Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A15-000674

BETWEEN:

T.P.

Applicant

and

TD GENERAL INSURANCE COMPANY

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Caroline King

Heard: January 17, 18, 19, 2017 & June 6, 7, 8, 22, 2017, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: Ryan Naimark for T.P.'s Litigation Guardian - Office of the Public Litigation Guardian
Darrell Daughney for the Office of the Public Guardian and Trustee Guardian
Pamela A. Brownlee for TD General Insurance Company
Stephen MacAulay for TD General Insurance Company

Issues:

The Applicant, T.P., was injured in a motor vehicle accident on June 5, 2008. He applied for and received statutory accident benefits from TD General Insurance Company ("TD General"), payable under the *Schedule.*[1] A dispute arose about the benefits payable to T.P. The parties were unable to resolve their disputes through mediation, and T.P. applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as

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

amended. At the pre-hearing discussion, it was decided that a hearing on a preliminary issue would be decided in advance of a hearing on the substantive issues in dispute.

At the hearing, the parties agreed that the preliminary issue is:

1. Did the parties enter into a binding settlement on September 2, 2009?

Result:

1. The parties did not enter into a binding settlement on September 2, 2009.

INTRODUCTION:

This proceeding was commenced by the Applicant's litigation guardian, the Public Guardian and Trustee. The Applicant was not present during the proceedings.

This case is about whether there is a binding settlement between the Applicant and the Insurer. The Applicant seeks a finding that the parties did not enter into a binding settlement on September 2, 2009. The Applicant agrees that he has the burden of proving that the settlement was not binding, and seeks to prove either that: 1) The Applicant did not sign the settlement documents; or 2) If the Applicant is found to have signed the settlement document, the settlement is not binding as the Applicant did not have the requisite capacity to sign the settlement documents and did not have capacity during the cooling-off period.

This decision is set up in three parts preceded by background information to set the stage. The first section considers the evidence relating to who signed the settlement documents. The second section considers the evidence and issue of capacity. The third section considers what impact a finding of incapacity has on the settlement documents. The conclusion reached at the end of this decision is that, on the balance of probabilities, the Applicant did sign the settlement documents on September 2, 2009, but the parties did not enter into a binding settlement on September 2, 2009 by reason of the Applicant's incapacity.

EVIDENCE AND ANALYSIS:

Background:

The Applicant was twenty-two years old when he and his parents were involved in a car accident on June 5, 2008. The Applicant and each of his parents were individually represented by counsel Ms. Olivia Akpari, (the "Lawyer"), who negotiated settlements for each of them. The parties agree that on September 2, 2009, the settlement documents for the Applicant and for each of his parents, were signed. In 2011, the tort claims for each of the three were subsequently transferred from the Lawyer to Mr. Ryan Naimark, (the "Current Lawyer"), who is now representing the Applicant in this proceeding.

The parties agree that the Applicant's settlement documents complied with the legal requirements. The parties agree that the settlement funds were deposited into the Applicant's bank account on or about September 24, 2009, and that these funds were repaid to the Insurer on May 16, 2014. It was not disputed that the Insurer did not know, or could have known, that the Applicant may have lacked capacity at the time the settlement documents were signed on September 2, 2009, or in the cooling off period.

I. WHO SIGNED THE SETTLEMENT DOCUMENTS?

The evidence regarding who signed the settlement documents consisted of the conflicting evidence of Andieu Presilus, who is the Applicant's father ("Father"), and the Applicant's former lawyer Ms. Akpari (the "Lawyer") and of the evidence from the parties' respective forensic hand-writing expert witnesses. The father gave his evidence with the assistance of a Creole/English language interpreter.

1. The Conflicting First-Hand Accounts:

The Lawyer and the Father each claim that they were present when the Applicant's settlement documents were signed. For the reasons that follow, I prefer the evidence of the Lawyer over the Father.

As stated, the Applicant and each of his parents were individually represented by the Lawyer. She had carriage of each of their accident benefits claims. Settlement documents for each of the Applicant, his Father, and mother were signed on September 2, 2009.

a. The Father's Account:

The Father testified under oath that on September 2, 2009, while he was at the Lawyer's office, he signed the Applicant's name and initials on the Applicant's settlement documents in front of the Lawyer. The Father testified that he had a discussion with the Lawyer about him signing the Applicant's name on the settlement documents and that she suggested that he could do that. He subsequently varied his testimony, and said that the Lawyer didn't tell him that he should sign the Applicant's name on the document, but that she did not object to him signing them. The Father was frequently evasive in his responses.

The Father's testimony conflicted in two significant ways with the handwritten statement dated November 1, 2016.[2] First it conflicted with his testimony because in paragraph 5, the statement indicates that the Father signed the documents, and then "brought" them to the Lawyer, implying that the Father was not in the Lawyer's office when he signed the documents. Second, in paragraph 1 it states: "On the date that my son signed the settlement documents he had jumped off the 3rd floor of our apartment building…" [my emphasis], which suggests that the Applicant did sign the settlement documents. Approximately two and a half months later, the Current

[2]Exhibit #7. The Father provided a verbal statement to the Current Lawyer. The Current Lawyer hand-wrote out the Father's statement and the Father signed the statement and initialed each paragraph. The Father confirmed at the hearing that they were his words in the statement and that "everything I told [the Current Lawyer] he wrote down". The Father confirmed that the statement was read back to him before he signed it and he did not express any disagreement with the contents of the statement before he signed it.

Lawyer emailed the Insurer's counsel[3] to assert that the Father signed the Applicant's settlement documents in the Lawyer's office and implied that the word "brought" should not have been used in the statement. The explanation offered was that this was due to a communication error as the Father's first language was not English.

When considered in the context of the Father's testimony as a whole, his practice of communicating with the Lawyer and instructing her in English, as well as his practice dealing with the Current Lawyer's law clerk only in English, I am not satisfied he had any plausible explanation for these inconsistencies based on language.

The Father testified that he didn't tell anyone that he signed the Applicant's settlement documents until 2016. When the Applicant's father was asked what he told the Current Lawyer in 2016 he answered: "I told [the Current Lawyer] that I signed it [for the Applicant]". He was asked: "What did [the Current Lawyer] say? The Applicant's father answered: "He didn't tell me anything. It was what he wanted to hear from me, and then it was finished".

b. The Lawyer's Account:

The Lawyer's evidence was that on September 2, 2009, the Applicant attended her office after his parents had left, and signed and initialled his settlement documents in her presence.
She provided the context of her professional relationship with the Applicant and stated that after the first meeting where she met with the Applicant, his father, and mother together, she never met with the three of them again at the same time. She stated she did not discuss the Applicant's case with his Father. This evidence was not shaken in cross-examination. Her business records support a finding that she had personal interactions with the Applicant who attended her office numerous times during the period she was representing him.

When the Lawyer discovered years later that the Current Lawyer was trying to overturn the Applicant's settlement, she confronted the Father. She testified the following:

[3]Exhibit #8

> So [the Applicant's father] was telling me that he was called into the Current Lawyer's office. They brought all three AB files[4], and told him that all the settlement they had on AB were too low, so he and his wife can sue me personally so that they can get more on housekeeping, but they are going to open [the Applicant's] file, because - – and he has to give affidavit to lie that he signed the settlement document I witnessed.
>
> That was when I was really, really shocked. I asked him 'why would you lie', because they said that -- 'how can you lie that you forged someone – your own signature for somebody's signature', because it's a criminal offence, and he said that 'there is a $2 million to be made on the file, and the money is going to be for the family', so they asked him to agree to say that he signed [the Applicant's] signature…

The Lawyer's evidence about this conversation was not contradicted.[5]

In considering the conflicting 'first-hand' evidence of the Father and the Lawyer, I prefer the Lawyer's evidence. The Father was frequently evasive in his responses and his evidence was often inconsistent. No plausible explanation or argument was offered about why the Father waited six and a half years to make the statement that he signed the Applicant's settlement documents on September 2, 2009. This delay is particularly perplexing when considered in the context that the Father had a solicitor/client relationship with the Applicant's Current Lawyer as he took carriage over the tort claim for each of the Applicant, and his parents, sometime around February 2011.

The Lawyer's evidence was consistent, plausible, and supported, in part, by the Father's evidence. Her evidence that the Applicant signed his own settlement documents was supported by paragraph 1 of the Applicant's father's statement cited above. The fact that the Applicant often attended the Lawyer's office in person, and she dealt with him on a one-on-one basis also

[4]Referencing the Applicant's and his parent's accident benefit or 'AB' claims.

[5]The Current Lawyer was given an opportunity to call the Father back to respond to the Lawyer's evidence. Indeed the Current Lawyer stated that he may recall the Applicant's father to give rebuttal evidence. He stated that this decision would be made after receiving the transcripts from the Father's evidence and getting direction from the Public Guardian and Trustee. The Current Lawyer did not call the Applicant's father back.

makes her evidence more plausible. Unlike the Father's evidence, her evidence remained consistent on cross-examination. I find the suggestion that this experienced personal injury lawyer advised or condoned the Father to sign the Applicant's settlement documents to be highly implausible given that she could have risked her reputation and standing as a lawyer, and gained very little in return. Conversely, based on the evidence before me, it is the Father's belief that he and his family stand to gain a lot. Her disappointment and dismay over learning that the Father was asserting he signed the Applicant's settlement documents was apparent. Nothing that I heard or observed persuaded me that this experienced personal injury lawyer encouraged, or otherwise condoned, the Applicant's father to commit fraud.

2. The Experts' Accounts:

Two expert forensic handwriting experts gave evidence at the hearing. Ms. Diane Kruger appeared for the Applicant. Mr. Dan Purdy appeared for the Insurer. They were provided with the questioned signatures found on the Applicant's settlement documents, and known samples of both the Applicant's signature and the Father's signature. Fifteen known samples of the Applicant's signature were provided for analysis, five of which were reproductions or photocopies. The experts were not given any known samples of the Applicant's signature which were authored within six months before or after September 2, 2009. Twenty known samples of the Father's signature were provided for analysis, fifteen of which were reproductions or photocopies. Only one sample of the Father's signature authored in the six months before and in the six months after September 2, 2009 was provided. Surprisingly, the Father's signature on his own September 2, 2009 settlement documents was not provided even though it presumably could have been obtained by the Current Lawyer.

Both experts agreed that it would have been preferable to have more samples. Both experts agreed that photocopies and reproductions are not as good as original signatures, as some characteristics or information may not be captured in the reproductions such as pen pressure, and pen lifts. Both experts agreed that signatures can vary over time and may be influenced by a number of external and other factors. Both experts agreed that vision and medication can have an impact on signatures.

Both experts concluded that, based on the evidence before them, it was highly probable that the Father authored the questioned signatures on the Applicant's settlement documents.

The experts disagreed about whether the Applicant could be categorically eliminated as the author of the questioned signatures on the settlement documents. Mr. Purdy did not believe that the evidence before them was sufficient to make a categorical elimination, for reasons including low sample size and sample quality. Ms. Kruger came to the conclusion that the Applicant was not the author of the questioned signatures on the settlement documents. When questioned, Ms. Kruger confirmed that she did not know that the Applicant was hospitalized on same date shortly after the questioned signatures were authored, and did not know that the Applicant was, or became, psychotic. She did not know that the Applicant had been off and on powerful anti-psychotic medications, in the period afterwards when many of the Applicant's signatures were taken. In fact, the medical records show that in the four years since September 2, 2009, the Applicant had been in hospital approximately twenty-one times and that he was prescribed anti-psychotic medications, which he sometimes took and sometimes refused to take. The medical records show that the Applicant complained of having blurred vision as a result of the medication, for example, on January 3, 2012, and at other times. When Ms. Kruger was presented with new information about the Applicant's health issues and medication issues, she continued to assert that the Applicant was not the author of the questioned signatures.

3. Conclusion – The Applicant signed the settlement documents.

I have had not only the benefit of hearing from the experts, but of hearing all the evidence, and considering it in the context of the whole case, including the procedural history and the timing of this current application. When I considered the "first-hand" witnesses, and the expert witnesses together, I am not satisfied that the expert evidence can be given as much weight as the first-hand evidence of the Lawyer whose evidence I found to be consistent, plausible, and unshaken.

The forensic handwriting experts do not know who signed the settlement documents, they can only provide their opinions based on the evidence available to them. While I acknowledge that they both concluded that it was highly probable that the Father signed the settlement documents,

their evidence, and the reliance I place on it, is limited by the small number of sample signatures and the quality of the sample signatures (being that many of them were not originals).

I question Ms. Kruger's categorical conclusion that the Applicant was not the author of the disputed signatures. I do so not only because of the issues raised by Mr. Purdy about such a conclusion in the context of the evidence available, but also because her report and her evidence at the hearing appeared to be result-driven rather than evidence-driven, and she appeared to be closed to considering other possibilities. For example, Ms. Kruger omitted from her report that there were a number of similarities between the Applicant's signatures and the questioned signatures which she corrected only on cross-examination. Perhaps more significantly was her lack of openness to other possibilities, without much apparent evaluation, when she was presented with new information about the Applicant's medical and mental health which overlapped with periods when almost half of the Applicant's sample signatures were authored.

I give no weight to the Father's evidence on this matter as I did not find him to be credible. Unlike the Lawyer's evidence, the Father's evidence was inconsistent, frequently evasive, and implausible when considered in the context of this whole case. The medical records taken on September 2, 2009, suggest that the Father only had intermittent contact with his son in the months prior to September 2, 2009 as the Applicant was living apart from his parents.[6] Together with the Lawyer's records, which indicate that the Applicant had been seeing the Lawyer independently and separately from his parents, it suggests that at the time the settlement documents were signed, the Applicant was conducting his own affairs, not his Father. The un-contradicted evidence of the Lawyer was that the Father believed that if he agreed to say that he, and not the Applicant, signed the Applicant's settlement documents, his family stood to benefit 2 million dollars from the Applicant's accident benefit claim related to these proceedings. This evidence, combined with the inconsistencies in his evidence, the implausibility of his explanations, the perplexing six and a half year delay in asserting that he signed the Applicant's

[6]This information was recorded contemporaneously by hospital staff, before this proceeding was contemplated and more than five years prior its commencement. I am not satisfied that the Father's memory seven and a half years later is more reliable than the information he may have provided the hospital professionals in 2009.

settlement documents, and the lack of any contemporaneous corroborating evidence, undermined the Father's credibility.

Therefore, having considered all of the evidence, I find that the Father lacks credibility, and I find on the balance of probabilities that he lied when he claimed that he signed the Applicant's settlement documents.

I find that the Applicant has not provided sufficient, reliable evidence to establish on balance that the Applicant did not sign the settlement documents. I find that it is more likely than not that the Applicant signed the settlement documents.

II. WAS THE APPLICANT INCAPACITATED?

The evidence on this issue included various medical records, a psychological report dated April 24, 2009 which predates the settlement, the Applicant's mental capacity assessment report dated November 15, 2016, and the evidence and testimony of the Lawyer and the Applicant's Father.

1. Medical Evidence:

There is a marked difference in the documented medical evidence in the period just before September 2, 2009, and the medical evidence on and after September 2, 2009.

a. Medical evidence which predates the settlement:

The parties agreed that the Applicant had no relevant physical or psychological pre-existing condition one year before the accident. Just four and a half months before the settlement documents were signed, the Applicant underwent a psychological assessment in which the assessors did not find any signs of cognitive impairment or psychotic process.[7] Nine days before

[7]The assessment was done by R. Mihajlovic, M.A., supervised by Billy Mangos of Trillium Assessment. It is at Exhibit#3, Tab 12.

the settlement documents were signed, the Applicant had an orthopaedic assessment and no issues or concerns about the Applicant's capacity were identified.[8] This is sharply contrasted by the medical documents produced on and after September 2, 2009.

b. Medical evidence at, and post, settlement:

It is agreed that at approximately 8:02 p.m. on September 2, 2009, and in the four weeks that followed, the Applicant had a total of five separate psychiatric hospitalizations where he was diagnosed with psychosis, and was involuntarily detained under Form 1 of the *Mental Health Act*. In the years that followed, there was an ongoing pattern of further psychiatric hospitalizations with similar diagnoses under Form 1 of the *Mental Health Act*.[9] On February 28, 2012, the Public Guardian was appointed the Applicant's guardian for property.

The first psychiatric hospitalization: September 2-5, 2009

On Wednesday September 2, 2009, approximately eight hours after settlement documents were signed, the Applicant was admitted to the Hospital at 8:02 p.m. where he was ultimately diagnosed with paranoid psychosis, paranoid ideation and hypomania.[10] The Applicant was involuntarily detained in the Hospital under Form 1 and was not released until September 5, 2009. On September 2, 2009, the medical staff gathered the following history, including that the Applicant had been homeless for one to two months prior, that he had been acting bizarre and agitated for the three previous days, and that he jumped off his parent's third floor apartment balcony on September 2, 2009. They recorded that the Applicant was "religiously preoccupied" and admitted to having "auditory hallucinations" and was found to be "frankly psychotic". They found that: the "[Applicant] presents with evidence of thought and mood disturbance in keeping

[8]Exhibit #3, Tab 13, Orthopaedic Assessment Reported by Dr. C.B. Paitich. Assessment date August 24. 2009.

[9]A summary chart of the Applicant's psychiatric hospitalizations between September 2, 2009 and October 13, 2009 is attached to this decision as Appendix A.

[10] Exhibit 1 Tab A2

with an acute psychotic episode. Query evidence of a substance induced psychotic episode. Patient presents with no insight and at great risk to his personal safety and the safety of others."[11]

The September 5, 2009 consult report indicated that the Applicant explained that he jumped off his parent's third floor balcony on September 2, 2009, because his parents didn't want him to leave, and it was the only way he could leave their home. The Applicant was medicated during this hospitalization. On September 5, 2009, it was found that the Applicant had "settled well". His cognition was found to be "grossly intact", but his insight was described only as "partial". The treatment plan was either to have the Applicant *continue to be involuntarily detained* under Form 1, or to be discharged with his Father. [12] He was discharged with his Father.

The Second Psychiatric Hospitalization: September 8-11, 2009

Three days after the Applicant was discharged, the police brought him back to a hospital on September 8, 2009. He was diagnosed with psychosis and again involuntarily detained under Form 1. The Emergency notes indicated that the police found the Applicant "hog-tied", and the Applicant believed that he was god and that his parents were keeping him locked up in their apartment. [13] The Applicant reported that he had no previous contact with psychiatry, that he had no medical problem and that he was not taking any medication. Based on the medical records, we know this to be inaccurate. It was noted that the Applicant had conflict with his family and the Applicant did not agree to take any medications, and his drug screen was negative. [14]

[11]Exhibit 1 Tab A2, p.8

[12]Exhibit 1 Tab A2, pp. 16-17

[13]Exhibit 1 Tab A3 p. 18

[14]Exhibit 1 TabA3 p. 25

The Third Psychiatric Hospitalization: September 13, 2009

On September 13, 2009, just two days after he had been discharged from hospital, the police found the Applicant wandering along the 403 highway in traffic and brought him into the hospital. The Applicant was admitted to hospital at 1:18 p.m. The hospital records indicate that the Applicant was in an agitated state with police and was not oriented to time or place. He was medicated with Haldol and Ativan. The hospital doctor concluded that the Applicant was unlikely to have a substance psychosis and it was questioned if the Applicant has manic psycho bipolar I disorder. The notes indicate that the Applicant's parents insisted on taking him home.[15]

The Fourth Psychiatric Hospitalization September 14-23, 2009

The Applicant's discharge clearly was not successful, as the next morning, on September 14, 2009, his parent's called 911 and the police brought him to the hospital where he was admitted at 9:47 a.m. He was diagnosed with acute psychosis, possible hebephrenic schizophrenia, or drug induced psychosis. He was again involuntarily detained under Form 1. The Form 42 under the *Mental Health Act* dated September 14, 2009[16] indicated in part that the Applicant has:

> … shown or are showing a lack of competence to care for [himself]"… and also that there is "…reasonable cause to believe that [the Applicant has] previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that will likely result in substantial mental or physical deterioration of [the Applicant] or serious physical impairment of [the Applicant]."[17]

The Applicant was found to have no insight into his problems and to have very unpredictable judgement.

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[15]Exhibit 1 Tab A4, pp. 26-30

[16]Exhibit 1 Tab A5, pp. 36-37. Form 42 under the *Mental Health Act* puts the Applicant on notice that a doctor has made an application for him to have a psychiatric assessment.

[17]Exhibit 1 Tab A5, pp.36

The Fifth Hospitalization: October 2-13, 2009

The Applicant was again admitted to hospital, on October 2, 2009, was again involuntarily detained under Form 1, and was again diagnosed with psychosis and schizophrenia. The notes indicate that the Applicant was not compliant with medications.[18]

c. The Capacity Assessment Report:

Dr. Lynn Lightfoot is a Designated Capacity Assessor under the *Substitute Decisions Act (1992)* and also "..conducts assessments for other forms of legal capacity where an opinion of capacity is needed to facilitate a legal proceeding or when the validity of a particular action or decision made by a person is in question due to possible incapacity". She did a paper review of the Applicant's hospital medical records from September 2 and 3, 2009 and her Capacity Assessment Report is dated November 11, 2016.[19]

She sets out the two-branch "understand and appreciate" test of incapacity under the *Substitute Decisions Act, 1992.* As stated:

> "Understand" refers to the ability to understand information that is relevant to making a decision, while "Appreciate" refers to the ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Failure to "understand" OR "appreciate" is grounds to conclude incapacity.[20]

Dr. Lightfoot opined that the medical records on September 2 and 3, 2009 are consistent with the presence of a "Psychotic Episode". She reports the following about psychosis and psychotic episodes: "Individuals who are experiencing Psychosis have impaired reality testing such that they are unable to distinguish personal subjective experience from the reality of the external

[18]Exhibit 1 Tab A6 p. 41

[19]Exhibit Volume 13, Experts Tab, Tab2 pp. 1-2

[20]Exhibit Volume 13, Experts Tab, Tab2 p. 2

world"; and "…Psychotic Episode and Substance Induced Psychotic Episode are associated with impairments in cognitive function including deficits in reality testing and in the individual's memory and executive functioning including their judgement."[21]

Dr. Lightfoot finds that on September 2, 2009, the Applicant fails both branches of the legal test of capacity and that it is more likely than not that he lacked capacity to contract. Specifically she finds that:

> …in all likelihood, [the Applicant's] psychotic mental state would have interfered with his ability to comprehend and retain information presented to him in regard to the proposed settlement.
>
> ….because of the cognitive impairments caused by his psychotic illness, [the Applicant] lacked the ability to realistically appraise the risks and likely outcome of a decision or lack of decision in regard to the settlement offer.[22]

Dr. Lightfoot also found that the Applicant was incapable of instructing counsel on September 2, 2009. She stated that:

> ..It is my considered professional opinion that he likely lacked the ability to understand and process information and advice offered to him by his lawyer. Furthermore he likely would have been unable to engage in the mental operation of appraisal of any options presented to him by his lawyer on this date. [The Applicant] would therefore have likely failed on both branches of the legal test of capacity to instruct counsel those being the "understand" and "appreciate" components.[23]

[21]Exhibit Volume 13, Experts Tab, Tab2 p. 5

[22]Exhibit Volume 13, Experts Tab, Tab2 p. 6

[23]Exhibit Volume 13, Experts Tab, Tab2 pp. 6-7

2. First Hand Testimonial Evidence:

The Lawyer and the Father gave conflicting evidence about their observations of the Applicant on September 2, 2009 and afterward.

The Applicant's Lawyer testified that she never had concerns about the Applicant's state of mind between September 2, 2009 and September 23, 2016. The Lawyer stated that the first time she learned that there was a question about the Applicant's state of mind was in an email sent to her from the Current Lawyer dated December 14, 2016. The Lawyer stated that on September 2, 2009, when the Applicant attended her office to sign the settlement documents, the Applicant was 'normal'. Sometime after September 2, 2009, the Lawyer commenced a tort action related to the accident and filed a statement of claim for the Applicant and that at that time he seemed normal to her. The Applicant's tort action, as well as his parents' tort action were transferred to the Current Lawyer in 2011.

The Father testified that the Applicant was not in his right mind and that he told the Lawyer this on September 2, 2009 and many times afterward. As stated above, I have already found the Father's evidence at this proceeding to lack credibility. Information the Father may have given to the hospitals in 2009 is likely to be more reliable as it was given more or less contemporaneous to the events of September 2, 2009 and was not provided in anticipation of any litigation.

I accept the Lawyer's evidence that the Applicant appeared 'normal' to her on September 2, 2009. However, I note that not much evidence was led to indicate whether the interactions on September 1 and 2, 2009 were of a significant duration and nature for the Lawyer to probe the Applicant's thought process and engage in any meaningful assessment about the Applicant's ability to understand and appreciate the settlement documents.

3. Conclusion – The Applicant was incapacitated.

The *Substitute Decisions Act* is clear that a party entering a contract is entitled to rely that the other person has capacity to contract unless the party has reasonable grounds to assume the

person does not have capacity.[24] It is agreed that the Insurer had no knowledge of any reasonable grounds to assume that the Applicant did not have capacity. Rule 10.1 of the *Dispute Resolution Practice Code* applies the presumption of capacity to statutory accident benefit claims. However, this presumption can be overridden where there is compelling evidence which must withstand the test of objective scrutiny.[25]

In this case, I find that there is compelling objective evidence to override the presumption of capacity. During the Applicant's first psychiatric hospitalization, the hospital medical personnel gathered information from the Applicant's family and girlfriend that the Applicant had been agitated and acting bizarrely not just on September 2, 2009 when he jumped off his parent's third floor balcony, but also three days *before* September 2, 2009. This information was not given in anticipation of litigation, but rather in response to the Applicant's mental health crisis.
The serious harm test under the *Mental Health Act*, was assessed and reported in the Form 1 dated September 3, 2009 at 12:30 a.m.[26] where the Applicant was found to be frankly psychotic and hearing voices and it was determined that the Applicant should be involuntarily detained in the hospital. He was not released until September 5, 2009. The Capacity Assessment report determined that as a result of the Applicant's illness, he was not able to understand and appreciate the information and consequences of entering into a settlement or to instruct counsel. This expert opinion, was not contradicted by any other expert report, nor was the doctor required to be cross-examined. I have placed less weight on the Lawyer's evidence about the Applicant's state of mind as there was no reliable evidence before me that the Lawyer was aware that she should probe and assess the Applicant's capacity and I am not satisfied that she did such a capacity assessment.

[24]Section 2(3) of the *Substitute Decisions Act*

[25]*Koch* (Re), 33 O.R. (3d) 485. A finding of mental incapacity must withstand objective scrutiny and include probing the thought process of the individual.

[26]Exhibit 1, Tab A2, pp. 10-12

The Applicant's persistent, and repeated issues with psychosis requiring repeated involuntary psychiatric hospitalizations during the period from September 2, 2009 to October 13, 2009, considered in conjunction with the Applicant's irregular, agitated, and bizarre behaviour in the three days before September 2, 2009, together with the un-contradicted Capacity Assessment Report in which the expert found the Applicant lacked capacity on September 2, 2009, leads me to conclude, on balance, that the Applicant lacked the requisite capacity when he signed the settlement documents.

I also find, on balance, that the Applicant lacked capacity during the two business days cooling off period, which concluded on Friday September 4, 2009. This flows in part from my finding that the Applicant did not have capacity when he signed the settlement documents and the related medical documents that show that he was involuntarily detained in hospital under Form 1 of the *Mental Health Act*, throughout the period September 2-5, 2009. But in particular, on September 4, 2009, the medical records indicated that the Applicant's mood was "unstable" and "hostile", that he had "no insight into his illness", and that the Applicant "has difficulty following directions and does not allow for reasoning". At 3:04 p.m. that day, the last day of the cooling off period, the Applicant had to be medicated and be put in restraints. [27]

III. HOW DOES THIS FINDING OF INCAPACITY IMPACT THE SETTLEMENT?

1. Statutory Accident Benefits Settlements are not ordinary contracts:

In the case of ordinary contracts, where a third party has no knowledge or reasonable grounds to believe that a contracting party lacks capacity, the third party is entitled to rely on the presumption of capacity, and the contract would only be voided due to issues such as mistake, misrepresentation, duress, and fraud. An automobile accident benefit settlement agreement should not be considered to be an ordinary contract. The Supreme Court of Canada held that a

[27]Exhibit 1 Tab A2, p.15

main objective of automobile insurance law is consumer protection.[28] In *Arbarca v. Vargas*,[29] the Ontario Court of Appeal stated that insurance principles must be considered when seeking to balance the parties' respective interests and that:

> Automobile insurance policies are, consequently more than mere commercial contracts. The entire regulatory structure of automobile insurance has become part of the social contract, and forms "part of an integral social safety net…"

The regulatory structure in Ontario for accident benefit settlements gives additional rights to insureds than they would otherwise have in contract law. Significantly, the legislature determined that insureds should have a two day "cooling off" period when they can reconsider and rescind a settlement under the s. 9.1(3)3 of *Settlement Regulation* RRO 1990, Reg.664. In applying the decisions from the Supreme Court of Canada and the Ontario Court of Appeal, and considering the settlement documents in the spirit of consumer protection legislation, I disagree with the arbitrator's statement in *Wachmenko and Primmum Insurance Company*[30] that settlement agreements are ordinary contracts. Further, that case is distinguishable as the arbitrator found there was no compelling evidence to override the presumption of capacity.

2. Applicant's incapacity renders settlement not binding

As stated above, based on the preponderance of medical evidence, I find that there is evidence which overrides the presumption of capacity. When this is considered in the context of consumer protection law, the Ontario Court of Appeal's determination in *Arbarca*, and the Settlement Regulation, I find that the Applicant's incapacity at the time that he entered into the settlement documents renders them void.

[28]*Smith v. Co-operators General Insurance Co.*, [2002] S.C.J. No. 34

[29]*Arbarca v. Vargas*, 2015 ONCA 4, 123 O.R. (3d) 561, para 37

[30](FSCO A04-001086, May 24, 2005), Brief of Authorities of the Insurer, Tab 6

Further, the Applicant's incapacity in the cooling off period and beyond, as evidenced by his repeated and persistent involuntary psychiatric hospitalizations throughout the September 2, 2009 to October 13, 2009 period, also renders the settlement documents not binding. Part of the consumer protection legislation intended to benefit insureds is that the settlement regulations provide a two-business-day window in which they can reconsider his/her decision and rescind a settlement agreement. A purposive interpretation of the cooling off period in the settlement regulations, requires that an insured have the capacity to reconsider his/her decision to enter into the settlement agreement. In the unusual circumstances such as this case, where an insured provides compelling evidence which overrides the presumption of capacity when the settlement documents were signed, and where it is found that the insured lacked capacity during the cooling off period and beyond, it must follow that the settlement agreement is not binding. To find otherwise, would deprive the insured the consumer protection objective of automobile insurance, and the rights of an insured to have a meaningful reconsideration of a settlement agreement.

CONCLUSION:

While the Applicant signed the settlement forms on September 2, 2009, they are not binding by reason of the Applicant's incapacity when he signed them. They are also not binding by reason of the Applicant's incapacity in the two day cooling off period.

EXPENSES:

The parties did not address the issue of expenses. If required, they may request an expense hearing in accordance with the process set out in Rule 79 of the *Dispute Resolution Practice Code*.

August 16, 2017

Caroline King
Arbitrator

Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A15-000674

BETWEEN:

T.P.

Applicant

and

TD GENERAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990 c. I.8 as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Regulation 664, as amended, it is ordered that:

1. T.P. and TD General Insurance Company did not enter into a binding settlement on September 2, 2009.

August 16, 2017

Caroline King
Arbitrator

Date

Summary Chart of the Applicant's Psychiatric Hospitalizations: September 2, 2009 to October 13, 2009

Dates	Hospital Diagnosis	Comments
Sept. 2-5, 2009	**Paranoid psychosis. Paranoid Ideation and Hypomania.** William Osler Health Centre	Admitted 8:02 p.m. Parents called police. Information gathered at the hospital included the following: the Applicant had been homeless for 1-2 months prior to hospital admittance, the Applicant was acting bizarre and agitated in the 3 previous days, information that the Applicant had jumped from the 3rd floor balcony of his parent's apartment. On September 2, 2009, he was "religiously preoccupied" and admitted to having "auditory hallucinations" On September 3, 2009 at 12:30 a.m., the Form 1 states the Applicant was "paranoid", "frankly psychotic", "hearing voices". It was reported that the Applicant was "sleeping on the streets"[1]. September 4, 2009 at 3:04 p.m., it was reported that: "[The Applicant mood is unstable, hostile, threatened to start a war if he is not let off the unit… No insight into his illness, states that he should not be here. He has difficulty following directions and does not allow for reasoning." He was medicated and put on "3 points restraints applied with security assistance". [2] The September 5, 2009 consult report indicated that the Applicant explained that on September 2, 2009, he wanted to leave his parents home, but they didn't want him to leave, so the only way to leave was to jump off his parents' balcony. MENTAL STATUS EXAMINATION: " … [Applicant] settled well. No evidence of agitation, paranoia or hallucinatory behaviour. Speech normal in rate and volume. Mood mildly expansive… No thought and perceptual disorder, but he has pseudo grandiose ideas about being able to read other people's spirits. "Cognition grossly intact. Insight partial…" PLAN: Depending on meeting with his dad, either he can be discharged or further inpatient stay under Form 1.[3]

[1]Exhibit 1 Tab A2, p. 10
[2]Exhibit 1 Tab A2, p.15
[3]Exhibit 1 Tab A2, p. 17

Dates	Hospital Diagnosis	Comments
Sept.8-11, 2009	**Psychosis** Scarborough Hospital Scarborough Hospital Grace Campus	Admitted 8:42 p.m. Brought in by police. The Emergency notes indicate that: the Applicant believes he is God: was found "hog-tied"; and that his parents keep him locked up in their home.[4] CHIEF COMPLAINT: Paranoid/Bizzare Behaviour[5] Form 1. September 9, 2009, CONSULTATION RECORD: [Applicant] brought in by police. "Delusional, grandiose behaviour…[Applicant] reports he has **Ø** med prob & **Ø** on any meds."[6] September 9, 2009, ADMISSION HISTORY, included the information that the Applicant advised the doctor that he had no previous contact with psychiatry, and that he is on no medications and doesn't want to take any medications.[7] September 11, 2009, DISCHARGE SUMMARY, included the following information: the Applicant's drug screen was negative, that the Applicant did not agree to take medications while at the hospital. The Applicant was to follow up with his family doctor.[8] When the Applicant was discharged at approximately 11:18 p.m., the records appear to indicate that the charge nurse gave the Applicant's father the Applicant's prescription, and subsequently when the Applicant saw his father, he hit his father. It was implied that the Applicant did not leave with his father.[9]

[4]Exhibit 1 Tab A3 p. 18
[5]Exhibit 1 Tab A3 p. 18
[6]Exhibit 1 Tab A3 p. 20
[7]Exhibit 1 Tab A3 p. 21
[8]Exhibit 1 Tab A3 p. 23
[9]Exhibit 1 Tab A3 p. 25

Dates	Hospital Diagnosis	Comments
Sept. 13, 2009	**Psychosis** Joseph Brant Hospital	Admitted 1:18 p.m. Brought in by police. Found wandering along 403 highway.[10] Applicant was reported to have been in an agitated state with police, disoriented, was disrespectful, and was spitting. At 1:19 p.m., the Applicant was not oriented to time or to place. The Applicant was medicated with Haldol and Ativan. His parents insisted on taking him home. Information provided related to Axis 1 included: that it was unlikely that the Applicant had a substance psychosis, appears to question if the Applicant has Manic psycho bipolar I disorder.[11]
Sept.14-23, 2009.	**Acute psychosis, possible hebephrenic schizophrenia, or drug induced psychosis**. William Osler Health Centre	Admitted at 9:47 a.m. Family called 911. Applicant reported to be very aggressive. Brought in by police. Reason for the visit: suicidal/arrested by police.[12] Form 1 dated September 14, 2009.[13] Form 42 dated September 14, 2009 which indicated, in part, that the Applicant has "shown or are showing a lack of competence to care for [himself]" and also that there is "…reasonable cause to believe that [the Applicant has] previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that will likely result in substantial mental or physical deterioration of [the Applicant] or serious physical impairment of [the Applicant]."[14] September 14, 2009, consultation report indicates that the family described him as being "normal prior to 3 months".

[10]Exhibit 1 Tab 4A, p. 26
[11]Exhibit 1 Tab A4, pp. 28-29
[12]Exhibit 1 Tab A5, p.31
[13]Exhibit 1 Tab A5, pp.33
[14]Exhibit 1 Tab A5, pp.36

Date	**Hospital Diagnosis**	**Comments**
Cont'd Sept.14-23, 2009	**Cont'd** **Acute psychosis, possible hebephrenic schizophrenia, or drug induced psychosis**. William Osler Health Centre	**Mental Status Examination:** "…Mood is very labile, at times he was euphoric, other times he was angry and agitated, wanted to leave…Thought process and content – his thinking is fragmented. He is very tangential. At times he was very suspicious and paranoid…He has no insight into his problems. He is not coping emotionally. His judgement is very unpredictable."[15]
Oct. 2-13, 2009	**Schizophrenia, Psychotic** William Osler Health Centre	Admitted 10:43 p.m. Notes indicate that the Applicant is not compliant with medications. Form 1 and Form 42 delivered[16].

[15]Exhibit 1 Tab A5, pp. 39-40
[16]Exhibit 1 Tab A6, p.41