IN THE SUPREME COURT OF NOVA SCOTIA
Citation: Hart v. Combined Insurance Company of America, 2005 NSSC 344

Date: 20051215
Docket: SAT 2605-180369
Registry: Antigonish

Between:

Darcy Hart, as Guardian *ad litem*, on behalf of Amanda Hart, and Darcy Hart

Plaintiffs

v.

Combined Insurance Company of America

Defendant

And Between:

Combined Insurance Company of America

Plaintiff

v.

Amanda Hart and Darcy Hart, as Guardian *ad litem* on behalf of Amanda Hart, and Darcy Hart, in her personal capacity and Kenneth Hart

Defendants

Judge:	The Honourable Justice John D. Murphy
Heard:	May 16, 17, 18, 19, 2005, in Antigonish, Nova Scotia
Final Written Submissions:	July 11, 2005
Counsel:	Gerald A. MacDonald, Q.C., for the Plaintiffs, and Defendants in Counter-claim J. David MacDonald, for the Defendant, and the Plaintiff in Counter-claim

Table of Contents

Paragraph

INTRODUCTION 1

PROCEDURAL HISTORY 2

FACTS NOT IN DISPUTE 3

ISSUES 12

ANALYSIS

Issue #1 Are benefits payable to Amanda Hart for hospitalization periods which the Defendant characterizes as respite care? 13

Evidence Concerning Hospitalizations 16

Findings - Reason for Hospitalization 41

Application of Insurance Policy

A. Policy Terms 49
B. Position of the Parties 50
C. Conclusion - Benefits are Payable 53
D. Plain Meaning of Contract 54
(i) Covered Sickness 55
(ii) Hospital 56
(iii) Totally disabled 57
(iv) Respite care 62
E. Ambiguity 64

Issue #2 Are benefits payable with respect to post-discharge periods following hospitalization characterized as respite care? 69

Issue #3 Are the Plaintiffs entitled to punitive and/or aggravated damages? 75

Issue #4 Should the Defendant's Counter-claim succeed? 89

CONCLUSION: DAMAGES, INTEREST AND COSTS

Damages 90
Interest 91
Costs 92

By the Court:

INTRODUCTION

[1] The Plaintiffs, 17-year old Amanda Hart and her mother and Guardian *ad litem*, Darcy Hart, claim payment of hospital and convalescent benefits for Amanda under the terms of an insurance policy issued by the Defendant. In addition to defined daily benefit amounts specified in the Policy, the Plaintiffs seek punitive and aggravated damages arising from the Defendant's alleged improper conduct denying payment. The Defendant counter-claims, alleging that the Plaintiffs and Kenneth Hart, Amanda's father, submitted erroneous claims and received monies to which they was not entitled under the insurance contract.

PROCEDURAL HISTORY

[2] Based upon a statement of facts submitted by the parties, this Court previously ruled that the disputed benefits were payable under the Policy, and issued written reasons, which will subsequently be referred to as "the Application Decision." An appeal by the Insurer was allowed, without prejudice to the position of the parties on the merits, on the basis that they had not agreed on the relevant facts essential to resolving the dispute. All issues were subsequently addressed at trial.

FACTS NOT IN DISPUTE

[3] Amanda Hart is severely disabled. She was born with Aicardi Syndrome, an extremely rare constellation of congenital abnormalities which involve problems with the development of the corpus callosum part of the brain. The condition causes, among many other medical conditions, chronic seizures, spine problems, and mental retardation. Amanda is blind in the right eye, cannot verbalize, has lower limb paralysis, and is unable to personally provide any of her daily needs or even turn herself. A congenital tumor was removed shortly after her birth, leading to numerous and continuing health issues including a colostomy, a vesicostomy, and many operations. She has multiple organ abnormalities, and a history of numerous infections, pneumonia, bronchitis, kidney stones, lung collapse, ulcers and pressure sores.

[4] Amanda remained at the I.W.K. Hospital in Halifax for more than three months after her birth in June of 1998 and has often returned to hospital. The primary dispute in this case involves the purpose and characterization of many of those hospitalizations.

[5] Except during the many times when she has been hospitalized, Amanda has lived in Canso with her parents, who are her primary caregivers and who sometimes employ private home care to assist. Although Amanda is developmentally delayed, she has attended school in Canso since she was nine years old.

[6] On September 16, 1991, Combined Insurance issued a Sickness Hospital Benefit Policy to Amanda, who was then three years of age. The Policy was sold to Mr. and Mrs. Hart by Dawn Hynes, who travelled door to door selling insurance policies in Canso. Ms. Hynes was informed about Amanda's condition, and she provided that information to the Insurer before the Policy was issued.

[7] The insurance policy is non-cancellable and continues in effect; the premium is $12.50 per month.

[8] The Policy does not cover loss caused by a pre-existing condition unless the loss begins after 12 months from the date the Policy is issued. Hospitalization and subsequent convalescent periods which otherwise qualify for benefits are compensable if Amanda entered hospital more than a year after the Policy was issued, despite the presence of illness or disease when the contract was entered.

[9] The benefit payable under the Policy was initially $60.00 for each qualifying day that Amanda was hospitalized for a covered illness, and also for each day, to a maximum of twice the number of hospitalization days, that she was totally disabled following hospital confinement. Benefits were subject to monthly maximums, and increased by five per cent for each six months the Policy remained in force, not to exceed a maximum increase of 50 per cent. Amanda's daily maximized benefit for eligible hospital and convalescent periods after five years from the date of Policy issue is $90.00; the maximum combined hospitalization and convalescent benefit is therefore $270.00 per day spent in hospital, recoverable subject to Policy terms.

[10] Beginning in 1992 following the one-year waiting period, claims were filed with respect to Amanda's hospital stays, and up to September 1999 they were paid

in approximate total amount of $124,000.00. The Defendant denies liability for claims submitted after that time, and seeks recovery of many of the payments made before September 1999, maintaining that hospital stays were for “respite care”, which the Insurer says does not qualify for benefits because it is not a “covered sickness” rendering Amanda “totally disabled”, as those terms are defined in the Policy. The Plaintiffs maintain that benefits are payable with respect to all Amanda’s hospitalizations and subject to confirmation of claim calculation, seek benefits for hospital and convalescent periods since September 1999 in amount $75,285.00, less payment made by the Defendant in amount $30,510.00 following the Application Decision. The Plaintiffs therefore claim payment of outstanding amounts totalling $44,775.00 to the date of trial, as well as punitive and aggravated damages, and interest.

[11] The Defendant seeks return of the $35,510.00 paid before its appeal of the Application Decision was allowed. That amount related to some of Amanda’s hospitalizations between 1999 and 2003, and the Defendant now maintains that documents received prior to trial indicate those hospital stays should have been attributed to respite care. The Defendant also counter-claims for $78,417.00, the amount it alleges was previously paid in error with respect to periods of respite care prior to September 1999.

ISSUES

[12] The following issues are to be determined:

1. Are benefits payable to Amanda Hart for hospitalization periods which the Defendant characterizes as respite care?
2. Are benefits payable with respect to post-discharge periods following hospitalization described as respite care?
3. Are the Plaintiffs entitled to punitive and/or aggravated damages?
4. Should the Defendant’s counter-claim succeed?

ANALYSIS

<u>Issue #1</u> Are benefits payable to Amanda Hart for hospitalization periods which the Defendant characterizes as respite care?

[13] The Insurer's obligation to provide benefits arising from hospitalizations which it describes as "respite care" must be assessed by determining the reasons for overnight hospital visits, and interpreting and applying policy terms.

[14] The insurance coverage provided to Amanda is described in the Defendant's standard sickness hospital benefit policy, which states in bold print:

> **This Policy...Provides Benefits for Total Disability During and After Hospitalization Caused by Sickness, to the extent herein Provided.**

[15] The term "respite care", which some doctors used on many occasions with reference to Amanda's hospitalization, does not appear in the Policy. (The specific Policy provisions which must be considered to decide whether benefits are payable will be quoted later in these reasons.)

<u>Evidence Concerning Hospitalizations</u>

[16] Following Amanda's initial discharge from the I.W.K., she frequently re-entered hospital for treatment of many symptoms. These hospital visits most commonly took place at I.W.K., Eastern Memorial in Canso, and St. Martha's in Antigonish. Hospital records show that she was sometimes in serious distress upon arrival, and indicate a variety of admitting and discharge diagnoses, almost always mentioning Aicardi Syndrome, with frequent references to seizures and infections, particularly urinary tract and respiratory. During 1992, the first year for which complete records were provided to the Court, Amanda was admitted to hospital overnight on 22 occasions between February 3rd and December 14th. Four of those visits were for seven days or longer, and there were three overnight admissions during each of February, April, July, September and November. No claim was made for the 17 hospitalizations during the first year the Policy was issued. Combined paid benefits for Amanda's hospitalizations and corresponding convalescence periods beginning when she entered hospital September 23rd, 1992, the first admission which occurred more than one year after the Policy was issued.

[17] The lists of hospitalizations provided by the Defendant (Exhibit D-1) show that Amanda's trips to hospital became less frequent and more evenly spaced beginning in early 1993. The Insurer continued to pay claims submitted until September 1999, when a dispute developed concerning the reason for Amanda's hospitalizations since 1993. The Defendant maintains that many post-January 1993 hospitalizations were for respite care, arranged primarily to benefit Amanda's parents by giving them a break from looking after her at home, and were not covered by the Policy. The Plaintiff's position is that all hospital visits were necessary to treat or monitor Amanda's condition and to prevent deterioration in her health, all caused by Aicardi Syndrome, and that the insurance policy should respond because she was confined overnight in hospital and totally disabled because of a covered illness.

[18] Between 1992 and 1999, Combined had processed and paid claims based upon information provided by Amanda's parents on forms prescribed by the Defendant, accompanied by signed physician's statements. Sample documentation in evidence showed both the "nature of sickness" on the claim form executed on the Plaintiffs' behalf and the "primary diagnosis" on the physicians' statements to be "Aicardi Syndrome." The claim forms authorized the Defendant to obtain additional medical information to determine eligibility for benefits.

[19] Combined's claims specialist, Jacqueline Zrihen, testified that after a claim was paid in September 1999, the Defendant learned that Amanda's admission to hospital had been for "respite care", which had not been established as a qualifying "sickness" under the Policy. Ms. Zrihen also recalled Mrs. Hart mentioning respite care during a telephone discussion in 1999, just before the Insurer took the position hospitalizations were not for a covered sickness. Documentation provided by the Defendant (Exhibit D-7) shows there had also been an isolated communication from the Insurer to Mrs. Hart attached to a cheque delivered about four years earlier, which advised that the portion of a claim relating to "respite care" from May 25th to 30th, 1995 was not covered under the Policy. Mrs. Hart and her husband stated that they had no recollection of that correspondence.

[20] Ms. Zrihen testified that when the issue arose in September 1999, the Insurer undertook an investigation of Amanda's past claims. Combined requested Mrs. Hart's authorization to obtain detailed hospital records, including admission and discharge summaries prepared by physicians, and long delays were encountered receiving permission. It is clear from Mrs. Hart's testimony that she

did not provide the authorizations requested because she was unfamiliar with claims procedures, and believed that she had fully authorized the Defendant to obtain all relevant information when she signed the "authorization to release" portion of the original claims forms. Ms. Zrihen advised that complete information was not obtained until 2001, due to repeated delays receiving authorization. During this investigation period, new claims were not being submitted promptly, and benefits were not being paid.

[21] Medical records obtained during Combined's investigation, primarily physicians' admission/discharge summaries, identified respite care as the reason Amanda was hospitalized on many of the occasions after 1993 for which insurance benefits had been paid.

[22] By letter dated May 16th, 2001, Combined informed the Plaintiffs' solicitor that all benefits claimed after September 1999 were being denied on the basis hospitalization was for respite care not covered under the Policy, and also advised that previous hospital stays which were for respite care should not have been paid.

[23] The Plaintiffs' claim for benefits since 1999, and the Defendant's counter-claim to recover amounts paid between 1993 and 1999, depend upon the reason for Amanda's hospitalizations. The Court must determine whether she was totally disabled and confined in hospital because of a covered sickness and therefore entitled to policy benefits, or whether, as the Defendant contends, her attendances were for what has been sometimes described as "respite care", and do not trigger the benefits.

[24] Darcy Hart gave evidence concerning arrangements for Amanda's disputed hospitalizations after January 1993, describing why she was admitted, and the treatment received. She testified that doctors who cared for Amanda at the I.W.K. arranged for her to enter the Eastern Memorial Hospital in Canso for three to four days once each month to have her condition monitored and "things done" as necessary. Mrs. Hart advised that she did not request that a program of periodic visits be established, but that the specialists at the I.W.K. contacted Dr. Vandenburg, a physician who cared for Amanda at Canso, to arrange that she visit hospital there monthly so that she would not continually be travelling back and forth to Halifax. Mrs. Hart explained that the system was put in place by the I.W.K., she coordinated the dates for hospitalization with Dr. Vandenburg, and during the monthly visits Amanda received follow-up treatment and tests as

directed by the doctors to monitor or prevent health concerns. Amanda's mother testified that she is "always sick" with multiple problems, and during the monthly visits to hospital her treatments were frequently changed. Darcy Hart explained that because of the nature of Amanda's sickness, she cannot always be looked after at home and doctors determined the need for periodic visits. Mrs. Hart emphasized she did not "have authority to put Amanda in and out of hospital in Canso", but her stays there reduced the need to go to Halifax and Antigonish. Mrs. Hart described some of the treatments Amanda received during these periodic visits, including addressing infections, seizures and ulcers, medication and diet change, and attending to a broken leg which would not have been discovered outside hospital.

[25] Kenneth Hart testified that "If it wasn't for her going in for checks, she perhaps wouldn't be here." His evidence suggested that Amanda spent three quarters of her time in hospital before Dr. Szudek of the I.W.K., who had been her doctor since birth, put the plan for monthly hospital visits in place.

[26] Mr. and Mrs. Hart explained that they lost confidence in the care Amanda was receiving in Canso, and her periodic hospital visits were moved to Antigonish. They testified that during a monthly visit in early 2002, Canso doctors advised that a sore on Amanda's left hip was not acute and discharged her home. Immediately thereafter, she was taken to the I.W.K. where it was determined that she had a stage two ulcer and that her condition was almost gangrene. She remained in hospital in Halifax for 30 days, after which doctors arranged for her to be hospitalized in Antigonish so that she could be visited more easily by her parents, and where the records show (Exhibit P-2, pages 320-321) she received treatment for approximately five more weeks as an inpatient at St. Martha's Hospital. Since 2002, Amanda's local hospitalization has been in Antigonish and not Canso.

[27] Amanda's mother testified that she is now doing better and does not attend hospital as frequently in Antigonish as she did in Canso. Mrs. Hart regularly reports Amanda's condition to Dr. Jean Cameron, her Antigonish physician, who then decides whether she should enter St. Martha's.

[28] Darcy Hart acknowledged on cross examination that admissions in Canso usually began on a Thursday and ended on Monday. Mr. and Mrs. Hart did not deny that hospitalizations provided them with some relief from the rigorous routine constantly experienced in caring for Amanda; however, the thrust of their testimony was that the primary reason Amanda made monthly hospital visits was

to enable medical personnel to monitor existing concerns and prevent deterioration in her health, resulting from complications arising from her underlying congenital Aicardi Syndrome.

[29] Susan Roberts, Health Records Technician at the Eastern Memorial Hospital in Canso, testified that the institution is an acute care facility where all beds are designated active care and none respite. Ms. Roberts advised that when she provided information to the Insurer indicating that the reason for hospitalization during May 1995 was "Respite Care Aicardi Syndrome Seizure Disorder", Amanda would have received treatment for the Aicardi Syndrome and seizure disorder during that hospitalization period. She also testified that Darcy Hart did not try to influence what she wrote to the Defendant.

[30] Amanda's current physician, Dr. Jean Cameron, who has treated her since 1990, advised that she has major medical illnesses which must be monitored regularly, including recurrent urinary and respiratory tract infections, seizures, and ulcers requiring extensive care. Dr. Cameron stated that the ulcers could become gangrenous and be fatal, and she does not call the care received during Amanda's admissions to hospital in Antigonish or Canso "respite."

[31] Dr. Cameron testified that Dr. Szudek in Halifax recommended that Amanda be admitted every month or two to monitor major medical illnesses, and that to maintain her "halfway healthy" status there must be a regular review of concerns, which is better done in hospital. She advised that Amanda's condition would make it very difficult to obtain necessary urine samples without hospitalization.

[32] Dr. Cameron usually defers to St. Martha's Hospital's bed utilization nurse to determine whether Amanda will be hospitalized for routine tests and x-rays. When hospitalized, even when she is not acutely sick, Amanda receives routine follow-up of her medical condition to prevent her from becoming very sick. During cross examination, Dr. Cameron advised that respite care would not include the investigations, monitoring, x-rays or blood work which are undertaken during Amanda's hospital visits.

[33] Dr. Cameron testified that when she signs documents, known as discharge summaries, indicating admission for respite care, treatments and routine follow-up were also provided during the hospitalizations. She advised that discharge

summaries do not always provide complete information, and doctors' office notes and charts may be more comprehensive.

[34] The Defendant introduced evidence from Dr. John Sullivan and Dr. N. Sidky, who work alternate weeks in Canso, concerning the nature of the care which Amanda received at Eastern Memorial Hospital. Dr. Sullivan first admitted Amanda to hospital in Canso during May 1997, and documentation indicated he did so on approximately 40 other occasions until February 2002. On many occasions, Dr. Sullivan showed respite care as Amanda's discharge diagnosis, and sometimes he would refer to other items such as "multiple congenital physical and mental deficits." On some documentation, he identified the purpose of the respite care as "family caretaker relief." He advised that he is careful about completing admission and discharge reports, although he admitted to misstating Amanda's condition as cerebral palsy on occasion.

[35] Dr. Sullivan testified on direct examination that Amanda's condition was chronic, and that the situation would have to be "stretched" to apply the term "medically necessary" to her visits, which he said were elective and allowed her parents freedom from care duties. He advised that Darcy Hart would contact hospital personnel concerning Amanda's entry for what he described as "elective pre-arranged stay." Dr. Sullivan acknowledged that tests and analysis of Amanda's condition were carried out during visits to Eastern Memorial, but suggested they could have been performed without hospitalization.

[36] Dr. Sullivan confirmed that he assumed responsibilities for Amanda's admissions from Dr. Ahmed, who is deceased, and that he did not know who started the periodic admission practice. He acknowledged on cross examination that he made no independent assessment whether Amanda's hospital visits were needed and did not contact the treating specialists who established the regime. Dr. Sullivan also indicated on cross examination that his memory of all the events was not good, and that he could not identify the biggest concern leading to Amanda's admission.

[37] Dr. Sullivan has not seen Amanda since February 25th, 2002, the day before she began hospitalization for more than two months at the I.W.K. and St. Martha's for ulcer treatment. The Discharge Summary executed by Dr. Sullivan February 25th, 2002 indicates the admission and discharge diagnosis for the final

Canso visit was “Respite care request by mother - four days.” He listed as “secondary”:

> Multiple Congenital Physical and Mental Deficits - recurrent epileptic seizures, colostomy, ureterostomy, multiple musculoskeletal contractures, recurrent bladder stones, recurrent and ongoing right ischeal tuberosity pressure sore.

[38] Dr. Sidky admitted Amanda Hart to Eastern Memorial Hospital regularly between 1997 and 2001. He testified that he last saw her in hospital three to four years before trial, and that he met her in outpatients approximately one year before trial. He described Amanda as unable to talk or walk, with little arm control and no ability to feed or dress herself, or to control her functions. He said that she was totally disabled.

[39] The discharge summaries prepared by Dr. Sidky usually describe Amanda’s discharge diagnosis as “respite care”, although his reports sometimes also referred to multiple congenital abnormalities, examinations, and routine urinalysis.

[40] Dr. Sidky expressed the opinion, both in correspondence to Defendant’s counsel (Exhibit D-1, page 79) and at trial, that it had been “medically necessary” to admit Amanda to Eastern Memorial Hospital on only four occasions. He considers an admission “medically necessary” if there are medical reasons that require a patient to be treated in hospital, in circumstances when outpatient attendance would be inadequate. Dr. Sidky advised that Amanda’s other admissions to Eastern Memorial Hospital were for respite care, “a good way to relieve the family”, which was a practice initiated by his predecessor, the late Dr. Ahmed. Dr. Sidky indicated he considers Amanda to be sick when her condition deviates from “the usual state of health” - when she develops further sickness that cannot be managed at home. When asked during cross examination if Amanda was sick “all the time”, he responded that she has a medical condition with no cure and the answer “depends how you define sickness.” He advised that she has a number of problems, and if she became sicker he would admit her.

Findings - Reason for Hospitalization

[41] Based upon the testimony and the extensive medical records provided during trial, I find that all Amanda Hart's overnight hospitalizations occurred because she has Aicardi Syndrome. I conclude that her state of health is precarious at all times and, as her parents suggest, she is "always sick." Severe physical and mental impairment makes her completely dependent upon others, and I find that Aicardi Syndrome is a sickness which causes Amanda to be "totally disabled."

[42] In reaching these conclusions, I have accepted Mr. and Mrs. Hart's evidence that Amanda's Halifax doctors instituted the program of regular monthly local hospitalization as the best method to provide the medical attention necessary to monitor and treat her chronic condition and symptoms, and to prevent deterioration resulting from her Aicardi Syndrome. Amanda's parents testified concerning the circumstances surrounding her hospitalizations in a forthright and straightforward manner, and as her caregivers, they clearly believed the hospitalization program arranged by Halifax specialists was essential for her well being. Their evidence was confirmed by Dr. Cameron, who has known and treated Amanda with increasing frequency since 1990, has been her primary physician for the last several years, and continues to see her regularly.

[43] I find that until September 1999 Mr. and Mrs. Hart were not aware that anyone had described Amanda's hospitalizations as respite care, and even if they had known the term was used, it would not have been significant for them. They had no knowledge or information which would suggest to them that coverage provided by the Policy for overnight hospital stays was dependent upon the terminology physicians or hospital staff used to describe the purpose of the hospitalization. Amanda's parents had no reason to see discharge summaries or other hospital documentation which used the term "respite" until the Insurer's 1999 investigation was underway. Prior to that time, benefits were paid based upon claims submitted using Combined's prescribed forms, including signed physician's certificate, which repeatedly described Amanda as totally disabled from Aicardi Syndrome. Eastern Memorial Hospital's correspondence to the Insurer mentioning respite care as well as Aicardi Syndrome and seizure disorder as reasons for the May 25th- 30th, 1995 hospitalization was not copied to Mr. and Mrs. Hart, and I accept their testimony that they did not recall any reference that respite care was

not covered during May 1995 in a note accompanying a $729.00 payment (Exhibit D-7).

[44] Where the testimony of Doctors Sullivan and Sidky, physicians requested to testify by the Defendant, differed from information provided by Amanda's parents and Dr. Cameron, I find Mr. and Mrs. Hart's evidence and that of Dr. Cameron to be more convincing. Both Dr. Sullivan and Dr. Sidky succeeded other Canso physicians who had implemented the monthly hospitalization program arranged by I.W.K. specialists. They apparently had no consultation with the doctors who established the regime; Dr. Sidky did not arrive in Canso until 1995, approximately two years after Amanda's hospitalization program there was established, and Dr. Sullivan first became familiar with Amanda in 1997. Except for one occasion when Dr. Sidky saw Amanda as an outpatient, neither had any recollection of contact with her since February 2002, more than three years prior to trial.

[45] The Defendant emphasized in its submission that Dr. Szudek, to whom the Plaintiffs attribute establishing the regime of periodic hospital visits, did not testify to explain why they were arranged. The reason for this potential witness' absence was apparent. The parties made agreements before trial concerning admission of medical reports, and the Plaintiffs expected to be able to introduce as exhibits correspondence from Amanda's Halifax doctors, including Dr. Szudek, pursuant to that understanding. Defence counsel properly objected to production of some documentation, including correspondence from Dr. Szudek, on the basis the materials were not medical records, but rather statements of expert opinion outside the ambit of the parties' agreement, which should not be admissible without proper notice pursuant to the **Civil Procedure Rules**. The documentation was excluded and Dr. Szudek was not present to testify.

[46] Although Dr. Szudek might have been able to provide useful evidence, given the circumstances concerning the exclusion of documents, it is not appropriate to draw an inference adverse to the Plaintiff because she did not. It would be inappropriate for the Court to speculate what the testimony might have been had she been called as a witness by either party. There was no evidence contradictory to Mr. and Mrs. Hart's explanation concerning establishing the arrangements for periodic hospital visits, and I accept the information which they provided.

[47] Amanda stayed in hospital in Canso overnight pursuant to a regime established by medical personnel. Dr. Sidky's characterization of prescribed

periodic hospital attendances as "not medically necessary" when immediate treatment was not required does not in Amanda's situation lead to the conclusion that she was not confined in hospital because of a covered sickness. Testimony from her parents and Dr. Cameron, the physician most familiar with Amanda's situation, established that treatment of her sickness required periodic overnight stays in hospital to monitor and address her chronic recurring symptoms, including serious infection and seizures, to adjust her medication and to prevent further crises. Susan Roberts confirmed that Eastern Memorial Hospital in Canso is an acute care facility where all beds are designated active care without "respite" beds. The medical records illustrate that Amanda spent significantly less time in hospital after the periodic admission program was initiated in Canso in 2003, suggesting that medical benefit accrued from the monitoring and treatment she received. The circumstances were not changed by introduction of the term "respite care" by some of the doctors describing her hospitalization, especially when it was not uncommon for their reports to also describe tests, procedures and treatments administered.

[48] The monthly local hospitalizations unquestionably provided some relief to Amanda's parents from the pressures related to constantly caring for a completely-dependent daughter. However, neither that benefit, nor employment of the term "respite care" by some doctors when completing documentation, changes the dominant and underlying reason for hospitalization, which I have found to be monitoring and treating severe effects of Aicardi Syndrome.

Application of Insurance Policy

A. Policy Terms

[49] The following Policy provisions must be considered to determine whether the disputed benefits arising from Amanda's time spent in hospital are payable. (I have added the underlining to highlight the most pertinent provisions.)

> Combined agrees to pay you, the Insured named in the application, subject to the terms and limitations of this policy, as follows:
>
> **SECTION A HOSPITAL BENEFIT — SICKNESS**
>
> If, because of a covered sickness you are totally disabled and confined in a hospital overnight as an inpatient, beginning while this policy is in force,

Combined will pay you, while you are so confined, starting with the first day of such confinement, and for up to your lifetime, a benefit of:...

under **PLAN C** $60.00 per day .....$1,800.00 per month,...

SECTION C ACCUMULATION

The benefits stated above in Sections A and B will be increased 5% for each six months the policy is kept in force, not to exceed a total maximum increase of 50% of the amount of the benefits selected on the application....

WHAT CERTAIN TERMS MEAN

"Covered Sickness" means a bodily illness or disease (including cancer, heart attack, heart disease or other heart condition, and stroke) you incur, including complications of pregnancy, but not including conditions caused by a bodily injury or pre-existing condition. A pre-existing condition will be considered a covered sickness if loss caused by such condition begins after 12 months from the issue date.

"Pre-existing condition" means a bodily illness or disease (including cancer, heart attack, heart disease or other heart condition, and stroke) which required medical advice or treatment in the 12 months before the issue date of the policy....

A "hospital" is an institution located only in Canada or the United States which meets all of the following requirements: (a) operates pursuant to law; (b) operates primarily for the care and treatment of sick or injured persons as inpatients; (c) provides 24 hour nursing service; (d) has facilities on its premises for diagnosis and surgery; (e) has a staff of at least one licensed physician available at all times.

"Hospital" does not include a clinic, nursing home, convalescent care facility, extended care facility or other facility which primarily provides rehabilitative or custodial care, including such a facility that is a part of or associated with a hospital.

"Totally disabled" means the inability to perform each of the substantial and material duties of your business or occupation (usual activities if not employed).

PRE-EXISTING CONDITIONS LIMITATION

> Loss caused by a pre-existing condition is not covered unless such loss begins after 12 months from the issue date....
>
> **EXCEPTIONS AND REDUCTIONS**
>
> This policy will not pay for losses resulting from: bodily injuries; mental or emotional disorders; or normal pregnancy or childbirth....
>
> **STATUTORY CONDITIONS**
>
> 1. (1) The Contract: The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

B. Position of the Parties

[50] While the parties strongly disagree about interpretation of the contract in the Policy, there is little dispute concerning general principles applicable. Richard Hayles in Disability Insurance, Canadian Law and Business Practice (Carswell 1998) comments as follows concerning interpretation of insurance policies, particularly exclusion clauses, at pages 230-231:

> Insurance policies are to be construed like other written documents, and the primary rule of interpretation is that language is given its ordinary or popular meaning unless the context in which it appears or the circumstances in which the contract was made compel some other conclusion. This principle is sometimes referred to as the "golden rule," of contract interpretation, or the "plain meaning" rule.
>
> Policy language is to receive its plain, ordinary, or popular meaning rather than an entymological, philosophic, or scientific meaning. The language of a disability insurance policy is to be taken in the sense it would be understood by ordinary policy holders, and not in a technical sense that would be understood only by underwriters, adjusters, and other professionals....
>
> If the policy language can be given an ordinary meaning which is clear and logical, it is neither necessary nor permissible to resort to any other rule of construction. It is nevertheless incumbent on the insurer to prove that the facts of the case fall within the exception.

[51] In **Fielding v. Combined Insurance**, [1996] N.S.J. #174, this Court said:

> The law is clear as regards the interpretation of insurance policies. Where there is no ambiguity to the meaning or scope of the limiting term of a policy, the plain language of the contract must prevail (See **Consolidated Bathurst Export Ltd. v. Mutual Boiler and Machinery Insurance Co.**, [1980] 1 S.C.R. 888).

[52] Each party submits that the Policy is not ambiguous and that its plain meaning supports their position. The Plaintiffs say, in the alternative, that if there is ambiguity, it should be resolved in their favour under *contra proferentem* principles, and that the reasonable expectations of the parties favour coverage. The Defendant maintains that rules of construction should not be used to create an ambiguity where none exists, and that the Court should give effect to the parties' reasonable expectation that no claims be paid for "respite care."

C. Conclusion - Benefits are Payable

[53] For the reasons which follow, I find that the Policy is not ambiguous, and according to its plain meaning the Plaintiffs are entitled to recover benefits for periods during which Amanda was hospitalized overnight. Alternatively, if there is an ambiguity, both application of the *contra proferentem* principle and assessment of the reasonable expectations of the parties dictate that the Policy provide benefits for her overnight hospital stays.

D. Plain Meaning of Contract

[54] The Plaintiffs claim that Amanda is entitled to benefits pursuant to the plain meaning of the contract language - that she has a "covered sickness", Aicardi Syndrome, requiring overnight stays in hospital, and that she is totally disabled. The Defendant maintains that Amanda's claim falls outside the plain meaning, because (i) she was admitted overnight for "respite care", which is not a "covered sickness"; (ii) an institution providing respite or custodial care is not a hospital as defined in the Policy; and (iii) she was not totally disabled as subjectively defined in the contract.

(i) Covered Sickness

[55] Amanda has been hospitalized because she has Aicardi Syndrome, which I find fits within the plain words contained in definition of "covered sickness" contained in the Policy, being a "bodily illness or disease incurred", not falling within any exclusion. I reject the Defendant's submission that she was admitted for "respite care" - the underlying reason for Amanda's hospitalization is Aicardi Syndrome, a covered sickness, and the Policy does not specify or exclude any type of hospital care received for a covered sickness - be it surgery, intensive, respite, palliative, or otherwise.

(ii) Hospital

[56] The disputed hospitalizations took place at Eastern Memorial Hospital in Canso. The evidence of Susan Roberts, which was not contradicted by the physicians practicing there who testified on the Defendant's behalf, established that the institution is an accredited acute care facility where all beds are designated active care with no respite beds. It meets all requirements of the definition of "hospital" in the Contract, and does not fall under any Policy exclusion.

(iii) Totally disabled

[57] The Defendant maintains that Amanda does not qualify for policy benefits because she does not meet the definition of "totally disabled" contained in the Policy, which "*means the inability to perform each of the substantial material duties of your business or occupation (usual activities if not employed)*." The Insurer says that is a subjective definition, and that the test is not what other children of similar age can normally do, but limited specifically to what the Insured can usually do. Combined maintains that Amanda is no more disabled while in hospital than she was before admittance, and therefore she is not "totally disabled" because there is no divergence from her usual condition.

[58] I reject the Defendant's position, and conclude that while in hospital Amanda is "totally disabled" as defined in the Policy. The uncontradicted evidence of all witnesses who have been in contact with Amanda very clearly establishes her total disability. At all times, she is unable to look after herself and is totally dependent on others for complete care. This has been her situation since birth. The thrust of the Defendant's suggestion is that an Insured cannot be "totally disabled" while in hospital, if they are "totally disabled" when not in hospital. That position is inconsistent with representations made to Amanda's parents when

they were solicited by Combined's representatives to purchase the Policy. Mr. and Mrs. Hart testified that Amanda's condition was fully disclosed to the Defendant's sales representative, Ms. Hynes, when the Policy was marketed. Their testimony was confirmed by a neighbour, Janis Boudreau, at whose house the discussions with Combined occurred during September 1991. Ms. Boudreau testified that Darcy Hart told the salesperson about Amanda's condition, and that the salesperson advised she would check with her superior before binding coverage. Thereafter, Combined accepted premium payments and issued the Policy. Mr. and Mrs. Hart and Ms. Boudreau testified that Combined's representative indicated that Amanda need only spend overnight in hospital to be eligible for policy benefits, and there was no suggestion she had to be more disabled in hospital than she ordinarily was.

[59] Beginning in September 1992, the Defendant paid claims arising from Amanda's hospitalizations, and continued to do so without questioning whether she was "totally disabled" until the respite care issue developed in 1999. The Defendant has been fully aware of Amanda's condition since selling the Policy in 1991, and should not now be allowed to attempt to rely on an exclusion clause to deny indemnification when it was previously aware of a possible basis for denial and acted as if coverage was in place. (**Snair v. Halifax Insurance, et al.**, [1995] N.S.J. No.424) Estoppel principles do not permit termination of benefits in the absence of a change in the beneficiary's condition when the Insurer knew the extent of the disability while it paid claims for seven years.

[60] Even if there were not a history of paying claims, I interpret the definition of "totally disabled" in the Policy as referring, in Amanda's case, to inability to perform the "usual activities" of her "occupation", being a 17-year old girl. Clearly, when Amanda is in hospital she is unable to undertake the activities usually performed by a 17-year old.

[61] The evidence advanced in this case establishes that because of Aicardi Syndrome, a "covered sickness" as defined in the Insurance Policy, she is totally disabled and has been confined to hospital overnight as an inpatient. According to the plain meaning of the Contract, she is accordingly entitled to receive a benefit for periods of hospitalization.

(iv) Respite Care

[62] My conclusion respecting the plain meaning of the Policy would not be different, even if I had found the primary reason for Amanda's hospitalizations was for respite care, rather than to monitor and treat her chronic condition and symptoms, and prevent deterioration resulting from Aicardi Syndrome. Statutory condition No. 1 included in the Policy states that the contract terms are the entire agreement, and respite care is not one of the "exceptions and reductions" stated. Although the law provides little formal definition of "respite care", the term contemplates benefit to a sick person as well as caregivers. Article 9.0 contained in the "In-home Support Program" developed pursuant to Section 18 of the **Children and Family Services Act**, referenced in **Dassonville-Trudel (Guardian ad litum of) v. Halifax Regional School Board**, [2004] N.S.J. No. 241, at paragraph 18 explains respite care as follows:

> 9.0 RESPITE CARE
>
> The main function of "respite care" is to relieve the parent/family/primary caregiver for a specific period of time while facilitating a positive and rewarding experience for the child with a disability or a chronic illness. Respite care includes: meeting the care needs of the child; offering the child opportunities to develop social, recreational and life skills; strengthening families by reducing stress and thereby improving long-term function and quality of life.

[63] An element of child respite care is meeting that young person's care needs. While I agree with the Defendant's position that respite care itself is not a covered illness, it can be a basis for hospitalization of a totally-disabled person such as Amanda, who suffers from a covered sickness. Accordingly, in the absence of a Policy exclusion, I find that even if respite care had been the main reason for Amanda's hospitalizations, she would be entitled to benefits under the Policy as a totally-disabled person confined in hospital overnight because of a covered sickness.

E. Ambiguity

[64] Alternatively, if the Insurance Policy does not have the plain and ordinary meaning which I have attributed to its words, I would identify any ambiguities, which would arise from use of the terms “covered sickness”, “totally disabled”, “hospital”, and absence of reference to “respite care.” Any such ambiguities would be resolved by application of the *contra proferentem* rule, and the Policy terms construed against the Defendant, who authored the document. “Where the meaning of a contract is ambiguous, that is, that its meaning is obscure, the application of the *contra proferentem* rule requires that the meaning least favourable to the author of the contract ought to prevail...” (See **Arnoldin Construction & Forms Ltd. v. Alta Surety Co.**, [1995] N.S.J. No. 43 (N.S.C.A.) (QL), at p.11; see also **Hillis Oil & Sales Ltd. v. Wynn’s Canada Ltd.** (1986), 25 D.L.R. (4th) 649 (S.C.C.) (QL).)

[65] Interpretation of the Policy to provide benefits for the disputed hospital visits is consistent with the reasonable expectations of the parties. Before selling the Policy in 1991, the Defendant was aware of Amanda’s sickness and had an opportunity to investigate the frequency of her prior hospitalizations. Mr. and Mrs. Hart both testified that while their business was being solicited, there was no suggestion that the Policy would not cover all Amanda’s hospitalizations and they were told that it would provide “peace of mind.” Mr. Hart said that he understood from the salesperson that the only limitation was that hospital stays be overnight - coverage had “nothing to do” with the type of care, as long as Amanda was in an acute care hospital.

[66] Mark Feltmate, who previously worked as a sales representative for the Defendant, advised that he was consulted by Mrs. Hart concerning the meaning of “overnight hospitalization”, and he told her that it meant overnight in hospital for sickness for any reason other than accident. He testified that Combined used purchaser’s “peace of mind” as a selling feature, and it was his practice as a Combined agent to tell prospective customers the Defendant would pay for hospitalization and convalescence for any covered sickness, except those excluded in the policy, which he would identify for prospective purchasers.

[67] There is no suggestion the Defendant ever communicated that the type of care received during a hospital stay, be it characterized as respite or otherwise,

would dictate eligibility for recovery. The evidence demonstrates that it was reasonable for the Plaintiffs to expect the Policy to provide benefits for the hospitalizations in dispute.

[68] Amanda is entitled to the disputed benefits according to the plain meaning of the Policy words, at the applicable daily rate for each of her overnight visits. If this result were not apparent from the language used in the Policy, pursuant to the reasonable expectation of the parties and applicable legal principles, any ambiguity should be resolved in favour of the Plaintiffs, and the conclusion would be the same.

Issue #2 Are benefits payable with respect to post-discharge periods following hospitalization characterized as respite care?

[69] The Defendant's position is that even if the Plaintiffs are entitled to recover benefits for days Amanda is confined to hospital, convalescent benefits are not payable under Section B of the Policy, which provides as follows:

> If, because of covered sickness you are totally disabled following a period of hospital confinement for which benefits are payable under Section A, Combined will pay you while you are so disabled, but not to exceed twice the number of days of such hospital confinement, a benefit of...

[70] Until the respite care issue arose, the Insurer did not question Amanda's entitlement to convalescent benefits, and for approximately seven years the Plaintiffs received, in addition to the prescribed amount for each day she was hospitalized, payment equal to twice that amount under the convalescent provision. The Defendant now maintains that convalescent benefits should not be paid with respect to the visits it has characterized as respite care, even if this Court directs Amanda recover benefits for those hospitalization days under Section A of the Policy. The Defendant says convalescent benefits need not be paid because:

(a) There is no resulting disability for convalescence following hospital confinement for respite care;
(b) after discharge from hospital Amanda was not totally disabled, i.e. not unable to perform her usual activities, and indeed she sometimes went directly to school.

[71] I conclude that the Plaintiffs are entitled under the Policy terms to convalescent benefits with respect to post-discharge periods following any eligible hospital visit. I have found that Amanda's hospitalizations occurred because she has Aicardi Syndrome, a sickness covered under the Policy, which causes her to be totally disabled. Her condition is not changed after discharge from hospital - she continues to be totally disabled from Aicardi Syndrome.

[72] During the convalescence periods described in the Policy, because of Aicardi Syndrome, Amanda does not perform the "usual activities" which a person who is not totally disabled would undertake. I do not agree with the Defendant's contention that being taken to school during convalescence indicates she is not "totally disabled" and performs "usual activities." In my respectful view, Amanda's physical location does not imply she performs usual activities or reduce her disability. Nothing in the evidence, whether testimony from Amanda's parents, physicians, or others, suggests there is a time when she is not totally disabled. Her physical and intellectual disabilities are very severe. When Amanda was brought by her parents to attend part of the trial, she was immobile in a wheelchair, accompanied at all times by a family attendant, and gave no indication she understood any of the events which were occurring. The Court was advised that she was encountering medical difficulties and she was taken out of the building before the hearing finished.

[73] Should I be wrong in concluding that the Policy terms require the Insurer to pay convalescent benefits following Amanda's disputed hospitalizations, I find that the Defendant is estopped from denying those payments. Combined routinely paid convalescent benefits following Amanda's hospitalizations for approximately seven years, until the "respite care" issue developed. During that time the Insurer had complete knowledge of the extent of Amanda's disability, which was fully disclosed when the Policy was purchased. The Defendant did not suggest during that time that attendance at school or move to another location during the period following hospitalization would diminish her "total disability" or affect its obligation to pay. Ms. Zrihen testified that Combined does not dispute payments for convalescence after hospitalization which it did not attribute to respite care. Amanda is no less disabled following the disputed hospitalizations than after visits for which the Insurer has acknowledged an obligation to pay convalescent benefits.

[74] It is reasonable for the Plaintiffs to rely upon receiving convalescent benefits following any hospitalization, and they would be prejudiced if the Defendant could

withhold those benefits following hospitalizations which the Court determines qualify for benefits. The estoppel principles referred to in **Snair v. Halifax Insurance, et al.** (*supra*) are applicable - Combined Insurance, well informed concerning Amanda's condition, adopted a course of conduct by paying convalescent benefits following hospital visits for which benefits were not in dispute. Mr. and Mrs. Hart's testimony established that they have limited financial means, and relied upon insurance payments. If they had known that convalescent benefits would be disputed, they may have organized Amanda's post-hospitalization treatment differently. Prejudice may be presumed and estoppel invoked where an insurer persists in defending a claim without early indication that the relevant issue was in dispute. (**Rosenblood Estate v. Law Society of Upper Canada** (1989), 37 C.C.L.I. 142) Once disputed hospitalizations are deemed by the Court to trigger benefits, the Insurer's pattern of paying convalescence benefits following qualifying hospitalizations must continue.

<u>Issue #3</u> Are the Plaintiffs entitled to punitive and/or aggravated damages?

[75] The Plaintiffs say that Combined Insurance exhibited bad faith in its dealings with respect to the Insurance Policy and they claim punitive and aggravated damages for conduct alleged to be egregious, malicious, oppressive, high-handed, and offensive to the Court's sense of dignity. The Plaintiffs say the Defendant's behaviour demonstrates a consistent prolonged pattern of bad faith, delay, misrepresentation and threats not consistent with its duty to honour the insurance contract. Mr. and Mrs. Hart submit that the Defendant's action warrants punitive damages for punishment and deterrence, as well as aggravated damages to compensate them for mental distress suffered due to the Insurer's actions.

[76] The Plaintiffs cite numerous examples of Defendant's conduct which they say supports an award of punitive and aggravated damages. I find that some of the alleged actions are established by testimony and documents provided to the Court, while in other cases neither the conduct nor the Insurer's responsibility for any consequence to the Plaintiffs has been demonstrated.

[77] Testimony and documentation show that the Defendant's conduct included:

(a) Advising Mr. and Mrs. Hart that if they pursued this claim, a counter-claim would be advanced to obtain a lien against their house. Mr. and Mrs. Hart testified this them caused concern and fear.

(b) Casting inappropriate aspersions on the Plaintiffs in correspondence to Dr. Sullivan and Dr. Sidky September 4th, 2001 (Exhibit P-4 and P-5), when the Defendant advised that prior claims had been paid on account of "what has been discovered to be misinformation" and without any qualification stated:

> Policy does not cover respite care. The extensive medical records of which we are now in possession indicate that substantially all of Amanda's stays in hospital were on account of respite for the benefit of her parents.

(c) Describing a $30,510.00 payment following the Application Decision as an "interim payment" in 2003, and subsequently advising in 2005 that the funds were not an interim payment (Exhibit P-6, Tab 20).

(d) Maintaining that Eastern Memorial Hospital was not a hospital, after receiving clear evidence to the contrary.

(e) Advising Darcy Hart during a telephone inquiry concerning a claim that "We're not Santa Claus."

(f) Using language such as the following to describe the Plaintiffs' actions and motives in briefs submitted to this Court and in its factum to the Court of Appeal following the Application Decision:

- (i) Referring to the Plaintiffs' action in making claims for hospitalization as "the ruse."
- (ii) Suggesting a "slip" was made when documents were submitted containing the term "respite care" in 1999, thereby implying that the Plaintiffs deliberately avoided indicating that earlier claims were for respite care.
- (iii) Stating that the Insurer was "hoodwinked" into paying claims.
- (iv) Stating that the Insured was "for years very careful not to state this factual true reason for admission to hospital."
- (v) Saying that medical records "revealed the atrocious extent of mischaracterized claims that were in fact for admissions for respite care for the benefit of the family."
- (vi) Describing the first claim which included documents showing respite care as "blatant."

[78] I find no evidentiary basis for the Defendant's suggestion that Mr. and Mrs. Hart were deceitful or misleading in connection with any claim advanced.

They submitted documents to their Insurer exactly as received from hospitals and physicians, and there was no attempt at any time to misdescribe what they understood to be a reason for hospitalization or basis of claim. Nothing in the evidence suggests the Plaintiffs contrived to falsely or improperly characterize hospitalizations. I am satisfied that Amanda's parents held a genuine belief that all her overnight stays were covered. As set out in paragraph 43 of these reasons, they were unaware until the Defendant raised the matter in 1999 that the term "respite" had been used, and they did not know that there was any issue respecting that term which might have led them to describe claims incorrectly.

[79] Examples of conduct which the Plaintiffs allege support its aggravated and punitive damages claim, but which I find were not established at trial, or which did not have the effect the Plaintiff maintains, include the following:

(a) The Plaintiffs say the Defendant, without their permission, disclosed the amount they received under the Policy while soliciting other sales in their community. The Defendant denies this allegation. Susan Roberts testified that a sales representative from Combined revealed the amount paid to the Plaintiffs between January and June of 1999 while he was attempting to sell her a policy, but Combined's claims specialist, Ms. Zrihen, who advised that Combined investigated a complaint arising from that incident, indicated the agent would have no access to that information, and to make such a disclosure would be contrary to company policy. I accept Ms. Roberts' testimony that disclosure was made, but as she was a records technician at Eastern Memorial Hospital familiar with the Plaintiff's claims and would have had access to relevant information, it is unlikely the Plaintiffs suffered any damages as a consequence.

(b) The Plaintiffs maintain the Defendant failed to communicate reasons for denying claims for a period of 20 months, when it was obliged to do so within 60 days, and then blamed them for the delay. I have concluded that the delay was not entirely the Defendant's fault. It was caused in part by the Plaintiff's reluctance to answer what they considered to be unreasonable requests for additional authorizations to obtain information. Communications between Mrs. Hart and Combined were very poor. When the Insurer made reasonable requests for additional information, Mrs. Hart, with no improper motivation, did not cooperate to make it available because she felt the forms she had previously signed were all that the Defendant

required to obtain the information. She was not aware that the validity of those authorizations was time expired. The Plaintiffs' reactions can be understood in the context of the inappropriate allegations being made against them; however, the release of some documents by the Plaintiffs only a few days before trial confirms that delay is not attributable only to the Defendant.

(c) Mr. and Mrs. Hart suggest that the Defendants exploited the uneven power balance between a large well-funded insurance company and unsophisticated parents of a totally-disabled daughter who were also raising two other children on a modest income in a small rural community. They say Combined's conduct amounted to bad faith when it employed litigation strategies which included using "respite care" as a defence to payment, refusing to pay undisputed claims because the counter-claim was a potential set-off, disputing that Amanda was totally disabled, and adopting an attitude to claims assessment which differed from the impression created by the sales agent. I do not agree that these tactics amounted to bad faith conduct, or that the Defendant's general denial of the claim constituted adopting a patently-unreasonable position. Mr. and Mrs. Hart were embarrassed when members of their community learned claims were being rejected, but the evidence did not provide any justification for their concern that Combined's refusal to pay claims amounted to a statement that they were keeping Amanda at home in order to obtain insurance benefits instead of placing her in permanent care.

[80] Punitive damages are awarded for punishment and deterrence, but only in respect of conduct which is harsh, vindictive, reprehensible and malicious (**Vorvis v. Insurance Company of British Columbia**, [1989] 1 S.C.R. 1085), and which offends the Court's sense of decency (**Hill v. Church of Scientology of Toronto**, [1995] 2 S.C.R. 1130). An award of punitive damages in a contract case, though rare, may be obtained if a claimant establishes an actionable wrong in addition to the breach sued upon. In a claim under an insurance policy, such actionable wrong can be a breach of the insurer's distinct and separate obligation to deal with its policyholder in good faith (**Whiten v. Pilot Insurance**, [2002] 1 S.C.R. 595); **Clarfield v. Crown Life Insurance Company**, [2000] O.J. No. 4074 (S.C.J.)). The Plaintiffs say the Insurer displayed bad faith in this case by intimidation, delaying the litigation, and ignoring medical evidence concerning the extent of Amanda's disability. Mrs. Hart testified that Combined represented that she would

have “peace of mind” after purchasing this Policy, and the Plaintiffs rely upon the Supreme Court’s observation in **Whiten** (*supra*) at paragraph 129 that the obligation to deal in good faith means the insured’s peace of mind should be the insurer’s objective, and a policyholder’s vulnerability should not be aggravated as a negotiating tactic.

[81] Aggravated damages are awarded to compensate a plaintiff for mental distress resulting from a defendant’s misconduct; unlike punitive damages, which are designed to penalize and deter wrongdoers, aggravated damages address intangible injuries such as humiliation and anxiety which a plaintiff suffers in addition to normally-assessed damages. Aggravated damages are essentially compensatory - the Court must determine whether a defendant should reasonably have anticipated consequences, such as mental suffering or anxiety, for which a claimant seeks compensation (**Vorvis** (*supra*)). Before aggravated damages are awarded, there must be a finding that the Defendant was motivated by actual malice (**Hill** (*supra*)) which increased the injury to the Plaintiff.

[82] The Defendant’s conduct in this case did not meet the standard the Court expects from an underwriter responding to a claim for benefits under an insurance policy. The Plaintiffs sought continued payment of benefits which the Insurer provided without question for several years. When a dispute developed concerning interpretation of terms used in the Policy, the reason for Amanda’s hospitalization, and the extent of her disability, the Defendant unnecessarily and inappropriately adopted an overly-adversarial approach. Resolution of the case required determination of the factual background to Amanda’s hospitalizations, and ascertaining the meaning of terms used in a contract drafted by the Defendant. Instead of focusing on those issues, the Defendant’s approach was to attribute improper and deceitful motives to the Plaintiffs, suggesting they misrepresented facts, including the reason for hospitalization. The aspersions which the Defendant cast upon Mr. and Mrs. Hart were unwarranted and should not have been advanced. There was no testimony to suggest the Plaintiffs attempted in any way to disguise or misrepresent the facts or circumstances - they were not aware when submitting claims, which were signed by doctors, that some physicians arbitrarily started to use the term “respite” on hospital documentation. When the investigation ensued, I am satisfied that the Plaintiffs, although sometimes slow authorizing release of documents which they understood the Defendants were already entitled to receive, were honest and forthcoming. The attitude adopted by

the Defendant, repeatedly ascribing improper motives to the Plaintiff, frustrated any possible resolution of the dispute, and contributed to the Plaintiff's anxiety.

[83] Mr. and Mrs. Hart have not enjoyed the "peace of mind" the Defendant's sales endeavours indicate sickness hospital benefit policies provide. With limited resources in a small community environment they have endured the stress associated with caring for a totally-dependent child whose condition is always precarious. All the medical and other evidence highlights the wonderful care Amanda has received. The sacrifices her parents have made and the toll it has taken upon them and their other children are very significant. The Plaintiffs' difficult circumstances have been exacerbated, rather than relieved, by the attitude and actions of the Defendant Insurer.

[84] I am not satisfied, however, that the Defendant's conduct has been so blatant and egregious that it meets the tests Courts apply to award punitive and aggravated damages. The Plaintiffs have not established that the increased anxiety, stress and financial pressure which they experienced following rejection of the insurance claim resulted from an actionable wrong committed by the Defendant in addition to its breach of contract, or that Combined was motivated by actual malice.

[85] Punitive damages may be awarded against an insurer who ignores undisputed facts and/or persists in advancing a defence with no reasonable likelihood of success in order to intimidate a plaintiff to the extent that the case will be abandoned or inappropriately compromised. In the present case, despite Combined's unwarranted attribution of improper motives and its use of inappropriate defence tactics, I am satisfied that a genuine dispute developed concerning the need for and circumstances surrounding some of Amanda's hospitalizations - this is not a situation where there were no facts to be determined or where undisputed facts were ignored; rather, it is a case where the Defendant inappropriately accused the Plaintiffs of misrepresenting the facts. Real issues arose involving the type of care received and Combined's obligation to provide policy benefits with respect to that care. The existence of legitimate questions to be determined is apparent from the Plaintiffs' failure to obtain judgment after the Court of Appeal considered the Application Decision, and from dismissal of their summary judgment application which was made at the commencement of trial.

[86] The Insurer's decision to defend a claim involving disputed fact and interpretation of contractual terms was not inappropriate. While unwarranted

attribution of deceitful conduct to the Plaintiffs is not condoned, I do not find the Defendant's behaviour, in the context of legitimately-disputed issues, to be so exceptionally reprehensible, malicious, oppressive, or high-handed as to be a breach of its duty of good faith or offensive to the Court's sense of decency.

[87] It was wrong for Combined to characterize the Plaintiffs' actions as a deceitful attempt to misrepresent the circumstances related to Amanda's hospitalization, and other defence tactics, including threatening a lien against Mr. and Mrs. Hart's property, undoubtedly contributed significantly and unnecessarily to their burden. However, the evidence did not substantiate the Plaintiffs' contention that the Defendant authorized disclosure of their private affairs to the community, or created a perception they were keeping Amanda at home to obtain insurance proceeds. Mr. and Mrs. Hart's vulnerable situation may have contributed to some overreaction to the Defendant's conduct. The Plaintiffs have not established that the Defendant acted with actual malice and should reasonably have anticipated the extent to which its actions contributed to Mr. and Mrs. Hart's anxiety.

[88] Although the Defendant's behaviour significantly influenced the course of the litigation and is a factor to be considered when awarding costs, the Plaintiffs have not established that the Defendant committed an actual wrong in addition to breach of contract, or was motivated by actual malice. The circumstances do not warrant awarding punitive or aggravated damages.

Issue #4 Should the Defendant's Counter-claim succeed?

[89] The Plaintiffs have established the right to retain all compensation received, and to further benefits in the amount prescribed by Sections A, B and C of the Insurance Policy with respect to additional periods of hospitalization and convalescence. Accordingly, the Defendant's counter-claim will be dismissed.

CONCLUSION: DAMAGES, INTEREST AND COSTS

Damages

[90] The Plaintiffs are entitled to the principal sum of $75,285.00 claimed as benefits for hospitalization and convalescent periods since September 1999. They

shall therefore retain the sum of $30,510.00 received following the Application Decision, and have judgment for an additional $44,775.00.

Interest

[91] Statutory Condition 10, incorporated in the Policy as required by Section 74 of the **Insurance Act**, R.S.N.S. 1989 c.231, provides that benefits will be paid by the Insurer within 60 days after it receives proof of claim. Plaintiffs' Exhibits P2A, P3A and Defendant's D1 tab 5, 6, 7 show the dates and durations of disputed hospitalizations and corresponding convalescence periods, and the parties have calculated the benefit amount in issue for each period. The Plaintiffs had established a program of submitting claims promptly following hospitalization until the Defendant began declining payment in 1999. Given the historical pattern of claims' submission, the Defendant's conduct, and the requirement that the Insurer make payment within 60 days of receiving claims, I have concluded that benefits ought to have been paid within 90 days of the final day of each convalescent period. The Plaintiffs will therefore recover interest from the 90th day after conclusion of convalescence on the amount of benefit payable for each hospitalization and convalescence. The parties have not agreed to the rate of pre-judgment interest, and given the amount of damages in issue, the cost to clients of providing submissions with respect to that rate could easily exceed the maximum recoverable interest. Statistical information provided by the Bank of Canada (www.bank-banque-canada.ca) shows the average prime chartered bank administered business lending rate between September 1999 and November 2005 to be 5.14 per cent, which I consider to be a reasonable guideline in the circumstance. I accordingly fix the applicable rate of interest at 5 per cent per annum.

Costs

[92] This action was commenced in June 2001, and trial occupied four days during May 2005, including hearing the unsuccessful Summary Judgment Application made by the Plaintiff at the commencement.

[93] Discretion to award costs pursuant to **C.P.R. 63** is exercised in the context of guidelines contained in tariffs established pursuant to the **Costs and Fees Act**, R.S.N.S. 1989, c.104.

[94] In determining an appropriate costs award in this case, I have considered particularly the following provisions in **Rule 63**:

> **63.02.**
> (1) Notwithstanding the provisions of rules 63.03 to 63.15, the costs of any party, the amount thereof, the party by whom, or the fund or estate or portion of an estate out of which they are to be paid, are in the discretion of the court, and the court may,
>
> (a) award a gross sum in lieu of, or in addition to any taxed costs;
>
> **63.04.**
> (1) Subject to rules 63.06 and 63.10, unless the court otherwise orders, the costs between parties shall be fixed by the court in accordance with the Tariffs and, in such cases, the "amount involved" shall be determined, for the purpose of the Tariffs, by the court.
>
> (2) In fixing costs, the court may also consider
>
> (a) the amount claimed;
>
> (b) the apportionment of liability;
>
> (c) the conduct of any party which tended to shorten or unnecessarily lengthen the duration of the proceeding;
>
> (d) the manner in which the proceeding was conducted;
>
> (e) any step in the proceeding which was improper, vexatious, prolix or unnecessary;
>
> ...
>
> (g) the neglect or refusal of any party to make an admission which should have been made;
>
> ...
>
> (j) any other matter relevant to the question of costs.

[95] The Plaintiffs achieved success on all issues except their claim for punitive and aggravated damages, and there are no special circumstances to suggest the Court should deviate from the general directive in **Civil Procedure Rule 63.03(1)** that costs follow the event. The amount sought in the principal claim was $75,285.00 (including the interim payment reclaimed by the Defendant), and the Defendant counter-claimed for $78,417.00. The amount in issue for the purpose of calculating costs payable by the Defendant is set at the sum of the claim and counter-claim, being $153,702.00.

[96] This proceeding was commenced prior to implementation of the 2004 Tariff, and the Tariff established during 1989 should therefore be considered. Under that regime, applying the basic Scale #3 to a case involving $153,000.00 would generate a costs award of $8,965.00, and Scale #5 would suggest an award of up to $12,975.00.

[97] One consideration when determining if a scale above #3 should be used is whether an unsuccessful party ought to be "punished" for inappropriate conduct. W. Augustus Richardson, in *A Primer on Party and Party Costs and the Taxation of Legal Accounts in Nova Scotia*), Canadian Bar Association Professional Development Conference, January 2002, at paragraph 44, and footnote 35, summarizes the authorities as follows:

> 44. A scale greater than 3 may be used where the court wishes to "punish" the unsuccessful party for inappropriate conduct; [35] or to recognize that the matter was more complex or more costly to the successful party, thereby entitling it to a higher award.
>
> [35] In *Chaddock v. Chaddock* (1993) 121 NSR (2d) 274 the successful wife was awarded costs on scale 5 because of the conduct of the unsuccessful husband, which had obstructed and delayed the proceedings. In *Turner-Lienaux v. NS (AG)* (1992) 115 NSR (2d) 200 (TD) costs on scale 4 were awarded against an unsuccessful plaintiff where her solicitor's conduct "had the effect of significantly increasing the costs of the successful party:" see para.89. See also *Landymore v. Hardy* (1992) 112 NSR (2d) 410 (TD), per Saunders, J at para.30, where scale 5 was awarded to the successful party because the defendant's advancement of unsubstantiated counterclaims; and failure to admit facts until the

> last moment; put the successful party to "wholly unnecessary expense."

[98] The tenor of this dispute was significantly altered by the unsupported allegations the Defendant advanced respecting the Plaintiffs' conduct and motives. Although the Defendant did not go so far as to allege fraud, it made unfounded statements which implied that the Plaintiffs were dishonest or that they engaged in other improper conduct, and which impugned their character and reputation. I find that the Defendant's actions, particularly in suggesting Mr. and Mrs. Hart behaved deceitfully by improperly characterizing hospitalizations, unnecessarily polarized the parties and made litigation more difficult than necessary. The resulting level of acrimony was apparent during trial, where Mrs. Hart in particular felt it necessary to defend the integrity of her family's actions. The climate created by the Defendant virtually guaranteed that the case would proceed to trial, when costs might have been avoided through settlement discussions in a different atmosphere.

[99] The Defendant's conduct, described previously with respect to the claim for punitive and aggravated damages, while not so egregious as to support an award of those types of damages, warrants an increased costs award (see **Battista v. Wawanesa Mutual Insurance Co.**, [2005] O.J. No.4865, at paragraph 5). In my view, even a Scale 5 award under the 1989 Tariff would be substantially inadequate. The 2004 Tariff, although not prescribed for this case, applies to litigation commenced less than eight months prior to the date of this trial, and would yield a costs award, following a four-day trial, of $24,750.00 on the basic scale or $28,938.00 if the revised elevated scale (now Scale #3) were used.

[100] Mr. and Mrs. Hart were exposed to very great risk in pursuing this claim, while facing a substantial counter-claim. The Defendant's solicitor wrote to Plaintiffs' counsel May 31st, 2001 indicating:

> Your client should understand that a judgment in my client's favour would attach to their property and I'm certain that a great deal of the $77,000 plus would be recoverable.

[101] The litigation process included the usual pre-trial proceedings, exchange of substantial documentation, and filing of post-trial briefs, which the

Defendant requested in lieu of oral submissions. Although aggravated and punitive damages are not awarded, it was not unreasonable for the Plaintiffs to advance those claims, given the nature of the Defendant's conduct.

[102] Based upon the foregoing considerations, I award the Plaintiffs' costs in amount $30,000.00. I have determined that the circumstances warrant their receiving a lump sum of approximately $17,000.00 in addition to the amount provided by Scale #5 of the 1989 Tariff, which coincidentally is slightly more than the amount suggested under Scale #3 of the 2004 Tariff.

[103] The Plaintiffs were also awarded costs following the Application Decision, and that ruling was not altered by the Appeal Division. Those costs shall be in addition to the award I have made, and unless they have been determined by agreement or by taxation, I am prepared to set the amount at the request of either party. Given the familiarity I have developed with the case, further submissions would not be necessary.

[104] Approximately one week before trial, the Plaintiffs made Application for Summary Judgment, which was heard on the first day scheduled for trial. The motion was dismissed upon determination that genuine questions of material fact leading to arguable issues involving interpretation of the Insurance Policy required resolution at trial. Decision with respect to costs of that Application was reserved. The Defendant suggests it should receive a substantial award, as the unsuccessful motion had to be addressed urgently at the same time the Defendant received both "last minute" disclosure of documents, which formed some of the substantial exhibits at trial, and written briefing with respect to issues in the main action. The Summary Judgment Application was ill timed and unsuccessful, but some of the Defendant's work in response was also applicable to the main proceeding. The Defendant is entitled to a set-off reduction of $1,000.00 against the costs which I have awarded.

[105] The Plaintiffs are therefore entitled to recover costs in the net amount of $29,000.00, plus any amount already fixed or to be determined arising from the Application Decision. They shall also recover reasonable disbursements, including any fee related to Dr. Cameron's court attendance. The Plaintiffs' recoverable disbursements for production of documents include charges incurred for compiling the original exhibit books introduced at the beginning of trial, but exclude the expense of producing replacement volumes delivered after the first day of trial to rectify difficulties caused by disorganization and

incorrect pagination in the original volumes. If the parties are unable to agree respecting disbursements recoverable, they may be taxed pursuant to **C.P.R. 63**.

J.