who wishes to serve an NDBI on HMQ not only to conduct a reasonable investigation, but to provide the particulars and the results of that investigation to HMQ before serving the NDBI.

In my opinion, certainly in cases involving HMQ, the “bad faith” and “deliberate misrepresentation” analysis as it may relate to what documentation/information has or has not been provided to HMQ has no application after the September, 2010 priority dispute regulation amendments, if indeed it ever had appropriate application for this kind of an issue in a priority dispute.

[23] At page 12.

The next decision that I will address is another decision of Arbitrator Jones in *Enterprise Rent A Car v. ING Insurance Company of Canada*.[24] This may be the closest case on the facts to the case before me, but there are still crucial points of distinction.

The facts were that the claimant was involved in an accident while operating a vehicle rented from Enterprise. He submitted a SABS application to Enterprise. There was no question that Enterprise had section 268 responsibility to pay SABS to the claimant. The only question was whether another insurer had a higher priority to pay SABS.

As a result of its investigation, Enterprise determined that the claimant was a specified driver on ING's policy, a higher priority level under section 268 than Enterprise. Enterprise served a NDBI on ING. ING wrote to Enterprise confirming that the claimant was a "listed driver" on the ING policy. Therefore, ING advised it accepted priority.

About a month after writing the letter mentioned, ING wrote again to Enterprise. In this letter ING stated that it had reviewed the coverages on its policy and determined that the policy only provided comprehensive coverage. Therefore, ING sought to withdraw its acceptance of priority.

This second letter attempting to withdraw the acceptance of priority followed ING's further investigation which determined that prior to the accident, ING, at the request of the named insured on the policy, purported to have reduced the coverage on

[24] Arbitrator Jones, November, 2006 ("*Enterprise v. ING*").

what was otherwise a standard motor vehicle liability policy, to a policy providing only comprehensive coverage.

The two issues arbitrated with Arbitrator Jones were the effect of ING's acceptance of priority, and the effect of the attempt to reduce coverage under ING's motor vehicle liability policy to only comprehensive coverage.

Arbitrator Jones once again made reference to the *Kingsway v. West Wawanosh*, and his own decision in *Motors v. Cooperators*, in declining to allow ING to withdraw its acceptance of priority. He reiterated his view[25] that:

> …a company can withdrawal (*sic)* its acceptance when a party has acted in bad faith or, potentially for other reasons.[26] It is not a power to be used lightly...Only in the most extreme situation should be withdrawal be permitted.

Arbitrator Jones considered the argument that ING should be permitted to withdraw its priority agreement because it had misconstrued the extent of its own coverage. There is no doubt that he did not consider this to be a sufficient reason to permit withdrawal. He stated:[27]

> A reasonable adjuster should know the difference between full motor vehicle liability insurance and comprehensive insurance and how it impacts on accident benefit availability. In this particular case, all relevant facts were in the possession of ING.

It is of note that after making these comments, Arbitrator Jones goes on to analyze the second issue – whether ING had been effective in its attempt to reduce the coverage under its policy from a standard motor vehicle liability policy to only

[25] At page 5.
[26] Arbitrator Densem's emphasis.
[27] At page 9.

comprehensive coverage. In beginning his analysis of the issue, Arbitrator Jones states[28]:

> As will become evident from my decision with regard to this issue, the question of the withdrawal of acceptance of priority by ING is academic.

Arbitrator Jones goes on to conclude that ING's attempt to reduce its coverage under a current policy of motor vehicle liability insurance to one of only comprehensive coverage was ineffective because ING did not use the appropriate OPCF 16 form mandated by the *Insurance Act* to accomplish the change. Therefore, ING's policy still provided SABS coverage on a higher priority level than Enterprise at the time of the accident. Secondly, had the OPCF 16 been used as required, SABS coverage under the policy would have been preserved in any event.[29]

Therefore, technically Arbitrator Jones' conclusion that ING's reason for wanting to withdraw its agreement to accept priority (misconstruing its own coverage) was insufficient in law, was *obiter dicta.*

Like *Motors v. Cooperators*, in my view there are a couple of important factual distinctions between *Enterprise v. ING*, and the facts of the case before me. In *Enterprise v. ING*, it was only ING which made a mistake in coming to its conclusions about coverage to make its priority decision. Here both Echelon and HMQ made the same mistake. The evidence confirms that had either of them realized the mistake and

[28] At page 10.
[29] Several years later in *Dominion of Canada General Insurance Company v. Optimum Insurance Company*, 2016 ONSC 985 (CanLII), Justice Perell confirmed that Arbitrator Jones' conclusions on the requirement to an OPCF 16 to reduce coverage, and its preservation of SABS coverage, were correct.

appreciated the certainty of Echelon's coverage then there never would have been a priority dispute proceeding, or it would have ended very quickly.

When it served its NDBI Enterprise did not know anything nor should it have known anything about the matter of ING's policy possibly having been reduced from full motor vehicle liability coverage to comprehensive coverage. It only knew that the claimant was a listed driver on whatever policy ING had underwritten which would have made ING the priority insurer. Here, there was sufficient information available from the beginning for Echelon to realize that its policy provided SABS and that there was no valid priority grounds to serve HMQ with a NDBI.

Further, Enterprise made no representations to ING that were factually or legally incorrect when it ought to have known differently. In this case Echelon represented to HMQ in the NDBI that the snowmobile involved in the accident was "uninsured". Later, in a letter enclosing underwriting information and a note, Echelon represented to HMQ that it did not insure snowmobiles in Ontario. The first representation was clearly wrong both in fact and law. The second representation, although it may have been correct in the sense that Echelon did not actively insure snowmobiles as described automobiles in their policies, it was most definitely misleading in the context of the ongoing priority discussions about whether the specific snowmobile involved in the accident was covered under Frazer Bird's Echelon policy.

Although I will discuss the issue of representations made by Echelon in more detail further on in my Award, I want to mention here that I find on the evidence there was no bad faith or deliberate misrepresentation on the part of Echelon in its conduct

towards HMQ. To the contrary, in my view the evidence confirms that both Echelon and HMQ were honestly mistaken about their interpretation of the information they had relative to the priority issue. Each believed incorrectly that Echelon's policy provided no SABS coverage for the snowmobile involved in the accident, and that absent coverage with another private insurer (a fact of which they were both correctly satisfied) HMQ by default was responsible for the payment of SABS to the claimant.

Enterprise v. ING is distinguishable on its facts, and because Arbitrator Jones' conclusion on the relevant issue was *obiter dicta.* The overall tenor of his decision indicates however, that no matter what his conclusion was on the issue of whether ING had failed to effectively reduce its coverage, he would not have permitted ING to withdraw its acceptance of priority in the circumstances.

Perhaps the "mutual mistake" facts of the case before me might come within the "*other reasons*" Arbitrator Jones alluded to in his analysis to permit an insurer to withdraw an acceptance of priority. There is little point in speculating on the matter. In any event, I would not want to be interpreted to have founded my decision on an "*other reasons*" exception carved out of an otherwise "extreme situation" general principle purported to be laid down by Arbitrator Jones for these types of cases.

To the extent then it is necessary for me to do so, for the reasons I have outlined earlier in this Award, I must respectfully disagree with my colleague, Arbitrator Jones' view of the law, that an insurer is prohibited from withdrawing a priority acceptance only in the extreme situation where there has been bad faith or deliberate misrepresentation on the part of the insurer proposing the priority acceptance.

The final case about which I will comment in the line of authority submitted by Echelon is *Aviva Insurance Company v. State Farm Insurance Company*.[30] The facts of this case are similar to those in *Motors v. Cooperators*. A SABS claimant was involved in an accident while driving his employer's vehicle. He submitted a SABS application his employer's insurer, Aviva. Aviva began paying benefits and through investigation determined that the claimant was a named insured on a State Farm automobile policy. Aviva served State Farm with a NDBI.

Once again, it is noteworthy that both insurers had section 268 responsibility to pay SABS. The question was which insurer was in higher priority.

About three months after being served with the NDBI State Farm wrote to Aviva confirming that the claimant was a named insured on the State Farm policy, and that State Farm would accept priority for the SABS claim.

A month and a half later State Farm wrote again to Aviva indicating that it had "inadvertently accepted priority", and that it was withdrawing its acceptance of priority pending further investigation as to whether the claimant was a deemed named insured on Aviva's policy.

As it turned out, State Farm did not do any further investigation on the deemed named insured issue. The implication from the award, although not explicitly stated, is that State Farm, after agreeing to accept priority, adverted to the fact that Aviva may have had higher priority because the claimant may have been a deemed named insured

[30] Arbitrator Shari Novick, March, 2012.

and an occupant of the Aviva insured vehicle at the time of the accident.[31] To finally determine priority however, if the matter had proceeded beyond the preliminary issue the Arbitrator would have had to decide whether the claimant met the test under what was then section 66 of the SABS to be a "deemed named insured" under Aviva's policy.[32]

Arbitrator Novick found on the evidence that no new facts came to light after State Farm had accepted priority. Proper diligence would have discovered them before that. On this point, it was significant to the Arbitrator that the State Farm adjuster demonstrated a lack of diligence in investigating the priority issue both before and after his purported attempt to withdraw acceptance of priority.

State Farm sought to characterize the situation as an "honest mistake" by the State Farm adjuster. Counsel sought to distinguish the cases of Arbitrator Jones on the basis that they overstated the *ratio* of *Kingsway v. West Wawanosh*.

State Farm argued that there was no legal basis to support restricting an insurer's entitlement to withdraw acceptance of priority to situations of "extreme or unusual circumstances" such as bad faith or deliberate misrepresentation.

State Farm's counsel raised the decision of the Superior Court in *GAN General Insurance v. State Farm Mutual Insurance*[33] as an example of a decision in a loss transfer matter which applied the equitable principle of unjust enrichment. The court set aside an agreement by GAN to indemnify State Farm in loss transfer for SABS paid,

[31] The result achieved by section 268 (5.2) where the claimant is a named insured (or deemed named insured) under the policies under consideration for priority.
[32] The "deemed named insured" provisions are now in s. 3 (7) (f) and (g) of the SABS.
[33] [1999] O.J. No. 4467 ("*GAN v. State Farm*").

and ordered the return of monies paid by GAN to State Farm. I will have more to say about this case later in my Award.

Arbitrator Novick distinguished the situation in the case before her from *GAN v. State Farm* by saying that there is a distinction between a loss transfer payment made on the basis of an "erroneous assumption", and a decision to take over the adjusting of a file based on acceptance of priority that was made without conducting any investigation or gathering any facts.[34]

As will be apparent from my comments later, accepting Arbitrator Novick's characterization of the facts in *GAN v. State Farm* and the facts in the case before her, in my view, the facts in the case before me are much more akin to those in *GAN v. State Farm* than *Aviva v. State Farm*.

There is no doubt that Arbitrator Novick was influenced by the two decisions of Arbitrator Jones which I have discussed. She repeated the rationale espoused by Arbitrator Jones arising from his reliance on the language in *Kingsway v. West Wawanosh* to severely limit the circumstances in which an insurer may withdraw agreement to accept priority, and appears to have relied upon it for her decision not to allow State Farm to withdraw its priority acceptance in that case.

The arbitrator was also influenced by a "floodgates" argument advanced by counsel for Aviva. She stated:[35]

> …the system cannot function efficiently if adjusters fail to investigate at the appropriate time, and then, after advising the first insurer that they accept

[34] See page 12.
[35] At page 11.

> priority to take over the claim, ask a colleague and change their mind. As (counsel for Aviva) warned, if this were allowed to happen on a regular basis, the system would devolve into chaos.

In other comments Arbitrator Novick seems to have allowed for some latitude in the determination of whether an insurer should be permitted to withdraw a priority acceptance. After repeating Arbitrator Jones' view that withdrawal should only be permitted in the extreme case of bad faith or deliberate misrepresentation/misleading on the part of the insurer seeking priority acceptance, Arbitrator Novick stated as follows:[36]

> There may be circumstances in which incorrect information is communicated by a reliable third-party that an insurer relies on to accept priority, that is subsequently determined to be untrue. Each case must be determined on its own facts, but it seems that in those cases, the prejudice suffered by each party, if any, should be balanced against the need for efficiency and expediency in deciding whether a withdrawal of priority should be accepted.

The latter part of this comment strikes me to be very much a statement of how, in a general sense, equitable principles and contract principles are applied in the appropriate case.

To the extent this case needs to be distinguished, in my opinion the focus of Arbitrator Novick's decision was State Farm's failure to properly investigate the priority issue before it accepted priority, and after it sought to withdraw its acceptance of priority. She distinguished *GAN v. State Farm* on the basis that it was a case of "erroneous assumption" which in my view is similar to "honest mistake". On the facts of the case before her, Arbitrator Novick appears to have concluded that what occurred

[36] At page 11-12.

was not so much an honest mistake on the part of State Farm, but instead the result of a "*lackadaisical*" approach to investigating priority.

As I have noted with respect to the decisions of Arbitrator Jones, in *Aviva v. State Farm* Arbitrator Novick was not dealing with a case involving HMQ, and section 3.1 of the priority dispute regulation which imposes a positive duty upon an insurer seeking to have HMQ accept priority to complete a reasonable investigation and provide HMQ with the particulars and the results of that investigation before serving a NDBI on HMQ.

Even if HMQ could be said to have an obligation to conduct its own priority investigation in addition to what the other insurer must provide to it, there is no evidence in the case before me that HMQ was "lackadaisical" in its approach to investigating priority. In fact, the evidence is to the contrary. After receiving Echelon's NDBI, HMQ's agent repeatedly pressed Echelon's agent for particulars and results concerning Echelon's investigation of the priority issue. HMQ's agent did not receive a prompt response from Echelon's agent, and when it did, the response was not complete. HMQ's agents pursued its own inquiries, not because the priority regulation required it to do so, but because it obviously wanted to get to the bottom of the priority issue to determine whether it did or did not have responsibility to pay SABS in the circumstances. Ultimately, HMQ's agent obtained the critical information (the statutory declaration of the claimant) from claimant's counsel as a result of its own efforts. It was only much later, and after further entreaties to Echelon's agent, that the underwriting notes and the misleading statement about Echelon not insuring snowmobiles in Ontario was provided to HMQ.

There is no doubt that HMQ came to the wrong conclusion on the question of priority after it had obtained the necessary information. It was the same wrong conclusion that Echelon had arrived at before serving its NDBI. In my opinion, the evidence in this case demonstrates that both Echelon, and HMQ made an “honest mistake” in coming to their erroneous conclusions concerning priority.

I will not repeat here all of my earlier expressed reasons for not agreeing with the view of the law set out in the cases of Arbitrator Jones and Arbitrator Novick which I have reviewed.

It will be observed that I am of the view that there is insufficient legal foundation for such a severe narrowing of the circumstances in which an insurer may withdraw an agreement to accept priority – especially considering the section 3.1 amendment to the priority dispute regulation for cases involving HMQ. I find as well that the many factual differences in these cases from the facts in this case render them distinguishable, and therefore inapplicable to the facts in the case before me.

For the reasons I have outlined, in my opinion it is appropriate to apply principles of equity, or, if necessary, principles of contract law in deciding whether HMQ should be permitted to withdraw its acceptance of priority.

Is also my view that I need go no further than to consider the court’s application of the equitable doctrine of restitution as was done by Justice Pitt in *GAN v. State Farm* to resolve the issue in this case.

The facts of *GAN v. State Farm* were that a heavy commercial vehicle (“GAN’s truck”) insured by GAN rear-ended a stationary car. This caused a multi-vehicle or

"chain" collision involving five vehicles in total. State Farm insured a vehicle in the line of vehicles ahead of GAN's truck, but it was not the car directly ahead of GAN's truck so GAN's truck had not collided with State Farm's car.

State Farm paid SABS to its insured, and, pursuant to the loss transfer scheme created by section 275 of the *Insurance Act*, State Farm sought indemnity from GAN for the SABS paid.

Claims of this nature under the loss transfer scheme are governed in part by the Fault Determination Rules ("FDR") prescribed in Regulation 668 under the *Insurance Act*. The FDR are used to determine fault for the accident which in turn fixes the percentage of indemnity, if any, that the insurer against whom loss transfer is sought may owe.

GAN accepted loss transfer and paid approximately $11,000.00 to State Farm in loss transfer indemnity. Sometime later however, GAN contacted State Farm requesting the return of monies it had paid taking the position that it had incorrectly applied the FDR and that it did not owe that money to State Farm.

The matter proceeded to arbitration on the issues of whether GAN was obliged to indemnify State Farm on a proper application of the FDR.

The arbitrator applied FDR 5, and held that GAN was obliged to indemnify State Farm in loss transfer. GAN appealed to the Superior Court.

For the purposes of the issue before me, suffice it to say that Justice Pitt concluded that the arbitrator erred in applying FDR 5 to the circumstances, and arrived

at the incorrect legal result. Justice Pitt held that FDR 9 applied to the circumstances and required a different legal result which meant GAN was not obligated to indemnify State Farm.[37]

In addition to the issue as to whether the arbitrator erred in interpreting the FDR, the following issue was submitted to the court for decision:

> …(3) If the Arbitrator erred in ordering GAN to indemnify State Farm, is the amount already paid by GAN to State Farm recoverable by GAN?

Justice Pitt relied upon the decision of the Superior Court in *Corporation of the Township of Moore v. Guarantee Co. of North America*[38] in holding that where monies have been paid because of a mistake of law or fact, recovery may follow, subject to equitable defences in cases where, for example, the payee has changed his position or where the payment was made in settlement of an honest claim.

Justice Pitt quoted from the Superior Court decision in *Morgan Guaranty Trust Co. of New York v. Outerbridge*[39] in outlining the requirements for the equitable doctrine of restitution to be applied:

> The defendant was enriched by receipt of the $150,000.00 clearly paid to him by mistake; the defendant was enriched at the plaintiff's expense; there was no juristic reason for the enrichment. What remains to be considered is whether it would be "unjust" to allow the defendant to retain the benefit.

[37] Many years later the issue of the correct interpretation of the FDR in the circumstances of a "chain" collision resurfaced. It was dealt with in loss transfer arbitrations and again by the Superior Court. Ultimately, the Court of Appeal in *State Farm Mutual Automobile Insurance Company v. Old Republic Insurance Company of Canada*, 2015, ONCA 699 CanLII, interpreted the FDR in a manner which effectively supported Justice Pitt's approach in *GAN v. State Farm*.
[38] (1991), 2 O.R. (3d) 370 ("*Township of Moore v. Guarantee Co*.").
[39] (1990) 72 O.R. (2d) 161 ("*Morgan Guaranty Trust v. Outerbridge*").

> …if the defendant has changed his position so that it would be inequitable to require him to make restitution, then restitution will not be ordered. The onus of establishing a change in position is on the defendant asserting the change…But the mere fact that money or benefit conferred by the triggering mistake has been spent in itself is not sufficient to amount to a change in position giving rise to an equitable defence to a claim for restitution.

In *GAN v. State Farm*, Justice Pitt concluded that the prerequisites for the application of the doctrine of restitution had been satisfied – State Farm was enriched by mistake; it was at GAN's expense, and there was no juristic reason for it.

It remained for him to consider whether State Farm had made out any equitable defence to it being ordered to return the indemnity payments to GAN.

In *GAN v. State Farm*, Justice Pitt emphasized that the onus was on State Farm to demonstrate that it had detrimentally changed its position as a result of receiving the monies from GAN. He noted that State Farm did not advance this argument.

State Farm did argue however, that the monies paid to it by GAN were in partial satisfaction of a settlement of a claim – referring to the court's reference to the equitable defence of "settlement of an honest claim" in *Township of Moore v. Guarantee Co*., (which itself relied on a long line of authority concerning the law of restitution).

Justice Pitt rejected the argument that GAN had paid the loss transfer indemnity to State Farm in satisfaction of a settlement of an honest claim. He concluded as follows:[40]

> GAN did not pay those monies in satisfaction of a "settlement of an honest claim": it paid them pursuant to a statutory scheme and it did so in error.

[40] At paragraph 27.

> There was nothing to "settle". I believe Eberle J. (*in Township of Moore v. Guarantee Co.*) is referring to settlement of lawsuit claims…If a defendant pays a sum pursuant to a settlement in a claim brought honestly against it, then it is appropriate that in that case it should not be able to reclaim the monies it paid in satisfaction of the settlement agreed to. This case, however, is not such a case, and GAN should recover the funds it paid to State Farm.

In my opinion, apart from the fact that the payments by HMQ to Echelon in this case were made pursuant to the statutory SABS priority scheme set out in subsection 268 (2) of the *Insurance Act* and Regulation 283/95, as opposed to the statutory loss transfer scheme established by section 275 of the *Insurance Act*, there is no practical difference between circumstances of *GAN v. State Farm*, and the circumstances of the case before me.

HMQ agreed to accept priority and paid monies to Echelon in error. Echelon was enriched by HMQ's mistake. There was no juristic reason to support the enrichment. There was never a question of HMQ actually or potentially having priority for the payment of SABS in the circumstances. Echelon always had priority on a proper interpretation of its policy, and section 268 (2) of the SABS.

As the case law requires, I must address whether it would be unjust to require Echelon to return the monies received from HMQ, and to declare it the priority insurer for the purposes of the payment of SABS to the claimant.

I will deal first with the question of whether the agreement to accept priority and to indemnify Echelon by HMQ was made in the "settlement of an honest claim" as that phrase has been interpreted. I am not bound to follow Justice Pitt's reasoning on this

issue in *GAN v. State Farm*, but I nevertheless find it persuasive and applicable to the case before me.

Without trying to come up with an exhaustive definition of what “honest” means in the phrase, “settlement of an honest claim”, I agree with Justice Pitt that it makes sense to interpret it as meaning the settlement of a lawsuit claim, because that is the context in which the courts appear to have considered the term.

Even if it could be interpreted to include settlements of disputes apart from lawsuits in the traditional sense, in my view it still contemplates that the settlement be made where there are some sort of arguable facts or law which might potentially see either party succeed if the matter proceeded to judgment on the merits of the priority issue.

In any case, that is not fact situation here. There is no lawsuit to be settled. Further, in my view there never was an arguable case on the facts or the law that would have led to a correct arbitral or judicial finding whereby HMQ, and not Echelon, would have been found in priority for the payment of SABS.

I adopt the reasoning of Justice Pitt in finding that the combination of HMQ accepting priority by mistake, and making payments to Echelon pursuant to a statutory scheme, supports the application of the principles of unjust enrichment and restitution in this case.

To say that *GAN v. State Farm* dealt with the statutory loss transfer regime but this case deals with the statutory priority regime is, in my opinion, highlighting a distinction without a difference. Both regimes create an entitlement to indemnification for

SABS paid by one insurer from another insurer which does not exist at common law. Both regimes prescribe the terms of entitlement to that indemnity and the procedures to be followed in claiming such indemnity.

Therefore, I would reject as a defence on the part of Echelon to the unjust enrichment claim of HMQ that HMQ's acceptance of priority and payments to Echelon were made in the settlement of an honest claim.

The next question to be answered is whether it would be unjust to allow HMQ to withdraw its agreement to accept priority and require Echelon to make restitution of the monies paid by HMQ because Echelon detrimentally changed its position or its circumstances in reliance upon HMQ's decision.

The law is clear that the party arguing for this defence is not able to submit as a detriment the fact that righting of the wrong created by the unjust enrichment will make them worse off than they would have been had the wrong not been righted. There needs to be some other kind of prejudice or change of circumstances in reliance upon the mistake made by the first party which is significant enough to make it unfair to order restitution.

I am not satisfied that the evidence demonstrates Echelon has established this defence.

The only evidence in this case which is germane to this defence relates to Echelon taking down (reducing to zero) some of the reserves it had set up for Ms. Barnes' SABS claim after HMQ had agreed to accept priority.

All of the witnesses who testified on both sides – each one an experienced insurance professional, agreed that the setting of reserves is an important exercise for an insurance company and indeed, it is a requirement in the insurance business imposed by law and monitored by the Superintendent of Financial Institutions.

Susan Verghase of Crawford, a witness called to testify by Echelon, stated that for claims anticipated to be worth more than $100,000.00 she would make recommendations regarding the amount of reserves to Echelon, and Echelon would make the decision as to whether to approve her recommendation. For claims anticipated to be worth less than $100,000.00 she had the discretion to set reserves on behalf of Echelon.

In this case, Ms. Verghase testified, after HMQ accepted priority the reserves for claims such as medical and rehabilitation benefits, income replacement benefits, and attendant care were reduced to zero. Reserves for adjusting expenses were left in place.

On cross-examination, Ms. Verghase conceded that once it was apparent that there was going to be a dispute with HMQ as to whether it could withdraw its acceptance of priority, and Echelon's file had been sent to counsel, she "*set minimum reserves at this time*". It was not explained in her evidence what "minimum reserves" meant other than they were different than the reserves set when the claim was first reported.

While I would accept as a statement of general truth that the setting of reserves is an important function for an insurance company to perform, and that doing so

inadequately or improperly could have serious legal consequences, or even imperil the financial stability of the company, in my opinion that is not sufficient to establish the defence of detrimental change of position in this case.

Echelon's taking down of the reserves it originally posted for Ms. Barnes SABS claim, and then re-establishing only "minimum" reserves when it became apparent that there was going to be a priority dispute in this matter, is not sufficient, in my opinion, to prove that the Echelon has detrimentally changed its position to the point where it would be unfair to order restitution to HMQ. Echelon led no evidence about how re-establishing adequate reserves for this claim as an insurer might do, for example, with a new claim, would cause it serious hardship or prejudice. I suspect that this was not an oversight on Echelon's part in advancing its case. The explanation is more likely that having to do so would not cause serious hardship or prejudice.

In my opinion, the only real prejudice to Echelon that would occur by ordering restitution is that Echelon would have to pay back HMQ and reassume responsibility for the payment of SABS to the claimant. That is not the "prejudice" or detrimental change of position contemplated as an equitable defence to a claim for restitution. It is simply the consequence of righting the wrong which has occurred, and essentially putting Echelon back in the position priority insurer – a position in which it should have remained according to the facts and law of this case.

Lest it be said that *GAN v. State Farm* is an "old" case, and that priority dispute law has evolved differently since then, I would emphasize that the concept of unjust enrichment has recently been applied in arbitral decisions and by the court to permit

recovery of administrative expenses in priority disputes. The principles discussed in these cases are the same as those employed by Justice Pitt in *GAN v. State Farm*.[41]

Given the conclusion which I have reached on the applicability of the equitable doctrine of restitution, it is technically not necessary for me to consider the other legal grounds advanced by HMQ for its argument that its acceptance of priority should be set aside and Echelon declared the priority insurer.

In the event I am found to be in error in analogizing this case to *GAN v State Farm*, and my application of the law of restitution, I will briefly address these other grounds.

If the unjust enrichment approach in the nature of *GAN v. State Farm* is found to be inappropriate for this case, I would find that there was a contract between HMQ and Echelon whereby HMQ agreed to assume priority for the payment of SABS to the claimant. I would find however, that the contract was *void ab initio* based on the mutual mistake in belief of the parties as to a fundamental term of the contract. The entire basis of HMQ agreeing to accept priority was its mistaken belief that it was the priority insurer under section 268 (2), because Echelon had no section 268 (2) responsibility. Echelon held the identical mistaken belief.

This legal principle has been stated in many cases. One of those cited by HMQ is *R. v. Ontario Flue-Cured Tobacco Growers Marketing Board*.[42] The Court of Appeal said:

[41] See *Ontario (Minister of Finance) v. Lombard Insurance Co. of Canada* [2010] O.J. 1210, Perell J., *Aviva Insurance Company of Canada v. Sovereign General Insurance Company*, January 27, 2016, Arbitrator Samis, *HMQ v. Guarantee Company*, July 25, 2012, Arbitrator Densem.

> Where the parties contract under a false and fundamental assumption, going to the root of the contract, and which both of them must be taken to have had in mind at the time they entered into it as the basis of their agreement, the contract is void.

In my opinion, there is no question on the evidence in this case that both HMQ and Echelon were mistaken about a fundamental assumption going to the root of the contract – that Echelon's policy did not insure the snowmobile involved in the accident. Neither of the parties would have entered into the agreement whereby HMQ accepted priority for the claim had they not been mistaken about Echelon's coverage.

Relying on another line of legal authority, HMQ has submitted that if it had a settlement contract with Echelon, the contract should be rescinded on the basis that Echelon made misrepresentations about a material term of the contract, inducing HMQ to enter into the contract. HMQ relies upon the following statement of law:

> A material misrepresentation, whether innocent or fraudulent, may be grounds to set aside a contract entered into by one party in reliance on the representation…For innocent misrepresentation the representation might be entirely honest and careful, there is no need for promissory intention, the negligence of the party seeking relief is no defence, and there is a presumption that a material representation did in fact cause the misrepresentee to enter into the transaction. The presumption can be rebutted by proof of no reliance on the misrepresentation.[43]

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[42] 1965 CanLII 212 (ONCA).
[43] *Barclays Bank v. Metcalfe & Mansfield*, supra, note 4, at pargraph 156 ff.

HMQ also points out that it is not necessary that the misrepresentation was the sole inducement for the misrepresentee, or only one of several factors contributing to the misrepresentee's decision to enter into the contract.[44]

In my opinion, the evidence confirms that Echelon made misrepresentations to HMQ about a term that was fundamental to the agreement – the insurance status of the snowmobile, and therefore the coverage issue that was at the root of the priority issue.

Echelon's first misrepresentation was contained in the NDBI where it stated that the SABS claimant was a passenger on an "*uninsured snowmobile*". The second misrepresentation, although arguably less clear, was the statement as part of a letter accompanying underwriting notes to the effect that Echelon did not insure snowmobiles in Ontario.

As I have stated, there was no bad faith or intent to deceive on Echelon's part in making these representations to HMQ. Echelon had a genuine, but mistaken belief that its policy did not provide SABS coverage for the snowmobile. This was the same mistaken belief that HMQ developed before it accepted priority.

In the context of this legal issue, the essence of Echelon's position could be described as HMQ should be responsible for its own negligence in failing to come to the correct coverage conclusion even though it had the necessary information to do so at the time it made its decision.

[44] *Barclays Bank v. Metcalfe & Mansfield*, supra, note 4, at paragraphs 158 – 159.

As the law confirms however, even if HMQ was negligent in coming to the incorrect priority conclusion, such negligence is not a defence to a misrepresentation claim.

The more difficult aspect of this particular cause of action is, in my view, whether Echelon has established that HMQ placed no reliance on Echelon's misrepresentations. I have discussed earlier, evidence that was elicited from a witness called on behalf of HMQ's agent to the effect that his decision to recommend acceptance of priority to HMQ was based on the information generated from his priority investigation. He commented that generally speaking, one did not simply accept the word of another insurer in a priority matter, one had to do one's own due diligence.

Considering the entirety of the evidence however, I am of the view that the unequivocal assertions made by Echelon in the NDBI, and later in the underwriting documents/notes submitted to HMQ, had some influence on HMQ's evaluation of the matter. The aforementioned witness, Victor Lam, testified on direct examination that he did rely on the underwriting note he received from Echelon stating that it did not insure snowmobiles in Ontario to support his conclusion that Echelon must not have insured the snowmobile in question.

One could debate the semantics of what is meant by "rely" in this context. It might mean that the recipient of the information had no reason to suspect the information was untrue, but based a decision exclusively on the recipient's own investigation and analysis, and not at all on what was stated by the sender of the information. The other extreme would be that the recipient of the information placed

complete faith in the information provided as being true, did not conduct any independent investigation, and thereby based a decision completely on what the recipient was told by the sender of the information.

Echelon urges me to conclude that the first scenario in the previous paragraph is what occurred here. As I have stated, considering the evidence as a whole I do not accept that the misrepresentations by Echelon, innocent though they were, had absolutely no impact on HMQ's decision-making.

There was no reason in the circumstances for HMQ to doubt the veracity of the representations made by a well-known, reputable Ontario insurer. Even if they were not the entire basis for HMQ's conclusion that Echelon did not insure the snowmobile, the conclusive statements of fact about "uninsured snowmobile" and not insuring any snowmobiles in Ontario were a reason for HMQ's decision. They would have influenced what HMQ directed its mind to when considering the claimant's statutory declaration and other underwriting notes. They certainly would not have increased the likelihood that HMQ would undertake a wider search for insurance coverage for the snowmobile.

I am of the view that the misrepresentation/reliance issue must be considered as well in the context of a priority case involving HMQ. Insurers now have the statutory obligation to conduct a reasonable priority investigation, and to provide HMQ with full disclosure of the particulars and results of its investigation before serving a NDBI on HMQ.

It is my opinion, as my analysis of whether an investigation has been "reasonable" would indicate, this statutory obligation if anything, enhances an insurer's

responsibility to be quite sure it has grounds for serving a NDBI on HMQ, and if it is going to serve HMQ with a NDBI, it should anticipate that HMQ will place at least some reliance on the investigation particulars and results provided.

The other issue that should be addressed in the context of the misrepresentation about a settlement contract argument is the question of whether HMQ waived its rights to dispute priority.

The Supreme Court of Canada outlined the essentials of the waiver doctrine in *Saskatchewan River Bungalows v. Maritime Life Insurance Co* as follows.[45]

> …Waiver occurs where one party to a contract or to proceedings takes steps which amount to forgoing reliance on some known right or defect in the performance of the other party…
>
> …The essentials of waiver are thus full knowledge of the deficiency which might be relied upon and the unequivocal intention to relinquish the right to rely on it. That intention may be expressed in a formal legal document, it may be expressed in some informal fashion or it may be inferred from conduct. In whatever fashion intention to relinquish the right is communicated, however, the conscious intention to do so is what must be ascertained,
>
> Waiver will be found only where the evidence demonstrates that the party waiving had (1) full knowledge of rights; and (2) an unequivocal and conscious intention to abandon them…

HMQ submits that when the right which HMQ had is properly identified, it will be seen that it could not have been waived in the circumstances.

[45] [1994] 2 S.C.R. 490 ("*Saskatchewan v. Maritime Life*"), at paragraphs 18, 19, and 20.

HMQ identifies the right as the right to dispute priority because coverage existed for the snowmobile under Echelon's policy. HMQ submits that it could not have waived this right because it mistakenly never directed its mind to it before accepting priority.

HMQ submits that to be found to have waived this right, there would have to be a finding that HMQ adverted to the fact that Echelon's policy covered the snowmobile, but in spite of that, HMQ decided to accept priority. At the risk of stating the obvious I would observe that there was zero chance of HMQ deciding to accept priority if it had realized there was coverage under Echelon's policy.

Echelon argues that HMQ did have full knowledge of its rights when it decided to accept priority. This argument is based on the "sophisticated litigant" theory underlying other parts of Echelon's case. Echelon submits that it is irrelevant whether HMQ directed its mind specifically to the appropriate definition and "other automobile" coverage provisions. As a sophisticated litigant it should be deemed to know about the coverage provisions it did not turn its mind to in this case.

If more than a "deemed to know" level of knowledge is required, Echelon points to a 2009 arbitration decision in HMQ's own Brief of Authorities where HMQ successfully argued the application of the "other automobile" provisions in an allegedly uninsured automobile case as evidence of HMQ's actual knowledge of these provisions.[46]

Echelon submits that the evidence of the HMQ decision maker in this case, Kees Van Brink, reinforces its "actual knowledge" submission because Mr. Van Brink

[46] *The Economical Insurance Group v. Her Majesty the Queen in Right of Ontario As Represented by the Minister of Finance*, Arbitrator Shari Novick, January, 2009.

indicated that he was aware of such cases involving HMQ prior to this one where the "other automobile" provisions were argued by HMQ.

Finally, Echelon draws my attention to a decision I made in the loss transfer arbitration case *Intact Insurance Company v. St. Paul Fire & Marine Insurance Co*.[47] in support of the argument that HMQ should at the very least be deemed to have had knowledge of the definitions and "other automobile" provisions in the OAP 1 which would have covered the snowmobile under Echelon's policy, at the time HMQ made its decision to accept priority.

I would not characterize the "right" which is under consideration as to whether it was waived in the terms that HMQ has characterized it. In my opinion the right that HMQ may or may not have waived is the right to dispute priority after being served with a NDBI. The combination of the definition in Echelon's OAP 1 and the "other automobile" provisions in 2.2.3 of the policy are the grounds upon which HMQ could exercise its right to dispute priority, they are not the right in itself.

Nevertheless, I am of the view that based on the evidence in this case, HMQ did not waive its right to dispute priority. The facts of this case are distinguishable from a situation such as in *Intact v. St. Paul*. The main difference is that unlike this case, there was no evidence St. Paul had acted as a result of an erroneous assumption as to the underlying facts or had mistakenly failed to direct its mind to the relevant facts and/or law bearing on the issue of whether it had an obligation to indemnify Intact in loss transfer.

[47] November 4, 2013 ("*Intact v. St. Paul*").

In *Intact v. St. Paul* I cited excerpts from the arbitral and Superior Court decision in *Motors Insurance Corporation v. Old Republic Insurance Company*[48] in my consideration of the waiver defence advanced by St. Paul. I felt that the facts in *Intact v. St. Paul* were analogous to those in *Motors v. Old Republic*.

In both cases, unlike the case before me now, the evidence demonstrated that the insurer seeking to avoid a previous agreement to accept loss transfer was fully aware of the factual and legal grounds which could give rise to a right to deny loss transfer indemnity at the time it made his decision to accept loss transfer.

In *Motors v. Old Republic*, Motors advanced a claim for loss transfer indemnity based on its interpretation of FDR 12 (4). There was no misrepresentation regarding the status of insurance on the Motors vehicle. Old Republic was well aware that the issue in the case was how, if at all, FDR 12 (4) may apply to the facts of the case. Old Republic was well aware that it needed to look into the facts and law relevant to the application of FDR 12 (4) to decide whether to accept loss transfer indemnity.

Initially, Old Republic denied liability to Motors. After receiving three Loss Transfer Requests for Indemnity, Old Republic obtained a legal opinion on the issue in dispute. Although the opinion expressed by counsel is not specifically described, a reasonable inference to draw is that Old Republic was told by its own counsel that it should accept responsibility for loss transfer.

Old Republic wrote to Motors advising that, "*Upon reviewing our file information and our investigation, we…will accept…loss transfer*." Some months later Old Republic

[48] Arbitrator Guy Jones, November, 2008, affirmed on appeal with respect to waiver, June 24, 2009, Herman J., unreported, (Ont. Sup. Ct.) ("*Motors v. Old Republic*").

wrote to Motors stating, "*we have now completed our investigation…we will give no further consideration to your requests for...loss transfer*." Old Republic asked Motors to reimburse what had been paid.

Arbitrator Jones refused to allow Old Republic to withdraw its agreement to accept loss transfer. His findings and conclusions point out the important differences however, between the facts of *Motors v. Old Republic* and the facts of the case before me. He stated:[49]

> Old Republic, after conducting an investigation of the facts and obtaining an (*sic*) legal opinion, made a conscious decision to pay the loss transfer request, and it did so for these reasons and the desire to avoid arbitration expenses
>
> …The decision by Old Republic to accept the loss transfer liability…was not a payment made by mistake or oversight. Old Republic made a deliberate decision after considering all relevant factors.[50]

In this case, HMQ did not make a conscious decision to accept priority "after considering all the relevant factors". By mistake, HMQ failed to turn its mind to the crucial factor of the wording in the OAP 1 policy which provided coverage for the snowmobile. There is also no evidence that it decided to accept priority to avoid arbitration expenses.

Justice Herman approved of Arbitrator Jones' decision. In particular, he commented that Arbitrator Jones' finding that *"(Old Republic) did not make a payment by mistake, but rather, made a conscious decision to pay to avoid the cost of arbitration was reasonable given the evidence before him…"*

[49] At page 5.
[50] Arbitrator Densem's emphasis.

In *Intact v. St. Paul* I made similar findings in about the extent of St. Paul's knowledge of the relevant loss transfer legislation during the course of St. Paul's handling of Intact's Loss Transfer Indemnity Requests. I found that at the time St. Paul decided to indemnify Intact in loss transfer, it was aware that a requirement for a valid loss transfer claim was that St. Paul insure a heavy commercial vehicle – *i.e*. that it weigh at least 4,500 kilograms.

There was evidence from correspondence sent by St. Paul to Intact during the period in which it was paying loss transfer indemnity to Intact which demonstrated that St. Paul understood and had considered the terms of the loss transfer regulation before paying Intact's Loss Transfer Requests for Indemnity.

It applied the appropriate statutory deductible to three Loss Transfer Requests for Indemnity from Intact during this time. It also paid less than the full amount of indemnity claimed by Intact in the Loss Transfer Requests for Indemnity citing case law that expenses incurred under sections 24 and 42 of the SABS regulation were not recoverable in loss transfer. Based on this evidence I concluded[51], **"***…the record of correspondence between Intact and St. Paul clearly demonstrates that St. Paul had knowledge of the requirements of the loss transfer scheme (when it agreed to pay loss transfer indemnity)"*.

In *Intact v. St. Paul*, I specifically rejected an argument by St. Paul that the loss transfer indemnity payments it had made were made under a mistake of fact or law. I held there was no evidence that St. Paul failed to direct its mind to the correct law

[51] At page 22.

applicable to the facts, or that it had been provided with incorrect facts compelling it to come to an incorrect conclusion about whether to pay loss transfer indemnity.

Similar to Arbitrator Novick's finding in *Aviva v. State Farm*, I was of the view that the evidence did not demonstrate an "honest mistake" or erroneous assumption on the part of St. Paul, but instead showed a lack of diligent investigation when there was an obligation on St. Paul to conduct such an investigation. One of the important facts in that case was that despite its obvious knowledge of the heavy commercial vehicle aspect of the loss transfer regulation, St. Paul had taken no steps to weigh its vehicle (and the contents) until it was too late, and long after arbitration proceedings were underway.[52]

As I have indicated, I do not dispute that insurers are sophisticated litigants with a professional knowledge of the statutory priority and loss transfer schemes, as well as the underlying insurance legislation. In my opinion however, it would be imposing a standard of virtual perfection in claims handling on an insurer to say that it had made a decision to waive its rights consciously, and with full knowledge, when there is clear evidence of "an honest mistake"; that because of the mistake, the insurer had not "considered all relevant factors"; and there is no evidence that the insurer has failed to diligently investigate the matter.[53]

I am not prepared to find that because HMQ had deemed or actual knowledge of previous cases involving the OAP 1 definitions and "other automobile" coverage, that HMQ should be deemed to have made a conscious decision to waive its rights to

[52] A "test vehicle" had to be weighed since the vehicle involved in the accident had been scrapped by the time efforts were made to determine the weight of the vehicle involved in the accident.
[53] Query the extent, if any, of such an obligation on HMQ in priority cases given section 3.1.

dispute priority having considered these relevant factors, when clearly the evidence supports the opposite conclusion.

I would reiterate here that the circumstances of this case leave much to be desired for Echelon to seek to impose such a stringent standard on HMQ. In essence, it submits that: "*HMQ, as a sophisticated insurer, ought to be forced to live with its erroneous decision to accept priority because it had everything it needed to come to the correct coverage conclusion, and it is HMQ's own fault it did not do so*." In my opinion, with respect to the decision to issue a NDBI, one could substitute "Echelon" for "HMQ" in this statement and it would be equally true. Add to the mix that Echelon complicated matters by misrepresenting the status of the snowmobile as "uninsured" in every important communication it had with HMQ, and it is very difficult to see how imposing such a standard on HMQ would be appropriate in this case.

Therefore, in conclusion on the issue of waiver, I am not prepared to find that on the facts of this case HMQ made a conscious decision, having considered all relevant factors, to waive his right to dispute priority.

I do not find it necessary to undertake a lengthy analysis on the issue of promissory estoppel. As the case law as indicated, waiver and promissory estoppel are essentially the same in principle, but promissory estoppel requires the added finding of detrimental reliance on the part of the party seeking to hold the other party to a choice it has made.[54] For the reasons I outlined in my discussion of the law of waiver, there is

[54] *Saskatchewan v. Maritime Life*, *supra* note 45, at paragraph 18.

insufficient evidence of detrimental reliance on the part of Echelon in this case to apply the promissory estoppel doctrine, if indeed it should be considered at all.

I reiterate here, that my analysis of mutual mistake in contract, misrepresentation, and the defences of no reliance, waiver and promissory estoppel on the issue of whether HMQ should be allowed to withdraw its priority acceptance are being considered by me as alternatives. My primary finding is that the evidence in this case supports HMQ being entitled to the remedy of restitution based on the concept of unjust enrichment, as that doctrine was applied in *GAN v. State Farm*.

Before concluding, as I indicated I would do, I will return to the question of whether my finding that Echelon breached the terms of section 3.1 should give rise to a "special award" of some sort. As I have stated, in my view the concept of special award is intended to punish and deter bad behaviour on the part of the insurer. Without attempting to lay down any general requirements for when a special award is appropriate for a breach of section 3.1, in my opinion a special award is not appropriate in the circumstances of this case. Although the evidence, in my opinion, supports the conclusion that there was a breach of the section, there is no evidence of any type of bad faith, or egregious conduct on the part of Echelon. The misrepresentations made by Echelon to HMQ were innocent, and the result of the same mistake HMQ itself made respect to conclusions about coverage.

Despite the fact that I have found that Echelon did not conduct a reasonable priority investigation because it should have discovered the fact that it had coverage before sending its NDBI to HMQ, in this context, this deficiency is offset by the fact that

HMQ must bear some responsibility for its own failure to not recognize that there was coverage.

In this case, because both parties made the same mistake, in my opinion they are equally responsible for the fact that the matter ultimately descended into a dispute which required arbitration to resolve. Therefore, I would not impose a special award on Echelon on the theory that it was solely responsible for the time and expense required to have this matter arbitrated.

In my view, the appropriate time to consider whether a special award is appropriate against an insurer is during the time that the insurers are interacting with each other before the matter ends up with counsel in arbitration. If there is no reason to impose a special award on an insurer during this period of time, I do not think it would be appropriate to do so simply because it continues the dispute through the arbitration process. Echelon had an arguable case here, so I place no blame on Echelon or its counsel for wishing to defend its position through arbitration.

Conclusion

I would like to conclude my analysis of this case by emphasizing the trite, but true legal adage, “each case must be decided on its own facts”. I do not subscribe to the “floodgates” school of thought, which is frequently invoked as an argument for narrow and restrictive interpretations of the law governing the priority dispute and loss transfer systems. I would not however, want my decision in this case to be interpreted as a license for insurers to indifferently decide to accept priority, thinking, as Arbitrator

Novick put it in *Aviva v. State Farm*[55]*,* that later on if they wish they will be able to simply "*ask a colleague and change their mind*".

The facts of this case however, support, in my view, an application of the equitable doctrine of restitution as applied by Justice Pitt in *GAN v. State Farm*. Even without getting into the nuances of the equitable and legal doctrines, the common sense equities of this case in my opinion justify setting aside HMQ's agreement to accept priority and restoring it to its rightful place with Echelon – where it should have been all along.

There was no doubt from the outset that Echelon's policy provided SABS. There is no doubt that in the priority scheme HMQ, as the payor of last resort, has no legal responsibility to pay SABS if another insurer has that responsibility. There is no doubt that Echelon made exactly the same mistake in concluding that its policy did not provide coverage as was made later by HMQ. If anything, Echelon's mistake was worse – especially considering its section 3.1 obligations, and the fact that it compounded the mistake by repeating it to HMQ in authoritative fashion while HMQ was considering its position.

Apart from making the same mistake Echelon did, there is nothing in the conduct of HMQ which could result in it being suggested that HMQ comes seeking arbitral relief without "clean hands". There is no "juristic reason" to allow Echelon to retain a windfall benefit at HMQ's expense.

[55] *Supra*, note 30, at page 11.

Both parties made the same mistake. Neither party has acted in bad faith towards the other. Balancing the equities of the situation, and considering that the only "prejudice" to restoring the situation to what is legally correct under section 268 (2) of the *Insurance Act* is that Echelon must now deal with a SABS claim for which it was solely, legally responsible in the first place, fairness dictates that this is what should happen.

The equitable and legal doctrines have developed over many years in many cases to address this very kind of situation. There is no equitable or legal reason why they should not be applied in this case to effect an appropriate remedy.

Therefore, I make the following findings and orders:

1) HMQ is permitted to withdraw from its agreement to accept priority for the claimant SABS claim.

2) Echelon is the priority insurer pursuant to section 268 (2) of the *Insurance Act*, and, if the claim remains open, has the responsibility to continue handling the claimant's SABS claim.

3) HMQ is entitled to restitution from Echelon of any monies HMQ has paid to Echelon, and monies paid to or on behalf of the SABS claimant, Anne Louise Barnes.

4) HMQ, as the successful party in this arbitration, is entitled to recover its costs from Echelon, including its share of the Arbitrator's fees and disbursements already paid or payable. If the parties are unable to agree on costs, they should schedule a

conference through my Coordinator to discuss the format and procedure for submissions on costs.

Dated at Toronto, August 29, 2017

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Arbitrator Scott Densem