

# Top Cases of 2025: 7 Important Recent Personal Injury Cases at Trial Level and at the Court of Appeal

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## Introduction

The following paper summarizes a selection of recent cases that span a variety of subjects—including Pierringer agreements, post-104 income replacement benefits, and costs awards, among other topics—and that provide clarification on some pertinent issues.

### 1. *Traders General Insurance Company v. Rumball*, 2025 ONCA 656

This recent Court of Appeal decision clarifies the test to be applied in establishing an entitlement to post-104 IRBs. Pursuant to s. 6(2)(b) of the *Statutory Accident Benefits Schedule*<sup>1</sup>, income replacement benefits (“IRBs”) are payable to an insured person after the first 104 weeks of disability if, as a result of the accident, “the insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience.” As noted by the Court: “much of the argument focussed on whether the test under s. 6(2)(b) requires reasonably suited employment to be employment in a competitive, real-world setting that is comparable to the insured’s former employment in nature, status and reward.”<sup>2</sup>

In dismissing this appeal, the Court concluded that s. 6(2)(b) of the *Schedule* establishes an “evidence-based test that, by its clear and unambiguous language, requires an insured person to suffer a complete inability to engage in employment for which they are ‘reasonably suited by education, training or experience’.” In making that assessment, a decision maker must consider all relevant factors, including the competitive, real-world setting and a job’s nature, status and reward.”<sup>3</sup> Crucially, however, these factors are not stand-alone components of the test,<sup>4</sup> “...nor are they determinative of whether an insured meets the test. It is an evidence-based, contextual analysis that must take into account the particular circumstances of the insured.”<sup>5</sup>

#### Background:

The appellant, Ms. Rumball, was involved in a motor vehicle accident in December 2014. She applied to her insurer, Traders General Insurance Company (“Traders”), for statutory accident benefits due to her

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<sup>1</sup> Statutory Accident Benefits Schedule, O Reg 34/10 [the “*Schedule*”].

<sup>2</sup> *Traders General Insurance Company v. Rumball*, 2025 ONCA 656 [“Traders”], at para 27.

<sup>3</sup> *Ibid* at para 27.

<sup>4</sup> *Ibid*, at para 42.

<sup>5</sup> *Ibid*, at para 44.

inability to work. Prior to the accident, she worked as an educational assistant with a school board. She had also started a business as a wedding planner. Following her accident, Ms. Rumball returned to work in February 2015 but stopped working again in May 2015. She claimed further benefits from Traders from May 2015 onwards. She asserted that she was unable to return to work, and she sought payment of income replacement benefits up to the 104-week mark and beyond.

### **Procedural History:**

#### **The LAT Decisions**

The adjudicator determined that Ms. Rumball was entitled to IRBs up to the two-year mark because she met the test, pursuant to the *Schedule*, of proving on a balance of probabilities that, as a result of her physical and psychological impairments from the accident, she was substantially unable to perform the essential tasks of her pre-accident employment as an educational assistant.

However, Ms. Rumball was not entitled to benefits after the 104-week mark because she did not meet the more stringent post-104-week test: that of a complete inability to engage in employment for which she is reasonably suited by education, training or experience.

The adjudicator found on the evidence that Ms. Rumball had not proven that she was disabled from any work that was suitable for her. She found that wedding planning was a job that was suitable for Ms. Rumball based on her education, training or experience. A subsequent reconsideration request was dismissed.

#### **Divisional Court**

Ms. Rumball appealed to the Divisional Court. The court dismissed the appeal, finding that the adjudicator applied the correct test for post-104-week IRBs and made no errors in her decision.

The court stated that “the only test to be applied in establishing an entitlement to post-104 [IRBs] is the one set forth in the *Schedule* and it does not include employment in a competitive, real-world setting, nor does it include any test that suitable employment should be comparable in terms of status and wages.”<sup>6</sup>

#### **Court of Appeal**

**Issue on appeal:** What is the proper interpretation of the test set out in s. 6(2)(b) of the *Schedule* for entitlement to IRBs beyond the 104-week period?

#### **Positions of the Parties:**

- The appellant argued that the complete inability test must consider employment in a competitive, real-world setting and must take into account the remuneration of the job as well as its status.
- The respondent argued that the interpretation of the post-104-week test for IRBs did not include the language the appellant sought to incorporate, which would have the effect of simply continuing the pre-104-week test.

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<sup>6</sup> *Ibid*, at para 16.

**Outcome:** Wilson, J.A., writing for a majority of the Court of Appeal, dismissed the appeal and concluded that the LAT adjudicator articulated and applied the correct test.

The Court concluded:

*[40] I am solidified in my view on the appropriate test under s. 6(2)(b) of the Schedule by the legislative text and context. It is clear that the test for post-104-week IRBs is a more stringent one than the test prior to two years, which requires that the insured person demonstrate that they are unable to return to the job they were doing at the time of the accident. The language of s. 6(2)(b) is clear and unambiguous. The decision maker must determine whether an insured is completely unable due to injuries from the accident to work at any job for which they are “reasonably suited by education, training or experience.” It follows that the status and nature of a potential job should be considered as well as the compensation. In determining if the test has been met, the decision maker is required to consider the evidence in the context of the insured’s circumstances and in doing so, must take into account the factors of the status, remuneration and nature of the proposed employment. To do otherwise does not accord with the legislation’s remedial purpose [...].<sup>7</sup>*

*[41] Nevertheless, as the foregoing analysis shows, the statutory text does not spell out each factor that the decision maker must consider when making the determination of whether or not the insured meets the test for post-104-week IRBs under the Schedule or treat those factors as stand-alone requirements under the test. For example, while much of the argument in this case focused on whether suitable employment meant employment in a competitive, real-world setting that is comparable to the insured’s former employment in nature, status and reward, there is no dispute that the decision maker must evaluate the insured’s medical status, even though s. 6(2)(b) does not explicitly state that medical status must be taken into account.<sup>8</sup>*

*[42] In sum, in determining entitlement to IRBs in the post-104-week period, the decision maker must decide, based on the evidence, if the insured person is completely unable to work in any job or capacity for which they are suited by education, training or experience. This is necessarily a contextual analysis. In order to make this determination, the decision maker must consider all the relevant evidence and factors, including whether any alternative employment is employment in a competitive, real-world setting that is comparable to the insured’s former employment in nature, status and reward. **These factors are not stand-alone components of the test but inform the evidence-based determination of whether the insured person has suffered a complete inability to engage in employment for which they are reasonably suited by education, training or experience.** [Emphasis added].<sup>9</sup>*

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<sup>7</sup> *Ibid* at para 40.

<sup>8</sup> *Ibid* at para 41.

<sup>9</sup> *Ibid* at para 42.

In applying these principles to Ms. Rumball's case, the Court confirmed that "...In a nutshell, the decision maker has to make the determination of whether or not the test has been satisfied by considering the totality of the evidence in each particular case. It is not done in a vacuum."<sup>10</sup>

In this case, the Court found that the adjudicator had reviewed the evidence carefully and found that the medical evidence was not sufficiently up to date to enable her to determine whether Ms. Rumball's impairments continued to the extent that it made it impossible for her to work. In addition, the medical experts did not obtain a detailed work history from Ms. Rumball so they were unable to offer opinions on what type of work she was capable of. As well, Ms. Rumball had failed to call evidence from a vocational expert, who could have assisted the adjudicator with the issue of whether there was other employment that was suitable in light of her education, training or experience.

### ***Traders Takeaways***

This decision confirms that the test for post-104 IRBs remains a more stringent one than the test prior to two years, and that the language of s. 6(2)(b) is clear and unambiguous. However, the test does require a contextual analysis of all the relevant evidence and factors, including consideration of alternative employment in a competitive, real-world setting that is comparable to the insured's former employment in nature, status, and remuneration—though these factors are not stand-alone components of the test. Based on this decision, evidence (or lack thereof) of alternative employment opportunities would have a significant bearing on whether an applicant is entitled to post-104 IRBs.

This decision also underscores that detailed and up-to-date medical evidence, a detailed work history, and evidence from a vocational expert must be considered in a case involving post-104 IRBs. A vocational expert should consider alternative employment for the applicant, and analyze whether the alternative employment is realistically available.

## **2. *Cadieux v. Cadieux*, 2025 ONCA 405**

This appeal arose from proceedings commenced after a motor vehicle accident. The plaintiffs entered into a Pierringer agreement with one of the defendants. The motion judge approved the agreement, and the pleadings were amended according to its terms. One of the non-settling defendants appealed the motion judge's order on the basis that they now risked paying a disproportionate amount of any judgment. The intervener, the Ontario Trial Lawyers Association, made submissions regarding the implications of Pierringer agreements in multi-party litigation. The appeal was ultimately dismissed, with the Court highlighting the public interest significance and value of Pierringer agreements and noting that they are a "valuable tool to encourage settlement in multi-party litigation".<sup>11</sup>

### **Background**

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<sup>10</sup> *Ibid* at para 46.

<sup>11</sup> *Cadieux v. Cadieux*, 2025 ONCA 405, at para 13.

Patrick Cadieux, the defendant driver of a minivan, entered an intersection on a red light and collided with a truck driven by Scott Ray. Mr. Cadieux's minor children were passengers in the minivan. Among the multiple defendants named in the statement of claim were Mr. Cadieux, Mr. Ray and his employer United Petroleum, as well as the City of Ottawa.

Mr. Cadieux's children were alleged to have suffered catastrophic injuries. The future care costs of one child were estimated to exceed \$14M—an amount which surpassed the combined insurance for Mr. Cadieux and the defendant United Petroleum. Expert evidence made it clear that Mr. Cadieux was likely to be found primarily liable for the collision.

The plaintiffs and the City of Ottawa entered into a Pierringer Agreement, which provided that the plaintiffs would amend their claims such that the non-settling defendants would remain jointly and severally liable only to the degree of their collective fault, and which eliminated any crossclaim for contribution and indemnity against the City of Ottawa. The agreement also provided that the trial court had full authority to apportion liability among all defendants, including Ottawa.

### **Motion Judge's Decision**

United Petroleum objected to the approval of the agreement. They argued that with Ottawa removed from the mix, they were left at risk of insufficient recovery from their co-tortfeasor, Mr. Cadieux.

United Petroleum argued that if the agreement was approved it was likely that they would have to pay Mr. Cadieux's portion, and if he turned out to be insolvent not only would they be unable to recover from Mr. Cadieux any amount exceeding his policy limits, they would also not be able to seek contribution from Ottawa.

The motion judge rejected the appellants' argument that the agreement substantially prejudiced them and approved the agreement. He provided 3 reasons for doing so:

1. Because of the several possible outcomes at trial, the purported prejudice to the appellants might never materialize;
2. Declining to approve the Agreement would undermine the policy objective of promoting agreements – which is important in complex multi-party litigation – and this policy objective outweighed any speculative prejudice; and
3. It is preferable to address any prejudice the appellants might suffer at trial once the consequences of the Agreement are known.

### **Court of Appeal:**

The Court of Appeal considered 2 issues:

1. Did the motion judge err by approving the Agreement when it could lead to United Petroleum, a non-settling party, being liable to pay a higher share of the underfunded amount arising out of the potential insolvency or impecuniosity of joint tortfeasor, Mr. Cadieux?
2. What procedural orders, if any, should be made to facilitate Ottawa's participation at trial?

### **Outcome:**

The appeal was dismissed. The Court found that the motion judge did not err in approving the agreement and also declined to disrupt the motion judge's decision to leave the appellants' procedural order requests to the trial judge or case management judge.

In its reasons, the Court made a number of comments emphasizing the importance of Pierringer agreements in multi-party litigation:

[31] When there is an insolvent or impecunious co-defendant, there is always a risk of having to pay more than one's proportionate share. This was a risk to Ottawa, as well as the appellants, from the start of the litigation. And if the objective is indeed to encourage settlements, as the Supreme Court puts it in *Sable*, at para. 29, "someone has to go first", and in this case Ottawa did. The ability to avoid joint liability with an insolvent or impecunious co-defendant is an incentive to settle and should not give rise to prejudice.<sup>12</sup>

[32] This is particularly important because complex multi-party litigation often relies on the first settlement to trigger what the intervener calls "cascading settlements". The public interest in facilitating such an outcome outweighs any prejudice the appellants can be said to have suffered.<sup>13</sup>

#### **Takeaways from *Cadieux*:**

This decision emphasizes that the *Negligence Act*<sup>14</sup> makes clear that a plaintiff is entitled to full compensation from any one concurrent tortfeasor, and reinforces the clear policy objective to make plaintiffs whole, even if it subjects one of the defendants to the risk of overpaying their share of liability.

This decision also highlights that a Pierringer agreement does not inherently prejudice non-settling defendants: the disadvantages to a non-settling defendant that are inherent in the basic form of a Pierringer agreement (such as their defence no longer being assisted by the settling defendant or the settling defendant no longer sharing in any joint and several liability) do not constitute "significant prejudice" such that a court would decline to approve the agreement.

This decision underscores the utility of Pierringer agreements as a valuable tool to encourage settlement in multi-party litigation and the strong support of the Court for utilizing this strategy. For defendants, it also highlights the strategic value of Pierringer agreements as a means of avoiding joint liability with an insolvent or impecunious co-defendant.

### **3. *Hussein v. Intact Insurance Company*, 2025 ONSC 842**

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<sup>12</sup> *Ibid*, at para 31.

<sup>13</sup> *Ibid*, at para 32.

<sup>14</sup> *Negligence Act*, RSO 1990, c N.1.

This appeal concerned a decision and reconsideration decision by the Licence Appeal Tribunal to dismiss an application for benefits under the *Statutory Accident Benefits Schedule*<sup>15</sup> due to a failure to satisfy the notice requirement. Ultimately, the Divisional Court found that the Insured's notification to the Insurer that he had been in an accident was sufficient to satisfy the 7-day deadline for notice under the legislation. Fundamental to the Court's decision was the fact that the *SABS* is consumer protection legislation, which the Court emphasized must be interpreted in a manner consistent with its objective—to reduce economic dislocation and hardship for victims of motor vehicle accidents.

## **Background**

The Appellant ("the Insured") was involved in an accident. He notified his insurer, Intact Insurance ("the Insurer"), one day later that he had been in an accident and reported that his vehicle had sustained heavy damage. The Insurer never questioned the Insured about whether he had suffered any personal injuries and never advised him of his entitlement to statutory accident benefits. He did not file his claim for accident benefits until seventeen months after the accident. His explanation for the delay was that he was not aware that he was entitled to accident benefits until he spoke to a paralegal. Initially, the Insurer approved the Insured's application for benefits, and he attended a few Insurer's examinations. However, over a year later, the Insured received notice that his benefits were being terminated on the basis that he had not given the insurance company notice of his claim for accident benefits within 7 days as required by Section 32 of the *SABS*.

## **The LAT Decisions**

The Insured applied to the LAT. In its decision, the LAT determined that the Insured had not notified the Insurer of his intention to apply for accident benefits within the prescribed time period of 7 days. Reporting to the Insurer that he was in an accident was not enough. He never advised the Insurer that he had suffered personal injuries and the Insurer had no obligation to inquire. The decision also found that his explanation for the 17-month delay in making his application was not credible since he knew enough to claim property damage and his policy set out that he was eligible for accident benefits.

A subsequent reconsideration decision similarly rejected the Insured's argument that the decision's interpretation of the notice requirement in the *SABS* was "narrow, incorrect, did not take into account decisions of the Tribunal, and was inconsistent with the consumer protection nature of the legislation." In coming to this conclusion, the LAT found that the Insurer had no obligation to advise the Insured of the availability of accident benefits, noting that "there is no such obligation in the *Schedule*."

## **Divisional Court**

The Insured appealed from both the decision and the reconsideration Decision to the Divisional Court.

The court considered section 32 of the *SABS*:

32 (1) A person who intends to apply for one or more benefits described in the Regulation shall notify the insurer of his or her intention no later than the seventh day after the circumstances arose that give rise to the entitlement to the benefit, or as soon as practicable after that day.

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<sup>15</sup> *Statutory Accident Benefits Schedule*, O Reg 34/10 ["the *SABS*"]

(2) The insurer shall promptly provide the person with,

- (a) the appropriate application forms;
- (b) a written explanation of the benefits available;
- (c) information to assist the person in applying for benefits; and
- (d) information on the election relating to income replacement, non-earner and caregiver benefits, if applicable.

In finding for the Insured, Justice Sachs reaffirmed the consumer protection purpose of the *SABS*, commenting at paragraph 38:

Consumers who have motor vehicle accidents are in a vulnerable position, particularly in the period immediately following an accident. Seven days is a very short notice period. Insurance contracts are complicated documents that the average consumer is unlikely to read. If they do read the document, they are unlikely to remember its contents if they have an accident, which could be many years later. The entitlement to damages for motor vehicle accidents in Ontario and the role of the *SABS* in that regime is not something that it is fair to assume the average consumer would be familiar with. Insurance adjusters and agents, on the other hand, can be presumed to know that if one of their insureds has an accident and is injured in that accident, they will want to make a claim for accident benefits. **An interpretation of s. 32(1) that recognizes these realities is one that fosters the consumer protection purpose of the *SABS*. An interpretation that ignores these realities does the opposite.**<sup>16</sup> [Emphasis added].

Justice Sachs concluded that in this case the notice requirement was met when the Insured advised the Insurer one day after the accident that he had been in an accident, and further commented (at paragraph 40):

[...] A reasonable insurer would assume that an insured who has been in an accident intends to access all the benefits available to them under their policy. If the insured has been injured in the accident, this will include accident benefits. If the Insurer in this case wished to clarify which specific benefits the Insured intended to access, the Insurer could have asked the Insured whether he sustained any injuries. As the Insurer chose not to ask any more questions, it should have acted on the assumption that the Insured would want to apply for accident benefits. At that point, the Insurer should have complied with its obligations under s. 32(2) of the *SABS*, which included sending out the necessary application forms and an explanation of the benefits available. This is an interpretation that fosters the consumer protection purpose of the *SABS*.<sup>17</sup>

## Outcome

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<sup>16</sup> *Hussein v. Intact Insurance Company*, 2025 ONSC 842, at para 38.

<sup>17</sup> *Ibid*, at para 40.



The appeal was allowed. The LAT decision and reconsideration decisions were set aside and the Insured's application for accident benefits was sent back to the LAT to be handled in accordance with the Divisional Court's reasons. The Insured was entitled to his costs.

#### **Takeaways from *Hussein*:**

This decision reaffirms the consumer protection purpose of the *SABS* and confirms that "notice" should be given a broad interpretation. Where an insured advises their insurer that they have been in an accident and reports property damage, this is sufficient to meet the notice requirement.

Plaintiff lawyers who are approached by accident victims who did not notify their insurer of their intent to apply for accident benefits within 7 days should critically analyze whether there are any collateral communications with the insurer that may satisfy the criteria for "notice" according to *Hussein*. Insurers should also be prepared to give effect to this broad definition and proactively ask an insured who notifies them of a collision if they intend on applying for accident benefits.

#### **4. *Barry v. Anantharajah*, 2025 ONCA 603**

The Court of Appeal upheld a trial judge's \$300,000 costs award to a plaintiff who recovered just \$16,160.50 after a pedestrian-vehicle trial, rejecting the defendant's appeal that the award was disproportionate.

##### **Background:**

The respondent, a pedestrian, was hit by the appellant's vehicle while crossing the street. The respondent started an action in 2016 and claimed over \$1,000,000 in damages. A litigation guardian was appointed for the respondent, requiring that any settlement of her claim would have to be approved by the court.

In 2018, the appellant, through her insurer Aviva, offered to settle for a dismissal without costs. This offer was reiterated in 2023 in response to the respondent's offer to settle for \$500,000 in damages plus costs and disbursements. The appellant stated that she appreciated that any partial or full settlement of the issues would require court approval. The appellant did not make a monetary offer to settle before or during the trial.

In 2024, the matter proceeded to trial before a judge and a jury. Both liability and damages were in issue. The appellant conceded liability after the appellant took the stand. The appellant's theory of the case was that the respondent's impairments were either pre-existing, minor, or had resolved by the time of trial. The appellant also argued that the respondent was 25% contributorily negligent. Ultimately, after accounting for the jury's finding that the respondent was 15% contributorily negligent, as well as the statutory deductible for general damages, the respondent's damages award amounted to **\$16,160.50**.

The respondent sought partial indemnity costs and disbursements in the total amount of \$404,809. The appellant submitted that no costs should be awarded to either party. The trial judge awarded the respondent **\$300,000** consisting of \$164,148.33 in fees, \$21,339.29 for HST, and \$114,512.38 in disbursements.

The trial judge was critical of the appellant's strategy, stating:

*[T]he defence's aggressive litigation strategy reflected a knee-jerk reaction that was premised at least in part on underlying stereotypes about the credibility and reliability of Plaintiffs with mental health disabilities and reflected an outdated view that mental health injuries are less worthy of compensation than physical injuries. That is the only way to rationalize the Defendant's decision to offer the Plaintiff nothing when its own psychiatrist admitted that she was damaged by the accident.<sup>18</sup>*

The trial judge concluded her analysis with the following:

*Given that the Defendant's clear tactic was to force the matter to trial in the hopes that the Plaintiff would either withdraw or settle her claim for no monetary compensation, it is fair and reasonable that the Defendant bear the costs of this aggressive litigation strategy. That said, I would reduce the quantum of costs by \$100,000 on the basis of proportionality and the higher legal fees necessitated by the Plaintiff's decision to retain two senior lawyers.<sup>19</sup>*

The appellant appealed the costs order.

#### Issues on appeal:

1. Did the trial judge err in finding that the respondent was **more successful than the appellant**; and
2. Was the costs award of \$300,000 wholly **disproportionate** to the net award of \$16,160.50?

#### Outcome:

The appeal was dismissed and the trial judge's costs order was upheld.

- In considering the **standard of review**, the Court of Appeal emphasized the deferential approach taken by an appellate court when reviewing a discretionary award of costs by a trial judge, noting at paragraph 25: "[a] court should set aside a costs award on appeal only if the trial judge has made an error in principle or if the costs award is plainly wrong."<sup>20</sup> The Court further clarified, at paragraph 31, that even if a trial judge had made an error in principle in the exercise of her discretion, "[i]n keeping with the high degree of deference owed, such an error is not fatal so long as there is an independent basis on which to uphold the costs order."<sup>21</sup>
- Regarding the issue of **success at trial**: the Court concluded that the trial judge had not, as the appellant argued, improperly assessed success by looking at whether the judgment exceeded the defendant's offer. Instead, the Court found that "[s]he concluded on the information

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<sup>18</sup> *Barry v. Anantharajah*, 2025 ONCA 603, at para 18.

<sup>19</sup> *Ibid*, at para 19.

<sup>20</sup> *Ibid*, at para 25.

<sup>21</sup> *Ibid*, at para 31.

available to the appellant that the respondent was going to be entitled to some damages and therefore the refusal to make an offer was not reasonable.” The Court elaborated at paragraph 41:

*...Put differently, a defendant is not required to make any settlement offers, but if that is the posture adopted, it must live with the consequences of that posture if its decision does not prove to have been a reasonable one. I see no error in principle in that regard.*<sup>22</sup>

- **Regarding the issue of proportionality:** the Court found that the trial judge had expressly considered the principle of proportionality. In declining to set aside the trial judge’s discretionary award, the Court commented:

*[58] ... the principle of proportionality will not and should not invariably triumph when a defending insurer has opted to take the risk of making no monetary offer of settlement. It is of course not required by law to make such an offer, but a party should appreciate that it does take a risk on costs in adopting such a posture. The principle of proportionality is not a perpetual umbrella that protects against a shower of costs legitimately incurred by a plaintiff and reasonably expected by a defending insurer.*<sup>23</sup>

### **Takeaways from Barry**

This case illustrates the potential risks on costs that can arise where a defendant decides not to make a monetary settlement offer, and that decision proves to have been an unreasonable one. Insurers must keep this in mind when assessing risk on a case that may otherwise be of even modest value.

## **5. Taylor v. Zents, 2025 ONCA 662**

This important Court of Appeal decision clarifies the rule in *Browne v. Dunn* and the law regarding participant experts and Rule 53 experts.

### **Background:**

This case arose from a motor vehicle accident in which Zents rear-ended Taylor’s stopped car at high speed, propelling it off the road and into a ditch. Taylor sued Zents in negligence, claiming damages for personal injuries, past and future income loss, and future care costs. His spouse also sought damages

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<sup>22</sup> *Ibid*, at para 41.

<sup>23</sup> *Ibid*, at para 58.

under the *Family Law Act*. The main injury the plaintiff alleged was a minor traumatic brain injury (concussion).

### **Trial:**

The trial began before a jury. The defendant's position at trial was that the plaintiff was a malingerer who was feigning, or at least exaggerating, his head injury. To support this theory, the defendant tried to bring out inconsistencies in how the plaintiff reported his symptoms to various medical practitioners.

#### The ear fluid questions:

One inconsistency, which the defence focused on, was a report of fluid leaking from his ear after the accident, which the plaintiff only mentioned for the first time over three years after the accident.

In cross examination, the defendant's counsel asked 3 of the plaintiff's medical witnesses whether that inconsistency undermined his credibility. But the defendant's counsel **did not ask the plaintiff about it**, and the trial judge found that the failure to do so breached *Browne v. Dunn*.

The third of those medical witnesses was the plaintiff's treating psychologist, who was also qualified as a Rule 53 expert, and it was the evidence of that witness that prompted the trial judge to raise the *Browne v. Dunn* issue.

#### The "Perry Mason moment":

In what the plaintiff's counsel said could be described as a "Perry Mason moment", the plaintiff's psychologist admitted in light of the ear fluid reports that the inconsistencies were "marked discrepancies" that caused her to "have to think about the confidence of [her] diagnosis". It was then that the trial judge, on her own initiative, raised concerns that the ear fluid line of questioning breached *Browne v. Dunn*.

The plaintiffs moved to strike the jury. The trial judge did so, and the trial proceeded before her alone.

Ultimately, she awarded the plaintiffs a combined total of more than a million dollars in damages.

The defendant appealed.

### **Issues on appeal:**

The appellant advanced 4 grounds of appeal:

1. the trial judge erred in finding a violation of the rule in *Browne v. Dunn*;
2. the trial judge erred in discharging the jury;
3. the trial judge erred in qualifying the plaintiff's treating psychologist as an expert under Rule 53;  
and
4. the trial judge misapprehended the evidence in her assessment of the appropriate damages.

### **Outcome:**

The Court of Appeal determined that the trial judge had made none of the alleged errors and dismissed the appeal.

## Some key points from the Court of Appeal's Analysis:

### Breach of the rule in *Browne v. Dunn*:

J.A. Wilson, writing for the majority, commented as follows:

*Ultimately, a trial judge is responsible for ensuring that the trial process is fair to all parties. Trial judges have the authority to control the proceedings over which they preside, and that authority entitles them to intervene when those proceedings run afoul of the law of evidence or when unfairness in the process occurs [...]. If counsel fail to raise an issue in a timely fashion that could be prejudicial to a fair trial, the trial judge must deal with it appropriately.*<sup>24</sup>

Justice Wilson concluded, at paragraph 46, that: “[t]he trial judge did that here, and Zents’ arguments for disturbing her conclusion on appeal must be rejected.”<sup>25</sup>

The Court rejected the appellant’s argument that the ear fluid evidence impeached the psychologist’s opinion, not the plaintiff’s credibility:

*[...] attacking the foundations of Dr. Hamilton’s opinion about the nature and extent of the head injury sustained by Taylor necessarily includes an attack on his credibility. The two are inextricably woven together. It was not possible to impeach the first without also impeaching the second.*<sup>26</sup>

The Court also rejected the appellant’s argument that the plaintiff was cross-examined on inconsistently reporting his symptoms, so a failure to raise this particular symptom did not breach *Browne v. Dunn*:

*[...] Browne v. Dunn does not require that a witness offer answers on “every scrap of evidence”, but this was no mere scrap: Quansah, at para. 81. [...] It went to the heart of the dispute being tried and the nature and extent of the injuries suffered in the accident, and it also went to the heart of the defence theory, that Taylor ought not to be believed about his symptoms. Trial fairness required that Taylor have an opportunity to address it.*<sup>27</sup>

### Discharging the jury:

The Court held that the judge made no reversible error in exercising her discretion to discharge the jury, commenting at paragraph 62:

*[...] The right to a trial by jury may be a fundamental and substantive right, but it is not absolute. It is subject to the discretion of the trial judge, so long as it is supported by reasoned justification. The trial judge supplied that justification here, untainted by any of the errors Zents now alleges. Part of her explanation for discharging the jury draws on her*

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<sup>24</sup> *Taylor v. Zents*, 2025 ONCA 662, at para 45.

<sup>25</sup> *Ibid*, at para 46.

<sup>26</sup> *Ibid*, at para 47.

<sup>27</sup> *Ibid*, at para 49.

*own observations of the jury and the courtroom and is a useful reminder of why significant deference is owed in this context. It bears setting out again, verbatim:*

*[Taylor’s counsel] referred to Dr. Hamilton’s concession that the inconsistencies amounted to marked discrepancies as a “Perry Mason” moment. This is not hyperbole. The courtroom was so quiet a pin drop would have sounded deafening. The jury was hanging on Dr. Hamilton’s every word at this stage. Her answer prompted an audible reaction from the jury. There was no walking back from this moment. The horse was already out of the barn. [Footnote omitted.]*<sup>28</sup>

The Court concluded that the trial judge “was in the best position to decide whether the jury’s Rubicon had been crossed, and she concluded that it had.”<sup>29</sup>

Moreover, the trial judge had explained why remedies short of discharge would not suffice.

#### **Qualification of the plaintiff’s treating psychologist as an expert under r. 53:**

The Court reviewed the governing legal principles regarding participant experts and Rule 53 experts, and noted that a trial judge’s admissibility decision was owed deference, absent an error in principle.

In finding that the trial judge did not err in qualifying the Plaintiff’s treating psychologist as a Rule 53 expert, the Court acknowledged that the trial judge did not expressly proceed through the discrete steps set out in *White Burgess*, nor did she specifically consider the potential assistance of Dr. Hamilton’s evidence against any dangers inherent in her testimony due to her relationship with the plaintiff. While it would have been preferable if she had done so, the Court found that in substance, the trial judge properly applied *White Burgess* and noted that “[s]he plainly appreciated that independence and impartiality were at issue, and she gave thorough reasons for concluding that Dr. Hamilton was capable of being objective and impartial.”<sup>30</sup>

#### **Takeaways from *Taylor***

The Court’s findings regarding the rule in *Browne v. Dunn* as well as the admissibility of the Plaintiff’s treating psychologist as a Rule 53 expert highlight the trial judge’s responsibility for ensuring that the trial process is fair to all parties, and emphasizes that a trial judge’s decisions in this respect will be entitled to significant appellate deference.

This case also serves as an important tool for trial counsel who intend on impeaching a witness’ credibility through a collateral witness, like defence counsel did in this case by attempting to impeach the plaintiff’s credibility through his psychologist. Failing to confront the party whose credibility they are trying to impeach as is required under *Browne v. Dunn* can derail an entire trial strategy.

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<sup>28</sup> *Ibid*, at para 62.

<sup>29</sup> *Ibid*, at para 63.

<sup>30</sup> *Ibid*, at para 78.

## **6. *Rodriguez-Vergara v. Lamoureux*, 2025 ONCA 620**

This appeal considered which excess insurance policy (the plaintiff's OPCF 44R or the defendant's PLUP) would respond to the plaintiff's claims after the primary policy of the defendants had paid its limits. The Court upheld the motion judge's decision, including his finding that the OPCF 44R stood in priority to the PLUP.

### **Background**

The plaintiff was struck by a vehicle owned by Ms. D'Souza and driven by her daughter ("the defendants").

The defendants' vehicle was insured by Certas under a standard automobile policy with liability limits of \$300,000. Certas also insured Ms. D'Souza under a personal umbrella liability policy ("PLUP") with limits of \$1 million.

Royal & Sun Alliance Insurance Company of Canada ("RSA") insured the plaintiff under a standard automobile policy with limits of \$1 million. Attached to the plaintiff's Standard Automobile Policy was a Family Protection Endorsement, OPCF 44R.

There was no dispute that the assessment of the plaintiff's damages exceeded the limits of Ms. D'Souza's \$300,000 standard automobile policy. The defendants were therefore inadequately insured motorists.

The parties also agreed that the defendants' automobile policy's third-party liability limits of \$300,000 was primary and would respond first to the plaintiff's claims.

However, a disagreement arose about whether the defendant's PLUP or the plaintiff's OPCF 44R would respond next in priority to the plaintiff's claims.

### **Motion Judge**

The defendants' insurer, Certas, brought a motion seeking a declaration that the plaintiff's OPCF 44R stood in priority to the defendant's PLUP. The plaintiff's insurer, RSA, brought a cross-motion seeking leave to commence a third-party claim against Certas and seeking a declaration that RSA could subrogate against Certas for any amounts it had to pay to the plaintiff.

The motion judge determined that:

- after payment of the defendants' third-party liability limits, the plaintiff's OPCF 44R would respond next, followed by the defendant's PLUP;
- the plaintiff's OPCF 44R could not deduct from its damages payment any amounts available from the defendant's PLUP, nor could it subrogate against the at-fault defendants for the payments made to the plaintiff;
- RSA could not issue a third-party claim against Certas.

RSA appealed the motion judge's findings.

### **Issues on Appeal:**

Whether the motion judge erred in finding that:

- 1) the OPCF 44R stands in priority to the PLUP;
- 2) RSA could not deduct the PLUP policy limit from payments under the Plaintiff's OPCF 44R;
- 3) RSA could not issue a third-party claim against Certas, and in finding that RSA could not subrogate against the Certas insured defendants for the amounts paid under the plaintiff's OPCF 44R.

### **Outcome & Reasoning:**

The Court of Appeal affirmed the motion judge's decision and dismissed the appeal.

In determining that the OPCF 44R stood in priority to the PLUP, the analysis hinged on whether the PLUP fell within s.7(a) of the OPCF 44R:

AMOUNT PAYABLE PER ELIGIBLE CLAIMANT [...]

7. The amount payable under this change form to an eligible claimant is excess to an amount received by the eligible claimant from any source, other than money payable on death under a policy of insurance, and is excess to amounts that were available to the eligible claimant from

(a) the insurers of the inadequately insured motorist, and from bonds, cash deposits or other financial guarantees given on behalf of the inadequately insured motorist;<sup>31</sup> [...]

The Court's analysis considered the differences between the OPCF 44R and the PLUP, with the Court noting that the PLUP falls outside Ontario's motor vehicle insurance regime and does not attach to a specific automobile as the OPCF 44R does. While a PLUP may, in some circumstances, provide coverage for motor vehicle accident injuries, it is not a motor vehicle insurance policy.

The Court agreed with motion judge's interpretation that s. 7 of the OPCF 44R referred to matters covered in the automobile regulations or motor vehicle liability policies, noting that:

[...] The language of s. 7 makes it clear that amounts available to the claimant from "insurers of the inadequately insured motorist" mean amounts from the total motor vehicle liability insurance or funds in lieu of insurance, not any and all types of insurance such as a PLUP.<sup>32</sup>

### **Takeaways from *Rodriguez***

This case confirms that when considering which excess insurance policy will respond to a plaintiff's claims in a situation where a defendant is underinsured, an OPCF 44R, which attaches to a specific vehicle, will respond before a PLUP, which is not a motor vehicle insurance policy.

## **7. *Fedoriuk v. Howard*, 2025 ONSC 2534**

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<sup>31</sup> *Rodriguez-Vergara v. Lamoureux*, 2025 ONCA 620, at para 16.

<sup>32</sup> *Ibid*, at para 19.



In this mid-trial ruling, the Court declined to require the jury to provide reasons for their findings on causation, citing risks of confusion—especially given that jurors may come to the same conclusion on causation but by using different paths.

## **Facts**

The 21-year-old plaintiff went to a hospital emergency room with complaints of tinnitus in his left ear and numbness on the entire left side of his body. He was seen by a triage nurse and assigned a CTAS Level 3, indicating a condition that could potentially progress to a serious problem requiring emergency intervention. He was told to wait in the waiting area. Over an hour later, a second nurse noted that the plaintiff was seated in the waiting area “in no distress and on his phone”. This constituted her “re-assessment” and the plaintiff was not taken back into the Triage area as per the guidelines to be re-assessed.

The plaintiff ultimately left the hospital without being seen. He collapsed shortly after and was brought back to the hospital. A CT scan confirmed a large right intracerebral hemorrhage and he underwent emergency brain surgery.

The evidence indicated that the plaintiff had already suffered a ruptured aneurysm by the time he had been assessed by the first emergency room nurse, and then suffered a re-rupture shortly after leaving the hospital.

The plaintiff was left with significant physical and cognitive impairments. He sued the two emergency room nurses and the hospital.

## **The Dispute**

The dispute giving rise to this mid-trial ruling was about the form of the jury questions on causation and whether the jury should be required to give reasons/particulars should causation be found. (Both parties agreed that there should be reasons given for any findings of breach of the standard of care, subject to the trial judge’s discretion).

The parties proposed the following questions on causation:

The plaintiff: “If your answer to question [\*] is ‘yes’, has the plaintiff satisfied you on a balance of probabilities that the breach of standard of care by [the defendant] caused or contributed to the Plaintiff’s injuries?”<sup>33</sup>

The defendants: “If your answer to question [\*] is ‘yes’, has the plaintiff proven, on a balance of probabilities, that but for the breach of the standard of care, the injuries of the plaintiff would not have occurred?”<sup>34</sup>

## **Outcome**

**On the issue of jury questions:**

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<sup>33</sup> *Fedoriuk v. Howard*, 2025 ONSC 2534, at para 16.

<sup>34</sup> *Ibid*, at para 17.

The Court determined that the jury questions on causation would use “but for” wording proposed by the defendants.

Justice Nicholson highlighted that “[t]he questions should be tailored to the particular factual matrix before the court.”<sup>35</sup>

The court emphasized, at paragraph 50, that the alleged negligence of the two nurses was better thought of as sequential as opposed to cumulative, with the triage nurse’s alleged negligence happening first in time, and the second nurse’s alleged negligence occurring later in time. It was not a case where the “circular causation” problem would likely arise.

Ultimately, the court found that in the circumstances of this case, the defendants’ “but for” formulation of the jury questions on causation was most appropriate, noting at paragraph 57: “[...] there is a risk of using the words “contribute to” that the jury will unwittingly stray into material contribution to the risk analysis where that exceptional causation analysis is uncalled for.”<sup>36</sup>

#### **Regarding the requirement for jury reasons or particulars:**

The court declined to require the jury to give “reasons/particulars” on the issue of causation, commenting as follows:

*[72] I disagree with asking the jury to give “reasons/particulars” with respect to causation in this case. The disadvantages outweigh the advantages. Importantly, the jury has a very difficult job to complete in order to arrive at a verdict. Judges with extensive legal training and experience struggle to articulate findings on causation. Asking six laypersons to explain their findings on such a complicated area of law as causation, simply invites more confusion, not clarity, especially given that they may all come to the same conclusion on causation but by using different paths. A failure of articulation could potentially lead to an invalidation of a very thoughtful jury verdict.*<sup>37</sup>

#### **Takeaways from *Fedoriuk***

The formulation of the critical causation question, especially in medical malpractice actions, continues to be a point of contention. This case will be a tool for litigators who advocate for the “but for” test in cases where the negligence is isolated or sequential. However, those on the opposite side can take solace in Justice Nicholson’s guidance that the causation question must be tailored to the specific factual matrix of each case.

This case also builds on the Court of Appeal’s guidance in *Cheung v. Samra*, 2022 ONCA 195, that in cases where there are more than one reasoning path that could lead to a finding of causation, requiring particulars is generally inadvisable as it may undermine the integrity of the jury’s verdict.

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<sup>35</sup> *Ibid*, at para 46.

<sup>36</sup> *Ibid*, at para 57.

<sup>37</sup> *Ibid*, at para 72.

## **Conclusion**

These rulings collectively reinforce and mark an important and continuing shift. Taken together, they are strategically significant, and signal a demand from the judiciary that's increasingly focused on clarity in drafting and pleadings, and advocacy grounded in sound statutory interpretation and a proper evidentiary foundation.

These cases serve as practical guidance, and reveal what judges are looking for, and where our advocacy needs to rise to meet that standard.