Date: 20020411
Docket: S. H. 155348C

IN THE SUPREME COURT OF NOVA SCOTIA

[Cite as: *Welsh v. Wawanesa Mutual Insurance Company of Canada,* 2002 NSSC 90]

BETWEEN:

LYNN WELSH

PLAINTIFF

- and -

WAWANESA MUTUAL INSURANCE COMPANY OF CANADA

DEFENDANT

- and -

J. BRIAN CHURCH

INTERVENOR

D E C I S I O N

HEARD BEFORE: **The Honourable Justice Arthur J. LeBlanc, Supreme Court of Nova Scotia, on November 22, 2001, in Chambers**

DECISION: **April 11, 2002**

COUNSEL: **Mr. David J. Bright, Q. C., for the Plaintiff (Watching Brief)**
Mr. S. Raymond Morse, Q. C., for the Defendant
Mr. Robert Barnes, Q.C., and Kenneth J. Winch, for the Intervenor

LeBlanc, J.:

[1] Brian Church applied for an order to be added as an intervenor, pursuant to *Nova Scotia Civil Procedure Rule* 8.01, and disallowing the limitation defence raised by the defendant, Wawanesa Mutual Insurance Company of Canada, pursuant to s. 3.2 of the *Limitations of Actions Act*, R.S.N.S. 1989. Counsel for Wawanesa concede, and I agree, that he is an interested party. I allow the application to have him added as an intervenor.

Background

[2] Lynn Welsh was involved in a motor vehicle accident in August of 1992. She retained counsel, Mr. Gilbert Gaudet, to act on her behalf with respect to her claim for damages and recovery of money. In addition to pursuing her claim against the driver of the other vehicle, Ms. Welsh initiated recovery of medical payments and disability income from the defendant, Wawanesa Mutual Insurance Company.

[3] Either Ms. Welsh or her counsel filed the appropriate proof of loss with respect to her Section B claim, and payments of disability income were made to the end of January, 1993. In July 1993, Wawanesa advised Mr. Gaudet that they were discontinuing payment, pending receipt of additional medical information from Mrs. Welsh's long-term disability carrier, Aetna Insurance. Disability income payments had been received by Ms. Welsh to the end of January 1993.

[4] Wawanesa requested that Ms. Welsh undergo a medical assessment and Dr. Howatt filed his medical report, dated July 1993, with Wawanesa, concluding that Ms. Welsh should return to full-time duties at her employment on October 1, 1993.

[5] Ms. Welsh also carried long-term disability insurance with Aetna Insurance and Aetna Insurance caused Ms. Welsh to be examined by Dr. Reginald Yabsley who reported on October 20, 1993 that Ms. Welsh should be able to return to her employment. There is no indication from the material filed that this recommendation was shared or communicated to the respondents at any relevant time. Aetna, however, decided to discontinue L.T.D. payments to Mrs. Welsh as of October 1, 1993.

[6] Ms. Welsh retained Mr. Brian Church to act on her behalf in October 1993. In July 1994, Ms. Mills requested that Mr. Church provide her with a copy of Dr. Yabsley's report and advised Mr. Church that it was not necessary to provide the Aetna's report, but any report from Dr. Yabsley. On August 30, 1994, Wawanesa paid $2,262.48 to cover benefits for the period January 29 to October 1, 1993, but stated that any further disability payments for the period October 1, 1993 would be subject to the receipt of Dr. Yabsley's and Dr. Loane's reports, upon which Wawanesa would review its position. At this time, however, disability payments were concluded as of October 1, 1993. There was further communication between Mills and Church on July 5, August 30 and September 16, 1994, requesting the reports from Dr. Yabsley and Dr. Loane.

[7] Ms. Mills wrote to Mr. Church on March 7, 1995, advising that he had not responded adequately and had not provided appropriate medical information. On August 3, 1995, Ms. Mills wrote to Mr. Church indicating that all Section B payments would be discontinued until they had an opportunity to evaluate additional medical information which they had previously requested. On August 4, 1995, Mr. Church provided all

medical information which he had in his file, noting that he did not have and never had Dr. Yabsley's report. On October 3, 1995, Wawanesa requested further medical information, including Dr. Yabsley's report.

[8] During the course of this period, Ms. Welsh, on her own, continued to submit requests for payments from Wawanesa directly, claiming payments of her disability income benefits and medical expenses.

[9] On April 13, 1999, Mr. Church initiated these proceedings. The defendant, Wawanesa filed its defence claiming the benefit of the limitation period set out in the insurance contract and *Insurance Act*, in particular, s. 7(c) of Section B.

[10] This application is made pursuant to s. 3(2) of the *Limitation of Actions Act*, whereby the applicant seeks to set aside the limitation defence pleaded by the defendant, Wawanesa. In reaching my decision I have considered and referred to the *Limitation of Actions Act*, and in particular the following sections:

> **3(2)** Where an action is commenced without regard to a time limitation, and an order has not been made pursuant to subsection (3), the court in which it is brought, upon application, may disallow a defence based on the time limitation and allow the action to proceed if it appears to the court to be equitable having regard to the degree to which
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> (a) the time limitation prejudices the plaintiff or any person whom he represents; and
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> (b) any decision of the court under this Section would prejudice the defendant or any person whom he represents, or any other person.
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> **Factors considered**
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> **(4)** In making a determination pursuant to subsection (2), the court shall have regard to all the circumstances of the case and in particular to
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> (a) the length of and the reasons for the delay on the part of the plaintiff;
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> (b) any information or notice given by the defendant to the plaintiff respecting the time limitation;
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> (c) the extent to which, having regard to the delay, the evidence adduced or likely to be adduced by the plaintiff or the defendant is or is likely to be less cogent than if the action had been brought or notice had been given within the time limitation;
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> (d) the conduct of the defendant after the cause of action arose, including the extent if any to which he responded to requests reasonably made by the

plaintiff for information or inspection for the purpose of ascertaining facts which were or might be relevant to the plaintiffs cause of action against the defendant;

(e) the duration of any disability of the plaintiff arising after the date of the accrual of the cause of action;

(f) the extent to which the plaintiff acted promptly and reasonably once he knew whether or not the act or omission of the defendant, to which the injury was attributable, might be capable at that time of giving rise to an action for damages;

(g) the steps, if any, taken by the plaintiff to obtain medical, legal or other expert advice and the nature of any such advice he may have received.

Application of Section

(5) The provisions of this Section shall have effect in relation to causes of action arising

(a) before the twenty-sixth day of June, 1982, if the time limitation has not expired before that date;

(b) on or after the twenty-sixth day of June, 1982.

Jurisdiction of court restricted

(6) A court shall not exercise the jurisdiction conferred by this Section where the action is commenced or notice given more than four years after the time limitation therefor expired.

[11] In addition, I have considered and referred to the following provisions of the *Insurance Act*. Section 145 of the *Insurance Act* provides as follows:

> Every action or proceeding against an insurer under a contract with respect to insurance provided under Section 139 or 140 shall be commenced within the limitation period specified in the contract but, in no event, shall this be less than one year after the happening of the accident. R.S., c. 231, s. 145.

[12] I refer to the relevant provision of Section "B" found in Schedule B of the *Insurance Act*:

1. All reasonable expenses incurred within four years from the date of the accident as a result of such injury for necessary medical, surgical, dental, chiropractic, hospital, professional, nursing and ambulance service and for any other service within the meaning of the insured services under the *Health Services and Insurance Act* and for such other services and supplies which are, in the opinion of the physician of the insured person's choice and that of the Insurer's medical advisor, essential for the treatment, occupational retraining or rehabilitation of the said person, to the limit of $25,000 per person.

Part II - Loss of Income

Subject to the provisions of this Part, a weekly payment for the loss of income from employment for the period during which the insured person suffers substantial inability to perform the essential duties of his occupation or employment, provided,

(a) such person was employed at the date of the accident;

(b) within 30 days from the day of the accident and as a result of the accident the insured person suffers a substantial inability to perform the essential duties of his occupation or employment for a period of not less than seven days.

(c) no payments shall be made for any period in excess of 104 weeks except that if, at the end of the 104 week period, it has been established that such injury continuously prevents such person from engaging in any occupation or employment for which he is reasonably suited by education, training or experience, the Insurer agrees to make such weekly payment for the duration of such inability to perform the essential duties.

Amount of Weekly Payment - The amount of a weekly payment shall be the lesser of,

(a) $140.00 per week; or

(b) 80 per cent of the insured person's gross weekly income from employment, less any payments for loss of income from employment received by or available to such person under,

(I) the laws of any jurisdiction,
(ii) wage or salary continuation plans available to the person by reason of his employment, and
(iii) subsection 2A,

but no deduction shall be made for any increase in such payment due to a cost of living adjustment subsequent to the insured person's substantial inability to perform the essential duties of his occupation or employment.

. . .

(4) a person receiving a weekly payment who, within thirty days of resuming his occupation or employment is unable to continue such occupation or employment as a result of such injury, is not precluded from receiving further weekly payment.

(5) where the payments for loss of income payable hereunder, together with payments for loss of income under another contract of insurance other than a contract of insurance relating to any wage or salary continuation plan available to an insured person by reason of his employment, exceed the actual loss of income by the insured person, the insured is liable only for that proportion of the payments for loss of income stated in this policy that the actual loss of income of the person insured bears to the aggregate of the payments for loss of income payable under all such contracts.

. . .

SUBSECTION 3 - SPECIAL PROVISIONS, DEFINITIONS, AND EXCLUSIONS OF THIS SECTION

(4) **Notice and proof of claim**

The insured person or his agent, or the person otherwise entitled to make a claim or his agent, shall,

(a) give written notice of claim to the Insurer by delivery thereof or by sending it by registered mail to the chief agency or head office of the Insurer in the Province, within 30 days from the date of the accident or as soon as practicable thereafter;

(b) within 90 days from the date of the accident for which the claim is made, or as soon as practicable thereafter, furnish to the Insurer such proof of the claim as is reasonably possible in the circumstances of the happening of the accident and the loss occasioned thereby;

© if so required by the Insurer, furnish a certificate as to the cause and nature of the accident for which the claim is made and as to the duration of the disability caused thereby from a physician.

(5) **Medical Reports**

The Insurer has the right and claimant shall afford to the Insurer, an opportunity to examine the person of the insured person when and as often as it reasonably requires

while the claim is pending, and also, in the case of death of the insured person, to make an autopsy subject to the law relating to autopsies.

. . .

(7) **When moneys payable**

(a) All amounts payable under this section, other than benefits under Part II of subsection 2, shall be paid by the Insurer within 30 days after it has received proof of claim. The initial benefits for loss of time under Part II of subsection (2) shall be paid within 30 days after it has received proof of claim, and payments shall be made thereafter within each 30-day period while the Insurer remains liable for payments if the insured person, whenever required to do so, furnishes prior to payment of continuing disability.

(b) No person shall bring an action to recover the amount of a claim under this section unless the requirement of provisions 3 and 4 of this subsection are complied with, nor until the amount of the loss has been ascertained as provided in this section.

(c) Every action or proceeding against the Insurer for the recovery of a claim under this section shall be commenced within one year from the date on which the cause of action arose and not afterwards.

[13] The applicant has argued that in relation to ongoing Section B benefits, a termination of benefits does not constitute one cause of action, but a continuous or 'rolling' cause of action each time a denial of benefits occurs. There is some support for this position. The New Brunswick Court of Appeal in *Couture v. Fidelity Insurance Co. of Canada*, [1987] N.B.J. No. 192 held that Section B benefits maybe discontinued without constituting termination on behalf of the insurance company. Acknowledging that notice that an insurance company was 'unable to continue' payments in a situation of ongoing payment of benefits was different from continued denial of benefits from the very beginning, the New Brunswick Court of Appeal stated:

> The appellant's letter of April 28, 1981 advised the respondent that "we are ... unable to continue [your] total disability benefit payments". For the purposes of the policy, the letter was either a denial of liability or constituted in effect a request for proof of continued disability. If it was a denial of liability it would give rise to a cause of action to be taken within one year of notification. On the other hand, if it was a request for additional proof then the respondent had a choice. She could either take the position that the request was unjustified, thus giving her a cause of action and sue within one year of the request for additional proof or, alternatively, she could provide further proof of continued disability which if not accepted by the appellant would extend here cause of action to one year from the insurer's refusal of her further proof.

[14] In coming to this conclusion the Court of Appeal reviewed many of the cases the plaintiff relies on. They did not expressly adopt or reject these cases.

[15] Further support for the applicants position can be found in *Pajic v.Wawanesa Mutual Insurance Co.*, [1994] 22 C.C.L.I. (2d) 65. Justice Leitch of the Ontario Court of Justice held that although a breach of contract occurs when the insurer refuses to pay or reimburse the insured in accordance with the contract, the onus is on the insurer to show on a balance of probabilities, that there has been a clear refusal to pay. The issue was also dealt with in *Wilson's Truck Lines Ltd. v. Pilot Insurance Co.*, [1997] 147 D.L.R. (4th) 242. The Ontario Court of Appeal decided in an earlier decision [(1996) 94 O.A.C. 321] that the plaintiffs claim was out of time. The Court was then asked to consider whether the whole claim was out of time, or only the claim for benefits for the period of time that was outside the limitation period. The Court re-convened for that issue.

> This appeal was disposed of by reasons released October 28, 1996. The appeal was allowed with costs and the cross-appeal dismissed without costs. The result was that the action was dismissed. Counsel then raised a question whether the entire action should have been dismissed or only part of it. We are grateful to counsel for drawing this to our attention. Further argument was invited and submitted. These supplementary reasons now dispose of the matter.
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> In the reasons released October 28, 1996, we concluded that Bourne's right to sue for damages had expired by reason of the passage of time. This would be true for claims related to the period up to the time the action against Pilot was commenced. We did not expressly consider claims relating to the period after that time.

The Court went on to hold that a portion of the claim was statute barred and the rest remained alive.

[16] The New Brunswick Court of Queen's Bench reviewed the concept of a 'rolling cause of action' more recently in *LeBlanc v. Zurich Insurance Co.*, [2000] N.B.J. No 441. Justice Creaghan stated the issue before him in paragraph 16:

> The legal issue presented on this Application, however, is whether there is a continuing advancement of the limitation period, such that it runs for each payment for a period of twelve months, so that even if payments that were to be paid twelve moths prior to the Notice of action being issued are prescribed, nevertheless, those that may be payable within or after that twelve moth period are not prescribed and can be recovered provided the terms of the policy have been complied with.

Creaghan J. reviewed the various authorities and concluded that as a matter of law, the plaintiff retains a right of action to claim recovery of Section B weekly benefits subsequent to the period prescribed by the Statute of Limitations.

[17] The defendant refers to *Dempsey v. Dominion of Canada General Insurance Co.*, [1996] N.S.J. No 423 to submit that Nova Scotia has not recognized a 'rolling cause of action'. Justice Carver was asked to consider whether an insurer is under continuing liability for each benefit in a system such as Section B where the benefit payments are regular and periodic. He held that they were not. His conclusion was that there was only one cause of action based on an initial denial of payment. Carver J. decided that s. 3(6) of the *Limitation of Actions Act* prevented him from giving consideration to an extension of the limitation period as the proceedings had been commenced more than four years after the end of the limitation period and as the initial payment was denied and there was no continuing obligation.

[18] The defendant has argued that I am bound by *Dempsey*. Indeed the doctrine of *stare decisis* (to stand by things decided) requires judges to follow principles of law decided by other judges of the same jurisdiction when similar issues arises. However, I am not convinced the decision of Justice Carver in *Dempsey* is a similar fact case. In the case before me, the claim is for Section B benefits, which falls under Schedule B to Part VI of the *Insurance Act* entitled Mandatory Medical and Rehabilitation Benefits, and Accident Benefits in Motor Vehicle Liability Policies. The relevant section of the *Insurance Act* is Section 7 in Schedule B, Part VI

> 7(a) All amounts payable under this section, other than benefits under Part II of subsection 2, shall be paid by the Insurer within 30 days after it has received proof of claim. The initial benefits for loss of time under Part II of subsection (2) shall be paid within 30 days after it has received proof of claim, and payments shall be made thereafter within each 30-day period while the Insurer remains liable for payments if the insured person, whenever required to do so, furnishes prior to payment proof of continuing disability.
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> (b) No person shall bring an action to recover the amount of a claim under this section unless the requirements of provisions 3 and 4 of this subsection are complied with, nor until the amount of the loss has been ascertained as provided in this section.
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> (c) Every action or proceeding against the Insurer for the recovery of a claim under this section shall be commenced within one year from the date on which the cause of action arose and not afterwards.

[19] Justice Carver in *Dempsey* referred only to a clause in the insurance contract that mirrored s.7(c). He did not refer to ss. (a) and (b) of s. 7 both of which are relevant to the concept of a 'rolling cause of action'. Also, the facts before Carver J. in *Dempsey* were significantly different than in the case before me. In that case the plaintiff had never received benefits. From the very beginning, his application for benefits had been denied. This is significant in that there was no continuing or ongoing obligation on behalf of the insurance company. The plaintiff was told that he had been denied benefits and although he kept applying, that position did not change. In the case before me, Ms. Welsh was receiving benefits on an ongoing basis for some time. The benefits were discontinued, but it was not clear in the beginning, whether the benefits had been terminated or whether the insurance company was exercising their right to request proof of continued disability. I believe the case of *Smith v. Commercial Union* (1995), 143 N.S.R. (2d) 240 supports this distinction. In *Smith* Grant J. was asked to consider when a cause of action arose for the purposes of ongoing payments under a Section B policy. He reviews the case law and at para. 153 comments that there is a distinction between a denial of benefits that preclude payments and a termination of ongoing payments.

> Some courts have taken the approach that a broad line is drawn at the date of commencement of action and then taken back for one year and thirty days. Anything prior to the one year and thirty days from the commencement of the action is prescribed, but what is within the year and one month is actionable. That appears to be the approach taken in some cases in Ontario. However, in the cases I could find and those cited to me there was already an ongoing cause of action, benefits had been paid previously.

[20] Ultimately, Grant J. did not have to decide this issue as the application for extending the statute of limitation period was made so late in the procedural history of the case that significant prejudice had accrued to the defendant and the issue was decided on that ground.

[21] The case law recognizing a rolling cause of action is not found within this jurisdiction. It is not clear whether a rolling cause of action would be recognized in Nova Scotia in the proper circumstances. Clearly, courts in other jurisdictions have recognized such a concept. I conclude that *Dempsey v. Dominion of Canada General Insurance,* supra, is not binding, as it must be distinguished based on the discussion above. I can find no other case law in Nova Scotia where the issue has

been squarely before the court and therefore conclude that it is open for judicial consideration.

[22] Unfortunately, I have concluded that this application requires both factual and legal findings that I am unable to make. The Nova Scotia Court of Appeal discussed the confines of a chambers judge in an application to strike a limitation defense in *Merner v. Nova Scotia Assn. of Health Organizations Long Term Disability Plan Trust Fund*, [2001], N.S.J. No 382. Justice Freeman stated that the test for striking a statement of claim under *Civil Procedure Rule* 14.25 is 'on the basis that it does not disclose a reasonable cause of action' or whether the claim is obviously unsustainable. Furthermore, Freeman J.A. concludes that when complex legal and factual issues arise, a decision about statute of limitations should be left for the trial judge. He states at para. 18:

> In my view however the introduction of the contractual limitation provision by amendment raises issues of a legal and factual nature which should be determined at trial.

and later at para 22:

> For greater certainty I would restore the claim with the intention that all issues raised by the pleadings, **including all issues related to the limitation defence**, be determined in a full hearing on the merits. Justice Goodfellow's findings of fact must be confined to the narrow context of the matter before him, the s.3(2) application on a limited record, and neither those findings nor any comments in this decision as to the issues should be allowed to prejudice the outcome. (**emphasis added**)

[23] These comments are consistent with the statements made by the Court of Appeal in previous cases. In *Wall v. Horn Abott Ltd.*, [1999], N.S.J. No 124 Justice Cromwell discussed the principle that disputed issues of fact are to be determined at trial. At para. 47 he states:

> This reluctance to assess the merits of a claim or defence before trial is based both on procedural values and practical concerns. The prime procedural value is that "plenary trial on the merits" is a key element of fair procedure: see Dawson v. Rexcraft Storage and Warehouse Inc. (1998), 164 D.L.R. (4th) 257 per Borins, J.A. at para 6. Practical concerns relate to the difficulty of making correct factual determinations on the limited material available on the interlocutory applications and the important advantages of a trial court in evaluation evidence in the light of the factual context of the entire case rather than on a selective and partial record at the interlocutory stage: see Rexcraft, supra, at para. 27.

[24] The matter before me would require complex factual findings as well as findings of credibility. As well, not all the evidence required is before me. A review of the case of *Wilson's Truck Lines Ltd. v. Pilot Ins.*, supra, shows the in-depth analysis necessary to come to a conclusion on this issue. The Ontario Court of Appeal stated in Pilot at paragraph 39:

> We now turn to the evidence relevant to the limitation period issue. It consists of the testimony of Bourne and his lawyer (no one testified on behalf of Pilot), the correspondence relating to bourne's accident benefit claim and Pilot's internal file.

[25] They then proceeded to go through a general background, a review of the evidence of the insured and his lawyer, a detailed review of the correspondence between the parties and a detailed review of the insurance company's internal file. This information was used to determine the intention and understanding of the parties which is relevant to when a limitation period issue arose. The Court said at paragraph 52:

> Pilot's internal file, the correspondence and the viva voce testimony establish that by April 14, 1982, Pilot had told Bourne that he did not qualify for accident benefits. Both Bourne's and Thompson's testimony confirm that Pilot never changed that position. Communications within Pilot and between Pilot and Thompson suggest a willingness on the part of Pilot to receive material with respect to Bourne's income loss and medical condition. From these communication an inference might be drawn that Pilot was willing to reconsider.

[26] I accept that this type of analysis must be done for in many cases where there is a question as to when the limitation period and cause of action. I am also sensitive to the direction from the Court of Appeal in *Merner*, supra, and have concluded that this type of detailed analysis of the evidence is best left to a trial judge. In any event, I do not have evidence from the original insurance adjuster, Ms. Pam Mills, the original lawyer for the plaintiff, Mr. Gilbert Gaudet, or Ms. Welsh. Obviously their evidence as to the understanding and communication between them would be relevant. There is some evidence regarding their written communication but often phone conversations are referred to. It may be that Ms. Mills and Mr. Gaudet understood the termination to be permanent from the beginning and therefore the cause of action arose in November 1993, 30 days after payment was refused. Equally it may be that Ms. Mills and Mr. Gaudet understood that payments had been discontinued until proof of continued disability was submitted, at which time payments would resume. A determination of when the cause of action arose will require findings of fact, a determination based on

evidence of what occurred between October 1993, and August 1994, and very likely findings of credibility, all of which are best left to a trial judge.

[27] A determination of whether Nova Scotia recognizes a 'rolling cause of action', and whether the applicant is entitled to medical benefits are matters of law and within my jurisdiction. To make such a determination however, would be to tie the hands of the trial judge who will have more evidence and be in a better position to judge of the issues as a whole. I have concluded that it is not appropriate to make a determination on some of the issues and leave some for the trial judge when, such as the case at bar, the issues are inextricably linked. The trial judge should not be pre-empted from deciding all of the issues based on the merits of the case. His or her findings on the principal issue may be determinative of all of the issues.

[28] I therefore decline to use my discretion to strike the limitation defence as plead by the defendant. The matters should be left to a trial judge without being prejudiced by any comments I may have.

[29] Costs shall be in the cause.

J.