

WHAT'S HAPPENING AT FSCO? THE LEGATE SABS UPDATE

For the week of July 27 to July 31, 2009

Believing before receiving – the importance of credibility.

Seyed v. Federation Insurance Co. of Canada; FSCO A07-002110; June 8, 2009; Arbitrator R. Feldman

MVC February 12, 2006. Insured denied injury to both police and insurer. Insured did not seek medical attention for three months. Medical records did not attribute injuries to the collision. Insured returned to work, but took a short term disability leave beginning in May of 2006. Insured applied for accident benefits in July of 2006. Insured claimed in a statutory declaration he suffered immediate pain and nausea following the collision. Insurer approved some claims, but denied others.

The Arbitrator found “numerous and significant inconsistencies” in the information provided by the insured. For example, most treatment providers were told the insured did not have a relevant medical history. However, two were advised the insured had experienced similar pain in the past. The Arbitrator remarked upon the insured’s delay in seeking medical attention and attributing his pain to the collision. The insured offered an explanation for this delay which the Arbitrator did not find to be credible or reasonable. The insured was also found to have deliberately misled the insurer in several respects, including making a meritless claim for a caregiver benefit. The insured did not qualify for this benefit as he was neither the primary caregiver of his children, nor lived with them at the time of the collision. The Arbitrator found that the insured’s inconsistent statements, delay and conduct raised concern about his credibility and causation.

Considering all the evidence, the Arbitrator concluded he was unable to rely on the word of the insured unless it was supported or corroborated by more credible evidence. The Arbitrator noted there was some objective evidence of the insured’s impairments, however there was also evidence of symptom exaggeration, self-limiting behaviour and reported impairments which were not corroborated through clinical examination. The Arbitrator noted that treatment providers and medical assessors rely on insured’s to accurately report information in regards to, amongst other things, medical history and functional limitations. Therefore, where an insured withholds important information, exaggerates or misleads medical professionals, their opinions will have little, if any, weight. The Arbitrator determined the insured was not being truthful and concluded he was unable to rely on the medical opinions provided.

Ultimately, the Arbitrator found that the insured had little, if any, credibility, stating there were too many suspicious circumstances, omissions and deliberate

misrepresentations to give any weight to his testimony, or the testimony of his spouse or anyone relying upon their word.

Implications

Although the facts in this decision present an extreme example, the Arbitrator's comments regarding credibility are important. Following a collision, many insured persons suffer soft tissue injuries with little objective evidence of impairment. As the Arbitrator stated, treatment providers, medical assessors, insurers and arbitrators must assess the reliability of an insured's reports of pain, functional limitations and the effects of treatment. An insured's credibility can be undermined when there is failure to disclose prior medical history consistently to medical practitioners, delay in seeking medical attention, failure to attribute injury or impairment to a collision, meritless claims for benefits, exaggeration, and dishonest conduct.

This decision suggests that an insured ought to report an injury and impairment consistently, honestly and in a timely manner and have a reasonable and credible explanation for any delays. The decision also suggests that treatment providers ought to consider the reliability of information provided by an insured when forming medical opinions. They should be alive to inconsistency in medical records and history and an insured's sincerity in reports of symptoms, limitations and the effect of treatment.

Accessing Arbitration Decisions

If you would like to read the arbitration decisions for yourself, they can be found at <http://www.fSCO.ca/english/insurance/auto/drs/decisions/default.asp>.

Please contact FSCO at 1-800-517-2332 ext. 7202 to obtain a password to gain access to the site.

If you have questions or comments about this edition of the newsletter, contact Carrie Simmons at Legate & Associates: csimmons@legate.ca.