IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Allen v. Sun Life Assurance Company of Canada,* 2024 BCSC 306

Date: 20240223
Docket: 28087
Registry: Cranbrook

Between:

Lorie Ann Allen

Plaintiff

And

Sun Life Assurance Company of Canada

Defendant

Before: The Honourable Madam Justice Lyster

Reasons for Judgment

Counsel for the Plaintiff:	J.M. Lalonde
Counsel for the Defendant:	E.J. Segal
Place and Date of Trial:	Cranbrook, B.C. July 12, 2023
Place and Date of Judgment:	Cranbrook, B.C. February 23, 2024

Introduction

[1] The defendant, Sun Life Assurance Company of Canada ("Sun Life") applies, pursuant to Rule 9-7 of the *Supreme Court Civil Rules*, B.C. Reg. 168/2009, for summary determination of this action.

[2] By way of background, Sun Life entered into an Accidental Death Insurance ("ADI") policy with Dr. Raymond Allen (the "Policy"). The plaintiff, Lorie Allen, is Dr. Allen's widow, and the sole beneficiary under the Policy. Dr. Allen died in very sad circumstances on or about January 22, 2017. Ms. Allen made a claim for ADI benefits (the "Claim"). On January 31, 2018, Sun Life denied the Claim. It did so on the basis that Dr. Allen did not die as a result of an accident and no other cause.

[3] On January 19, 2018, Ms. Allen filed a notice of civil claim. She seeks damages for breach of contract in the amount of $400,000. She also sought damages for breach of the duty of good faith and fair dealing, but did not pursue these heads of damages before me. On April 17, 2018, Sun Life filed its response to civil claim.

[4] In the present summary trial application, Sun Life applies to have the action dismissed. It says the issue for determination is whether Dr. Allen died as a direct

result of an accident, and if so, was the death independent of any other cause. Ms. Allen agrees the matter is suitable for summary disposition. She submits that the evidence before the Court supports that Dr. Allen's death was an accidental death and, as such, the benefits ought to be paid to her.

Is the matter suitable for summary trial?

[5] The parties' consent to have this case disposed of by summary trial does not displace the court's obligation to exercise its discretion to determine whether the matter is suitable for summary trial.

[6] To determine whether a case is suitable for summary trial, the court will consider the following factors: (a) the amount of money involved; (b) the complexity of the matter; (c) the cost of taking the case forward to a conventional trial in relation to the amount of money involved; (d) the course of the proceedings; (e) the cost of the litigation and the time of the summary trial; (f) whether credibility is a critical factor in the determination of the dispute; (g) whether a summary trial may create unnecessary complexity in the resolution of the dispute; and (h) whether the application would result in litigating in slices: *Inspiration Management Ltd. v. McDermid St. Lawrence Ltd.*, 1989 CanLII 229 (C.A.); *Gichuru v. Pallai*, 2013 BCCA 60 at paras. 30–31 [*Gichuru*].

[7] The Court in *Gichuru* made clear that it is incumbent on parties to a summary trial to put their best foot forward, failing which they bear the risk of having judgment granted against them:

> [32] All parties to an action must come to a summary trial hearing prepared to prove their claim, or defence, as judgment may be granted in favour of any party, regardless of which party has brought the application, unless the judge concludes that he or she is unable to find the facts necessary to decide the issues or is of the view that it would be unjust to decide the issues in this manner. This requirement was underscored by Madam Justice Newbury in *Everest Canadian Properties Ltd. v. Mallmann,* 2008 BCCA 275:
>
> > [34] It is trite law that where an application for summary determination under Rule 18A is set down, the parties are obliged to take every reasonable step to put themselves in the best position possible. As this court noted in *Anglo Canadian*

> *Shipping Co. v. Pulp, Paper & Woodworkers of Canada, Local 8* (1988) 27 B.C.L.R. (2d) 378 (B.C.C.A.) at 382, a party cannot, by failing to take such steps, frustrate the benefits of the summary trial process. Where the application is brought by a plaintiff, the defendant may not simply insist on a full trial in hopes that with the benefit of *viva voce* evidence, 'something might turn up': see *Hamilton v. Sutherland* (1992), 68 B.C.L.R. (2d) 115, [1992] 5 W.W.R. 151 (B.C.C.A.) at paras. 66-7. The same is true of a plaintiff where the defence has brought the R. 18A motion. [Emphasis added.]

[8] Ms. Allen seeks $400,000 in damages for breach of contract, that being the amount of the ADI benefit provided under the Policy. This is a not an inconsiderable amount of money from the perspective of an individual plaintiff. At the same time, the cost of taking this matter forward to a conventional trial would not be inconsiderable from the perspective of an individual plaintiff.

[9] The procedural history of this matter would tend to weigh in favour of summary trial. The parties exchanged lists of documents in 2018 and 2020. There are no outstanding demands for documents. A mediation was scheduled for 2021, but cancelled by Ms. Allen. Examinations for discovery have not been scheduled. Ms. Allen has taken no other steps to move her action forward.

[10] There is no issue with respect to the summary trial creating unnecessary complexity or litigating in slices. If the Court is able to decide the question in issue on this application, it will fully and finally dispose of this matter.

[11] The fundamental issue that has to be grappled with in deciding whether this matter is suitable for summary trial is whether the Court can, on the evidence before it, decide the question at the heart of this case: did Dr. Allen die as the result of an accident and independent of any other cause?

[12] When I raised the question of suitability with counsel during the hearing, both counsel remained of the view that the matter was suitable for determination at summary trial. Counsel for Sun Life noted they had recently received production of Dr. Allen's medical records, and an updated report from Ms. Allen's medical expert,

but she did not seek to adjourn the hearing on that basis, nor did she argue that their recent production rendered the matter unsuitable for summary determination.

[13] As will become clear in my analysis, I have concluded that I am able to make the necessary findings of fact on the evidence before the Court. It is just to decide the matters in issue on this application.

Facts

Undisputed facts

[14] Dr. Allen and Sun Life entered into the Policy in 2012. Ms. Allen was the sole named beneficiary. The Policy provides $400,000 in ADI benefits.

[15] Eligibility for ADI benefits is determined by the Policy terms and conditions, including the following:

> ACCIDENTAL DEATH INSURANCE POLICY
>
> […]
> **When we pay**
>
> We pay the beneficiary the accidental death benefit amount, if this policy is in effect and the insured person dies:
>
> - as a direct result of an accident
> - independently of any cause
> - within 90 days of the accident, and
> - before the *policy anniversary* date immediately following the insured person's 70th birthday.
>
> […]
> **When we will not pay the accidental death benefit (exclusions of coverage)**
>
> […]
>
> We also will not pay the accidental death benefit if the insured person's death or accident is directly or indirectly caused by or associated with the insured person
> [...]
>
> - taking any drug, unless the drug was taken as prescribed by a licensed medical practitioner
>
> [...]
>
> - having a mental or physical illness or receiving treatment for that illness….

[16] Dr. Allen paid all premium payments under the Policy.

[17] Dr. Allen died alone on or about January 22, 2017. He was 59 years old.

[18] Ms. Allen filed her claimant statement on March 30, 2017, by which she claimed the ADI benefit.

[19] Sun Life denied the Claim on January 31, 2018. Sun Life wrote:

> Under this policy, there are exclusions where the Accidental Death Benefit is not payable.
>
> "We also will not pay the accidental death benefit if the insured person's death or accident is directly or indirectly caused by or associated with the insured person:
>
> - having a mental or physical illness or receiving treatment for that illness"
>
> As part of our claims assessment, we learned Dr Allen's death was a result of an atherosclerotic cardiovascular disease, which falls under the exclusions …

Evidence Relevant to the Cause of Dr. Allen's Death

[20] The following evidence relevant to the cause of Dr. Allen's death had been submitted on this summary trial application.

Forensic Identification Examination Report

[21] A Forensic Identification Examination Report, dated January 22, 2017, was completed by Cst. J. Darby, who attended at the scene of Dr. Allen's sudden death. Dr. Allen died in his basement suite in Lethbridge, Alberta.

[22] Cst. Darby was requested to attend after someone checked on Dr. Allen because his vehicle had been parked on the street for days and had not moved. That person found Dr. Allen dead in his suite.

[23] According to Cst. Darby's report, he observed "apparent blood … in every room in the suite", including on the floor and the bed in the bedroom; on the floor and in and around the sink and light switch of the bathroom; on the walls leading to the living room, where a significant amount of blood was found on the couch and nearby table; and on the floor from the couch to the kitchen sink where Dr. Allen's

body was found. A pair of jeans were found on the bed. His body was found slumped over the kitchen sink with his arms tucked under his torso. He was standing with his feet resting on the floor. An empty bottle of vodka was found on the kitchen floor and a two-thirds full bottle of rye was found on the countertop. Dr. Allen had last been seen alive on January 18, 2017.

[24] The only clothing on Dr. Allen's body were two t-shirts, both soaked in blood. His body was cold to the touch and rigor mortis was heavily set in. His head, upper chest and arms had blood on them. The only injury observed by Cst. Darby was a swelling on the forehead above the left eye. He could not clearly see a cut in the area of swelling, but blood was hardened in the area making it difficult to see any lacerations.

[25] A number of prescription medications were found inside the suite.

[26] Cst. Darby photographed the scene and Dr. Allen's body. He wrote that the bloodstains seen throughout the suite appeared to be passive, mainly gravity-produced stains and transfer stains. Cst. Darby suspected that Dr. Allen might have been intoxicated and was removing his pants in the bedroom when he fell and hit his head. Cst. Darby opined that Dr. Allen then moved throughout the suite, spreading blood as he moved, and died at his last location at the kitchen sink. Nothing stood out as being the obvious impact point for his head. The stopper to the drain in the sink was not in place, so Cst. Darby could not speculate how much blood went down the drain.

[27] A Supplementary Occurrence Report was made by Cst. Balaz, who had also attended at the scene, on January 29, 2017. She had received a voicemail message from the Medical Examiner's Office, who advised that an exterior examination of Dr. Allen's body had been completed and showed signs of heart disease. The final toxicology report was still pending. Cst. Balaz made a second Supplementary Occurrence Report on December 23, 2017. She had reviewed the Medical Examiner's Report, which had determined the cause of death to be cardiovascular disease.

Sudden Death Investigators Report

[28] Cst. Balaz completed a Sudden Death Investigators Report, dated January 29, 2017. It contains much of the same information as the Forensic Identification Examination Report. Additional information includes that the suite was cool and below average room temperature when officers entered it.

[29] Of note, Cst. Balaz also wrote that "At 1504hrs, the Medical Examiner's Office was contacted and Cst. Balaz spoke with Jane Bartlett. She was advised of the findings and ordered an autopsy to be completed in Calgary."

[30] Despite an autopsy being ordered, a complete autopsy was never performed on Dr. Allen's body.

Proof of Death/Physician's Statement

[31] Dr. R. Holmes, Dr. Allen's family physician, provided a Proof of Death/Physician's Statement, dated June 28, 2017. Dr. Holmes wrote that the cause of death was "Unknown – Presumed accidental?". Dr. Holmes' statement is of limited evidentiary value, as he had last seen Dr. Allen on May 18, 2016, and had no first-hand knowledge of the scene or Dr. Allen's post-mortem condition.

Certificate of Medical Examiner

[32] A Certificate of Medical Examiner was competed by Dr. Angela Miller, dated December 12, 2017. Dr. Miller indicates that the "immediate cause of death" was atherosclerotic cardiovascular disease. She notes that no autopsy was performed. She states that the "manner of death" was "natural". She writes the following about the circumstances of the death:

> The decedent was found in his secured basement suite by his landlord on a welfare check when he had not been seen in several days. It appeared he may have fallen and hit his head. A history of alcohol abuse was reported. On examination, he had a laceration to the left eyebrow and a contusion to the left eye (no traumatic internal injury), and signs of cardiovascular disease. Toxicology was positive for ethanol, acetone, isopropanol, and benzodiazepine sedatives. No suspicious findings.

[33] Dr. Miller certified that she had viewed the body, and made all reasonable investigations to ascertain the cause and manner of death.

[34] On the External Examination Form, Dr. Miller expanded on her findings related to death, as follows:

> … Signs of cardiovascular disease (ear creasing, arcus senilis) were also noted. Toxicology was positive for ethanol over the legal driving limit, acetone and isopropanol consistent with alcohol abuse and poor oral intake, and prescription sedatives. Glucose was not elevated. In the absence of a traumatic or toxicological cause of death, and with the examination findings, cause of death is cardiovascular disease, the most common cause of death in men over 50 years.

Dr. Orde's Expert Report

[35] Ms. Allen obtained an expert report from Dr. Matthew Orde, a forensic pathologist, dated October 22, 2020, and an updated report dated June 30, 2023. The following references are all to the updated report. The most significant amendments related to Dr. Orde's review of Dr. Allen's medical records, which he had recently been provided.

[36] Dr. Orde was requested to provide a report as to the likely cause and manner of death of Dr. Allen. In preparing his report, he relied upon the documents I have already referred to. In addition, he had access to 840 pages of medical records from Interior Health from October 2014 to December 2016, and a cardiac catheterization report dated November 23, 2005.

[37] Dr. Orde summarized Dr. Allen's past medical history. He noted he was a family physician who was on medical leave at the time of his death. The medical records showed that Dr. Allen was suffering from a variety of ailments during the latter part of his life. His history was notable for alcohol use disorder, osteoarthritis of the hip, and mental health issues. There were numerous admissions to hospital in the months and years leading up to his death stemming from alcohol abuse, dehydration, impaired consciousness and ingestion of mouthwash. There were multiple references to suicidal ideation.

[38] The last recorded admission to hospital was on December 9, 2016. On that occasion, the records indicated he had failed to attend an Alcoholics Anonymous meeting, and he was discovered with impaired consciousness and seeming intoxication at the recovery house at which he had been staying. He was admitted to the psychiatric unit, and discharged on December 20, 2016. Treatment during his stay was essentially supportive, and there was no documentation of any cardiac or severe systemic health issues during this period. An electrocardiographic ("ECG") tracing during this period was "normal".

[39] Dr. Allen had previously been admitted to hospital on November 15, 2016, complaining of chest and abdominal pain following the ingestion of vodka and mouthwash. He had a slightly elevated heart rate and slightly elevated blood pressure. There were no other signs of significant cardiac disease. He was found to be severely acidotic, likely stemming from alcohol abuse and severe dehydration.

[40] Prior to that, Dr. Allen had been admitted to hospital between November 30 and December 5, 2016, having presented with intoxication and suicidal ideation.

[41] Dr. Allen had also been admitted to hospital in September 2016, having been found unconscious in his home. He had consumed vodka and gabapentin, with a view to taking his own life. He said he had been suffering from chest pain, but various investigations to assess the possibility of heart disease were all negative. He wrote that "[n]otably, a electrocardiographic 'tracing' was reported as showing no significant ability [reproduced as written], the blood troponin level was reported as being within normal limits, and a chest X-ray revealed a normal cardiac silhouette." Dr. Orde explained that troponin is a cellular constituent present in heart muscle cells, and an elevated level would be a marker of damage to the heart muscle, for example by way of heart attack. He further explained that the normal cardiac silhouette meant it did not favour significant cardiac enlargement, which might be associated with high blood pressure or ischaemic heart disease.

[42] Dr. Allen had also been admitted to hospital in August 2016, again reportedly related to the consumption of vodka and mouthwash. He was profoundly acidotic,

necessitating admission to the intensive care unit. There was also an admission in July 2016 for decreased level of consciousness associated with an alcoholic binge.

[43] During several of these episodes, Dr. Allen complained of chest and abdominal pain. Various investigations were performed, and they all failed to reveal any definitive sign of significant cardiac dysfunction.

[44] Going back some time to November 2005, Dr. Allen underwent cardiac catheterization and angiography. The reason for the procedure was not indicated in his records. The report indicated that the coronary arteries were widely patent and cardiac function appeared to be within normal limits.

[45] There is no reference to Dr. Allen being a smoker or suffering from diabetes.

[46] Dr. Orde went on to review the circumstances surrounding Dr. Allen's death, as outlined in the police reports I have already reviewed. He also reviewed Dr. Miller's post-mortem examination. Dr. Orde explained that "diagonal ear creasing", which was mentioned by Dr. Miller as a sign of cardiovascular disease, is also known as "Frank's sign". He stated that there is a statistical association with this observation and coronary artery heart disease, strongest in young individuals. He explained that "arcus senilis", also mentioned by Dr. Miller as a sign of cardiovascular disease, is a white, grey, blue, yellow or tan ring of discolouration around the periphery of the cornea which can have an association with cardiovascular disease.

[47] Dr. Orde commented on Dr. Miller's conclusion that the cause of death was atherosclerotic cardiovascular disease, also known as hardening of the arteries, as follows:

> 48. … This opinion is, in the absence of any definitive positive findings by way of internal post-mortem examination, necessarily subjective. The standard of proof required for determination of cause and manner of death in most instances in a medical examiner system is only on the balance of probabilities, and this would likely have been the standard applied here.

[48] Dr. Orde's opinion was that:

> 49. … the cause of death of Dr Allen has not been determined with any reasonable degree of certainty, and as such is best regarded as undetermined.
>
> 50. In short, the absence of a full internal examination of Dr Allen's body precludes reliable determination of the cause of death. The examination as undertaken by the Medical Examiner – an external examination with internal dissection limited to the head – does rule out lethal head trauma, but provides little further assistance in relation to determination of either the cause or manner of death.
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> 51. The assertion by the Medical Examiner that this death would have been due to atherosclerotic cardiovascular disease is reasonable, and indeed this may be the case, but this conclusion is not necessarily supported by the evidence. As discussed below, there are certainly other potentially lethal conditions which may well have been operative in this instance.
>
> 52. It logically follows that the manner of death has, in my opinion, also not been determined with any reasonable degree of certainty, and is too rightly regarded as undetermined.

[49] Dr. Orde commented on Dr. Miller's statement that cardiovascular disease is the most common cause of death in men over 50 years. He stated that that might well be correct, but he could not identify any definitive data to support that contention. He noted that in 2017 the most common cause of death in men aged 55–64 was malignant neoplasms, with diseases of the heart some distance behind in second place.

[50] Dr. Orde opined that the normal 2005 cardiac catheterization findings and the absence of detectable signs of significant heart disease during Dr. Allen's recent medical episodes "would perhaps weigh against the possibility of lethal atherosclerotic coronary heart disease, but it is acknowledged that there are few data pertaining to the rate of development and progression of such disease". He stated that the observations of diagonal earlobe creasing and arcus senilis were of interest, and tended to support that Dr. Allen's death was due to atherosclerotic disease. He stated, however, that "these signs are of limited reliability, and are by no means specific". He referred to a 2014 meta-analysis which indicated that earlobe creasing had an overall specificity of 0.67, equating to a false positive rate of 0.33. Dr. Orde further stated that diagnostic reliance is generally only placed on earlobe

creasing and arcus senilis in young individuals, because in older age groups these signs may simply be the result of the aging process.

[51] Dr. Orde commented that the position in which Dr. Allen's body was found suggested a fairly rapid demise. That would be in keeping with a cardiac death, but also other possible causes of death.

[52] Dr. Orde commented on the difficulty in determining the quantity of blood lost by Dr. Allen. He noted that the observations of the police officers on scene suggested significant blood loss prior to death. The source was likely the head wound, but haemorrhage from bodily orifices was also possible. The absence of an internal examination precluded further quantification of the amount of blood lost and assessment of possible internal sources of bleeding. He opined that, assuming the majority of the blood stemmed from the head wound, it is unlikely that blood loss would have contributed significantly towards death, but it was possible.

[53] Dr. Orde suggested that ketosis/ketoacidosis was a potential independent cause of death. The necessary analysis to quantify a ketone known as beta-hydroxybutyrate was not performed. He suggested there was a possibility of significant metabolic/biochemical disturbance, given Dr. Allen's multiple recent hospitalizations.

[54] Dr. Orde opined that the observations made at the scene and some of the post-mortem findings strongly raised the possibility of lethal hypothermia. Again, the absence of an internal post-mortem examination rendered it impossible to know if other findings supportive of a diagnosis of hypothermia might have been present.

Analysis

[55] The parties agree that the onus is on the insured to prove a loss falls within the initial grant of coverage to be eligible for benefits under a contract of insurance. If the insured meets that onus, the onus shifts to the insurer to prove on a balance of probabilities that an exclusion clause applies: *Wynward Insurance Group v. MS Developments Inc.*, 2016 BCCA 513 at para. 19 [*Wynward*].

[56] The parties disagree about whether Ms. Allen has proven that the loss fell within the initial grant of coverage. The question is whether Ms. Allen has proven, on a balance of probabilities, that Dr. Allen died as a result of an accident, and independently of any other cause. Sun Life does not take the position before the Court that any exclusions apply, contrary to the reference to exclusions in their January 31, 2018 letter denying the Claim.

[57] In *Wynward* at para. 17, the Court referred to the following passage from *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada*, 2010 SCC 33, for the general principles applicable to insurance policy interpretation:

> [22] The primary interpretive principle is that when the language of the policy is unambiguous, the court should give effect to clear language, reading the contract as a whole (*Scalera*, at para. 71).
>
> [23] Where the language of the insurance policy is ambiguous, the courts rely on general rules of contract construction (*Consolidated-Bathurst*, at pp. 900-902). For example, courts should prefer interpretations that are consistent with the reasonable expectations of the parties (*Gibbens*, at para. 26; *Scalera*, at para. 71; *Consolidated-Bathurst*, at p. 901), so long as such an interpretation can be supported by the text of the policy. Courts should avoid interpretations that would give rise to an unrealistic result or that would not have been in the contemplation of the parties at the time the policy was concluded (*Scalera*, at para. 71; *Consolidated-Bathurst*, at p. 901). Courts should also strive to ensure that similar insurance policies are construed consistently (*Gibbens*, at para. 27). These rules of construction are applied to resolve ambiguity. They do not operate to create ambiguity where there is none in the first place.
>
> [24] When these rules of construction fail to resolve the ambiguity, courts will construe the policy *contra proferentem* — against the insurer (*Gibbens*, at para. 25; *Scalera*, at para. 70; *Consolidated-Bathurst*, at pp. 899-901). One corollary of the *contra proferentem* rule is that coverage provisions are interpreted broadly, and exclusion clauses narrowly (*Jesuit Fathers*, at para. 28).

[58] Ms. Allen relies on the decision of the Court of Appeal in *Martin v. American International Assurance*, 2001 BCCA 130 [*Martin BCCA*], upheld by the Supreme Court of Canada in *Martin v. American International Assurance,* 2003 SCC 16 [*Martin SCC*].

[59] The issue in the *Martin* decisions was whether a death caused by an overdose of self-injected Demerol came within the accidental death benefit provision

of a policy of life insurance. The policy in that case was similar to the Policy in issue in the case at bar, requiring that the insured's death "resulted directly, and independently of all other causes, from bodily injury effected solely through external, violent and accidental means": para. 5. As stated by Madam Justice Huddart, writing for a unanimous five-person bench, at para. 8 of *Martin BCCA*, the beneficiary in that case submitted that:

> … What matters is how the ordinary person would view what happened. The only question that needs be asked is whether, in the ordinary person's mind, what happened would be considered an accident and, therefore, a risk he or she would reasonably expect to be covered by the insurance if he or she had bought the coverage.

[60] At para. 9, the Court of Appeal stated that the beneficiary's approach had much in its favour:

> … Most reasonable people would agree with her that the insured would have anticipated being covered for his death in the circumstances established by the evidence because most reasonable people would consider taking an overdose of drugs to be an accident. …

[61] The insured in *Martin BCCA* was a physician, and the trial judge had held that while he had miscalculated the amount of Demerol he could safely take, he had intentionally consumed a dose sufficient to come within the lethal range for that drug, rendering his death non-accidental. The Court of Appeal disagreed, and at para. 48 concluded that the insured's death was accidental as it was caused by an accidental overdose. It allowed the insured's appeal.

[62] The insurer appealed to the Supreme Court of Canada. The Supreme Court of Canada upheld the Court of Appeal's decision. The Supreme Court of Canada summarized Huddart J.A.'s judgment as follows at para. 8:

> The Court of Appeal allowed the appeal. Writing for a unanimous bench, Huddart J.A. also questioned the usefulness of the distinction between "accidental deaths" and deaths by "accidental means". However, she held that it was not necessary to decide this question. In her view, it was "enough, for the purposes of this appeal, to look at the action that caused the injury and all the circumstances surrounding it in a holistic way and to ask whether in ordinary and popular language the event as it happened would be described as an accident" (para. 26). Huddart J.A. then inferred from the circumstances of Dr. Easingwood's death that it was more likely than not that

> he had not intended to give himself a potentially lethal dose. Because an unintentional overdose would be regarded as an accident by the ordinary person, the court held that Dr. Easingwood's death occurred accidentally, and that the respondent could therefore recover under the policy.

[63] At para. 18, the Supreme Court of Canada held that the phrase "death by accidental means" in the policy under consideration did not refer to a narrower category of "accidental deaths". Both phrases "connote a death that was in some sense unexpected". The Court reached this conclusion because it accorded with the ordinary meaning of the phrase, and with the principle that insurance contracts are to be interpreted in a manner that gives effect, as far as possible, to the reasonable expectations of the parties: paras. 15–16.

[64] The Supreme Court of Canada then went on to consider what constitutes death by "accidental means". At para. 19, the Court stated:

> … As Spence J. pointed out in *Mutual of Omaha Insurance Co. v. Stats*, [1978] 2 S.C.R. 1153, at p. 1164, the word "accident" is "an ordinary word to be interpreted in the ordinary language of the people". Hence, as the British Columbia Court of Appeal emphasized in the case at bar, we must focus on the ordinary person's understanding of the phrase, and on "whether in ordinary and popular language the event as it happened would be described as an accident" (para. 26). Only in this way can the reasonable expectations of both the insured and insurer be protected. We must therefore inquire how the phrase "death by accidental means" is used in ordinary language.

[65] At para. 21, the Supreme Court of Canada stated that:

> The pivotal question is whether the insured expected to die. The circumstances of the death – what the insured said, or did, or did not do – may point to the answer. However, to the extent that the answer is unclear when the matter is viewed solely from the perspective of the insured, the court may consider whether a reasonable person in the position of the insured would have expected to die: *Candler v. London & Lancashire Guarantee & Accident Co. of Canada* (1963), 40 D.L.R. (2d) 408 (Ont. H.C.), at p. 423; *Johnson v. Mutual of Omaha Insurance Co.* (1984), 45 O.R. (2d) 676 (C.A.), aff'g (1982), 39 O.R. (2d) 559 (H.C.); *Stats*, *supra*, at pp. 1164-65.

[66] Ms. Allen says, relying on *Martin*, that a subjective and objective test must be applied. She submits that Sun Life relied solely on Dr. Miller's report, which was unreasonable in light of the information given in the police reports and Dr. Orde's opinion. She submits that she has shown Dr. Allen's death was the direct result of an

accident, and independently of any other cause. In particular, she submits that she has shown the death was caused by an accident related to hypothermia and/or blood loss.

[67] Sun Life says that while Dr. Allen's death may have been unexpected, it was not caused by an accident. It says it was caused by disease, and that there is no coverage "if the 'event' simply provided an occasion on which the pre-existing disease manifested itself": *Co-operators Life Insurance Co. v. Gibbens*, 2009 SCC 59 at para. 49.

[68] I do not find Dr. Miller's report persuasive evidence of the cause of Dr. Allen's death. The absence of a full internal post-mortem is inexplicable on these facts. The police were told that one would be performed, but Dr. Miller did not do so. A post-mortem would likely have provided important evidence that would have borne directly on the cause of Dr. Allen's death. In its absence, the Court must do the best it can on the evidence available.

[69] Dr. Miller opined that Dr. Allen's death was caused by atherosclerotic disease. It is not clear on the evidence before the Court what if any medical records Dr. Miller had access to in arriving at this opinion. She does not refer to any in her report. Her opinion was formed on the basis that:

a) Ear creasing was present;

b) Arcus senilis was present; and

c) Cardiac disease is the most common cause of death in men over 50.

[70] I find Dr. Orde's expert opinion of significant assistance in evaluating the factors relied upon by Dr. Miller in arriving at her conclusion. Ear creasing and arcus senilis are of limited reliability as markers of coronary artery disease. Earlobe creases have a false positivity rate of 33%. Both earlobe creases and arcus senilis are diagnostically reliable only in young individuals. Earlobe creases, in particular,

lose their positive predictive value in patients older than 60 years. Dr. Allen was 59 when he died.

[71] Dr. Orde says it is possible that Dr. Miller was correct in stating that cardiac disease is the most common cause of death in men over 50 years of age, but he was unable to identify any data that would support that contention. The data he did have showed that in 2017, malignant neoplasms, not diseases of the heart, were the leading cause of death in men between 55 and 64 years of age.

[72] Dr. Miller's report does not establish that Dr. Allen died of atherosclerotic disease on a balance of probabilities. As Dr. Orde opined, it is possible that Dr. Allen died from atherosclerotic disease, but that conclusion is not necessarily supported by the evidence.

[73] It is necessary to take a broader look at the evidence to determine the probable cause of Dr. Allen's death. Dr. Orde's review of Dr. Allen's recent medical history shows that he had had a number of recent hospitalizations, all seemingly related to his alcohol abuse disorder. He had undergone a number of investigations to determine his risk of significant heart disease, but they had failed to reveal any definitive sign of same.

[74] Sun Life submits that Dr. Orde failed to refer to a number of abnormal ECG reports that would tend to support that Dr. Allen died of a cardiac event. I have reviewed the medical documents referred to by Sun Life, and they do say "abnormal ECG". The difficulty is that, in the absence of expert evidence, I am unable to interpret what that means. Dr. Orde is an expert, and he reviewed Dr. Allen's medical records, and summarized those records that, in his opinion, were relevant to the determination of Dr. Allen's cause of death. It is incumbent on a party on a summary trial to put their best foot forward. If Sun Life wished to challenge Dr. Orde's opinion, or argue the significance of medical records he did not refer to in his report, it was incumbent on Sun Life to seek its own expert opinion. It did not do so. In the absence of such an opinion, I am not able to ascribe significant weight to uninterpreted ECG reports.

[75] I return to the observations of the police who attended the scene of Dr. Allen's death. They make clear that there was a great deal of blood all over the suite. There was a large amount of blood on two pillows on the single bed. Blood had soaked into the couch and a throw pillow in the living room. The two t-shirts Dr. Allen was wearing were soaked in blood. There was no way of knowing how much blood might have gone down the drain of the kitchen sink Dr. Allen's body was found slumped over. While it is possible an autopsy might have revealed internal bleeding, the only available source of all this blood on the evidence before the Court is the laceration to Dr. Allen's head. It is probable that he fell and hit his head, causing that laceration, and the heavy bleeding seen throughout the suite.

[76] The police reports also make clear that the suite was cool and below the average room temperature. This was January 22, 2017 in Lethbridge, Alberta. It is likely the outdoor temperature was cold. It is unfortunate that the police did not measure the temperature in the suite, so the Court does not know what the temperature was. Dr. Orde was of the opinion that the observations at the scene and some of the post-mortem findings strongly raised the possibility of lethal hypothermia. In this regard, he referred to the fact the suite was cool and below average room temperature. He also stated that it is possible the bruising identified on the front of Dr. Allen's legs post-mortem may represent part of the reddening process associated with hypothermia. Hypothermia has an association with alcohol use and ketoacidosis, which Dr. Orde opines would be supported by Dr. Allen's toxicology results. Persons with hypothermia are at risk of developing an acute delirious state, which may result in scene disturbance, injury and "paradoxical undressing". Dr. Orde opines that the fact Dr. Allen was dressed in only two t-shirts, and had multifocal bruises and abrasions, would most certainly be in keeping with hypothermia.

[77] Considering the evidence as a whole, I conclude that Dr. Allen's death was likely caused by a combination of hypothermia and blood loss caused by the laceration to his head. Adopting the language of Huddart J.A. in *Martin BCCA* at para. 26, the Court must "look at the action that caused the injury and all the

circumstances surrounding it in a holistic way and ask whether in ordinary and popular language the event, as it happened, would be described as an accident." Both hypothermia and loss of blood from falling and lacerating one's head are, in my view, properly described as accidents.

[78] The evidence does not establish that Dr. Allen suffered a cardiac event or that his death was otherwise caused by atherosclerotic disease. If he did suffer a cardiac event, which caused him to fall, hitting his head, then Ms. Allen submits that the reasoning of the Court of Appeal in *Ward v. Allstate Life Insurance Co. of Canada* (1994), B.C.L.R. (2d) 273, 1994 CanLII 3285 (C.A.) [*Ward*], would apply.

[79] In *Ward*, the Court of Appeal upheld the trial judge's decision that the insured's death was covered by the insurer's accidental death policy. The policy in that case bore a strong resemblance to the Policy in issue in the case at bar, requiring that the injury be caused by an "accident, directly and independently of all other causes": para. 8. The insured had suffered a seizure, and fell, with his head ending up lodged between the bed and night table, causing the asphyxia from which he died. At para. 13, the Court set out four categories of cases that had considered the issue of proximate cause where accident and illness are involved:

> (a) the case where the insured while suffering the effects of an illness, such as a heart attack, has an accident and the injuries sustained in the accident directly cause the loss. The illness although precipitating the accident ceases to be causative of the injury.
>
> (b) the case where the illness does not have any role in causing the accident but the injuries sustained in the accident operate with or activate an existing illness and result in the covered loss.
>
> (c) the case where there is no previous illness but the accident causes an injury and a disease or condition arises as a direct consequence of that injury causing the loss.
>
> (d) the case where the illness causes an accident and [an injury] but the injury in and of itself would not have led to loss but for the continuing operation of the illness.

[80] The insurer in *Ward* submitted that that case fell into category (d), and the loss was therefore not covered. The Court of Appeal disagreed, holding that it fell into category (a), and was therefore covered.

[81] In my view, if Dr. Allen did suffer a cardiac event that caused him to fall, setting into motion the chain of events that eventually led to his demise, the same result would follow. His death would remain accidental and still be covered by the Policy.

Conclusion

[82] For these reasons, I have concluded that Ms. Allen has established that Dr. Allen's death was an accidental death, independent of any other cause, and therefore covered by the Policy, and that the Claim ought to have been allowed. I grant judgment in favour of Ms. Allen in the amount of $400,000. Ms. Allen is entitled to pre-judgment and post-judgment interest in accordance with the *Court Order Interest Act*, R.S.B.C. 1996, c. 79. Unless there are matters of which I am unaware, Ms. Allen is entitled to her costs of the action at Scale B.

"L.M. Lyster J."

LYSTER J.