BAD FAITH: SUMMARY AND RECENT CASES

FALL 2011 UPDATE

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This paper considers recent cases and developments in the law of insurance bad faith, with a particular focus on cases within the past two years. This paper also sets out the general principles that apply in bad faith cases and considers several procedural and miscellaneous issues.

I. THE BASICS AND GENERAL PRINCIPLES

Bad Faith in First Party Policies

There have been some recent significant first party bad faith cases and much of this article will focus on those cases. The recent cases, like the first party cases before them, generally involve one of two factual scenarios: (1) denial of benefits under an accident or disability policy; or (2) an unwarranted allegation of arson in a property policy. Having said that, some of the recent cases consider bad faith in first party policies in other circumstances, and some recent cases arguably extend the scope of conduct that may be found to amount to bad faith in a first party context.

Before turning to the recent cases in detail, this section of the paper refers to the general underlying principles of first party bad faith, particularly as referred to in recent cases.

The principles have recently been well summarized in two decisions; *Sidhu v. The Wawanesa Mutual Insurance Company*, 2011 BCSC 1117; and *Wilson v. Saskatchewan Government Insurance*, 2010 SKQB 211. *Sidhu* involved an unwarranted allegation of arson, although that was not the focus of the finding of bad faith. The detailed facts and findings are referred to below. The case is referred to here for its statement of the general principles underlying bad faith claims. *Wilson* involved a claim arising out of the insurer's decision to cut-off rehabilitation benefits several years after the insured was injured in two motor vehicle accidents. Again, the facts of the case and the basis for the finding of bad faith are referred to in more detail below. The summary of the applicable principles in *Wilson* particularly emphasizes the "dual" obligation of bad faith, on both the insurer and the insured.

In *Wilson* the Court said:

> It is well established that insurance contracts are characterized by the common law as being contracts of *uberrimae fidei* or utmost good faith. This fundamental feature of insurance contracts has been widely recognized by Canadian courts.

The Court then referred to *Adams v. Confederation Life Insurance Co.* (1994), 25 C.C.L.I. (2d) 180 (Alta. Q.B.) and continued:

> The principle of utmost good faith applies to all types of insurance contracts and exists apart from the express terms of the contract. The principle applies to both the insured and insurer and lasts for the duration of the insurance contract. Overall, the principle requires the parties to treat each other with total honesty and to be completely fair in their dealings with one another

In both *Sidhu* and Wilson the courts referred extensively to the two key decisions of the Supreme Court of Canada on bad faith, *Fidler v. Sun Life Assurance Co. of Canada*, 2006 SCC 30; [2006] 2 S.C.R. 3; 39 C.C.L.I. (4th) 1 and *Whiten v. Pilot Insurance Co.*, 2002 SCC 18; [2002] 1 S.C.R. 595; 35 C.C.L.I. (3d) 1, and quoted the following language from *Fidler* (which was in turn quoted from *720535 Ontario Inc. v. Lloyd's London, Non-Marine Underwriters* (2000), 184 D.L.R. (4th) 687 (Ont. C.A.)):

> The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy.
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> ... an insurer will not necessarily be in breach of the duty of good faith by incorrectly denying a claim that is eventually conceded, or judicially determined, to be legitimate. ... The question instead is whether the denial was the result of the overwhelmingly inadequate handling of the claim, or the introduction of improper considerations into the claims process.

In *Wilson* the Court noted that in *Whiten* the Supreme Court of Canada:

> … confirmed that in order to meet its obligation of good faith, an insurer must, at all times, act fairly and promptly in responding to an insured's claim. This means an insurer must investigate and assess the claim objectively and on proper grounds, act with reasonable diligence during each step of the claims process to see the claim resolved in a timely way and, if no reasonable grounds for denying coverage or payment exists, pay the claim on a timely basis.
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> In *Whiten, supra*, the Supreme Court set out the principles that govern the award of punitive damages for breach of the duty of good faith. Where the breach in question is a denial of insurance benefits, a breach by the insurer of the duty to act in good faith will meet the requirements. The threshold issue that arises therefore, is whether an insurer breached not only its obligation to pay the benefit, but also the independent obligation to deal with the insured's claim in good faith.
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> The notion of the duty of good faith requires that an insurer will be fair, objective and even handed in its investigation and evaluation of the claim. The nature and extent of the investigation required will depend on the nature of the claim and the basis for the denial of coverage. A fair, objective and even handed investigation must take into account all of the reasonably available evidence on a particular point before rejecting the claim on that

> basis. This will generally require the insurer to interview the insured and any other witnesses who may reasonably be expected to have information pertinent to the insured claims.

It is then necessary to consider the principles that will apply in determining whether, and in what amount, to award punitive damages, following a finding of bad faith. In *Sidhu*, the Court, in considering this question, quoted the following from *Whiten* (at para. 155):

> Punitive damages are awarded against a defendant in exceptional cases for "malicious, oppressive and high-handed" misconduct that "offends the court's sense of decency": *Hill v. Church of Scientology of Toronto*, (citation omitted). The test thus limits the award to misconduct that represents a marked departure from ordinary standards of decent behaviour. Because their objective is to punish the defendant rather than compensate a plaintiff (whose just compensation will already have been assessed), punitive damages straddle the frontier between civil law (compensation) and criminal law (punishment).

A key passage from *Whiten* on the factors to take into account in awarding punitive damages, as quoted by the BCSC in *Spence v. ICBC*, 2005 BCSC 1838 at para. 37, is also worth referring to:

> Punitive damages are very much the exception rather than the rule, (2) imposed only if there has been high-handed, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from ordinary standards of decent behaviour. (3) Where they are awarded, punitive damages should be assessed in an amount reasonably proportionate to such factors as the harm caused, the degree of the misconduct, the relative vulnerability of the plaintiff and any advantage or profit gained by the defendant, (4) having regard to any other fines or penalties suffered by the defendant for the misconduct in question. (5) Punitive damages are generally given only where the misconduct would otherwise be unpunished or where other penalties are or are likely to be inadequate to achieve the objectives of retribution, deterrence and denunciation. (6) Their purpose is not to compensate the plaintiff, but (7) to give a defendant his or her just desert (retribution), to deter the defendant and others from similar misconduct in the future (deterrence), and to mark the community's collective condemnation (denunciation) of what has happened. (8) Punitive damages are awarded only where compensatory damages, which to some extent are punitive, are insufficient to accomplish these objectives, and (9) they are given in an amount that is no greater than necessary to rationally accomplish their purpose. (10) While normally the state would be the recipient of any fine or penalty for misconduct, the plaintiff will keep punitive damages as a "windfall" in addition to compensatory damages. (11) Judges and juries in our system have usually found that moderate awards of punitive damages, which inevitably carry a stigma in the broader community, are generally sufficient.

Summary of Key Principles

The key principles underlying the duty of good faith in a first party context can be summarized as follows;

1. The insurer must undertake a reasonable and unbiased investigation into the claim, considering all reasonably available information, including information available from the insured;

2. The insurer must undertake that investigation reasonably promptly, and must communicate the results to the insured reasonably promptly;

3. The insurer must not subject the insured to undue or unfair pressure or tactics intended to extract a low settlement;

4. The insurer may be wrong in its assessment of coverage, so long as its position is reasonable, or "fairly debatable". The insurer may be wrong, but not 'too wrong';

5. Where the insurer's conduct departs markedly from the required standard, the insurer may be subject to punitive damages, intended to punish the insurer's bad faith conduct, and calculated in proportion to several factors including the degree of harm caused and the severity of the misconduct.

Bad Faith in Liability Policies

While the same underlying principles apply in the liability context, the content and the pre-requisites for a finding of bad faith are of course very different. Interestingly, there are no recent significant cases considering bad faith in a liability context. For that reason this section of the paper refers to some older BC cases.

A number of the principles which apply to bad faith claims under liability policies are summarized in two key B.C. decisions, *Fredrikson v. I.C.B.C.* (1990), 42 C.C.L.I. 250 (B.C.S.C.) and *Shea v. Manitoba Public Insurance Corp.* (1991), 55 B.C.L.R. (2d) 15. In *Fredrikson* the insured, F, had limits of $500,000. N sued F as a result of a motor vehicle accident. The case went to trial and F was held liable to N for an amount in excess of $1,000,000. F's causes of action against ICBC were then assigned to N. The claim, brought in F's name, was for breach of an implied term of the policy or negligence arising from the insurer's alleged failure to properly investigate and defend the claim and failure to settle within limits.

Esson, C.J.S.C., referred to policy language requiring the insurer to investigate, defend and settle. Referring *Joe v. I.C.B.C.* (1984), 7 C.C.L.I. 81, Esson, C.J.S.C. accepted that "the contractual obligation to investigate and to defend the action carries with it the obligation to exercise reasonable care and skill in so doing". The Court then referred to Appleman at p. 181-183 in part as follows:

> It is not an extraordinary degree of care but the care that is required under these particular circumstances. It must use skill diligently and adequately to investigate a case, it must use skill in negotiation, it must select skilled trial counsel…

Esson, C.J.S.C. first considered the standard applicable to conduct of an insurer in considering settlement (p. 282). He rejected the "absolute liability" rule, adopted by some U.S. writers under which an insurer would automatically be found in breach of its duty to the insured, and liable for the amount of any excess judgment against the insured, where the claim could have been settled within policy limits. In considering the appropriate standard to apply to the insurer's conduct, at p. 284 Esson, C.J.S.C. quoted from Couch a list of factors as to whether the insurer had acted in bad faith:

> 1) failure to adequately investigate the grounds for the claim against its insured; 2) failure to advise the insured of settlement decisions that could adversely affect its interest; 3) failure to regard the advice of counsel or other agents; 4) failure to settle when the

> probability of success at trial is low and the risk of personal liability of the insured is high; and 5) failure to institute or participate in settlement negotiations

Esson, C.J.S.C., after considering various U.S. authorities concluded:

> To sum up, I am not persuaded that it would be either analytically correct, or in any sense in the interest of justice to import into our law the general doctrine of 'bad faith refusal to settle', in any of its forms. That is not to say that liability insurers are under no obligation to consider the interest of their insured in deciding whether to settle. Where there is a potential for a judgment over the limits, the interests of the insured are significant. The insurer has assumed by contract the power of deciding whether to settle.
>
> …although the insurer is not subject to the strict duty of a fiduciary, it must nevertheless exercise its power having regard to the interests of its insured, and in a manner entailing, in some sense, an obligation of good faith.

Esson, C.J.S.C. then said whatever the standard, it had been met by ICBC. ICBC had acted in a "fair and open manner". It approached the question of settlement as if only its resources were at risk and it followed the course which its insured wished it to take.

One significant point in Esson, C.J.S.C.'s reasons is his reference to the facts as given by the insured. The vehicle had been struck by a train. There was no good explanation as to why the vehicle, which had stopped before a level crossing, then proceeded into the path of the oncoming train. F professed no memory of the incident and gave statements to the insurer which conflicted with evidence of other witnesses as to whether F had been drinking. ICBC accepted F's statements, and that was one of its reasons for taking the case to trial notwithstanding the possibility of a judgment over policy limits. In considering that issue Esson, C.J.S.C. said (at p. 266):

> I conclude that ICBC and its advisors, either on the basis of the evidence known to them or that of which they reasonably ought to have known, were entirely justified to the point of trial in treating the case on liability as being so weak as to have no substantial 'settlement value'. My only reservation with respect to that is that ICBC's lawyers, by accepting Fredrikson as credible, may have given less weight to the risk of liability than they should have. Fredrikson's position rested on a rather suspicious failure of memory which was almost bound to, at least, create suspicion in the minds of the jury. But the present plaintiffs, naturally enough do not rely on that factor. Even those American courts which tend to be most liberal in holding insurers liable for judgment over the limit, have held that such liability cannot be founded upon the insurer having accepted its insured's version of the facts.

In the result, there was no liability for the excess judgment.

The other side of the coin is seen in *Shea v. Manitoba Public Insurance Corp.* (1991), 55 B.C.L.R. (2d) 15. In that case the infant plaintiff was injured while a passenger in a vehicle driven by his father and owned by his uncle. The uncle had only $300,000 in liability cover with MPIC. There was also no fault cover with MPIC. It was known early on that the damages would far exceed the limits. There was an issue as to whether the no-fault cover and the limits of the liability policy were cumulative or whether any no fault benefits would reduce available liability cover. The insurer appointed one lawyer to defend the uncle and father and to defend MPIC in the separate no fault proceedings. That counsel took the position that any monies

payable under the no fault benefits would be deductible from the liability limits. The insureds were not notified of this position, despite the fact that it clearly affected their interests. Plaintiff's counsel made an offer to settle for the $300,000 in limits, without prejudice to the plaintiff's right to assert it was entitled to additional no fault benefits. MPIC refused to settle. The action proceeded to trial. The plaintiff recovered judgment against the father and the uncle for approximately $1,000,000. MPIC paid the policy limits but refused to pay the balance. The father and uncle assigned to the plaintiff their rights against MPIC and an action was brought claiming the full amount of the judgment.

Finch, J. (as he then was) referred to *Fredrikson v. I.C.B.C.* Finch, J. noted that, in *Fredrikson* the only "conflict of interest" that had existed between the insured and insurer was the inherent conflict arising from the existence of a claim that was potentially over the policy limits. In such a case the insurer would have a legitimate interest in trying to effect a saving on the policy limit. That situation had to be distinguished from that in *Shea.* In *Shea* there was no doubt the policy limits would be exceeded. When there is no reasonable prospect of settling a tort claim for less than the limits of coverage the insurer can have no legitimate interest in trying to do so.

Finch, J. went on to consider the key issue. MPIC had taken a position directly opposite to the interests of the insureds. To the extent there was potential liability for the claim in excess of the limits it was in the insureds' interest to maximize the amount of accident benefits payable by MPIC and to have those benefits paid in addition to the limits of the uncle's policy. This was in direct conflict to MPIC's interest. A full defence for the insureds would have included arguments that court order interest and no fault benefits were payable in addition to the third party limits (para. 155). No such arguments were made. Nor were the insureds advised of the potential for such arguments. While the insureds had been told, at one point, that the judgment might exceed policy limits and that they should seek independent legal advice, Finch, J. found that they should "at a minimum have been told of the issues upon which advice should be sought" (para. 166).

In considering the nature of the insurers' duty of good faith Finch, J. quoted extensively from an article Barker et al "Is an Insurer a Fiduciary to its Insureds?" (1989) 25 Tort & Ins. L.J. 1. Among the passages quoted were the following:

> Unlike a fiduciary, an insurer engaged in determining and performing its contractual obligations may give consideration to its own interest, so long as it gives 'at least as much consideration to the welfare of its insured as it gives its own interests' and refrains 'from doing anything to injure the right of the [insured] to receive the benefits of the agreement'.
>
> …to provide appropriate protection for insureds while leaving insurers free to scrutinize and challenge doubtful claims, many courts have established *a level of duty intermediate* between the adversarial relationship applicable in the usual business context and the fiduciary relationship created by an undertaking to act solely in another's interest. This duty is based on an 'applied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement'. Consequently, the insurer may not use its superior size, sophistication, and bargaining power or the insured's special dependence on it to deprive the insured of the promised benefits of the insurance policy.

> Because 'the benefits of the agreement' do not include payment of unmeritorious claims, and because the very drawing of distinctions in the policy between covered and excluded risks implies a need to determine which category is involved in any given instance, scrutiny and challenge of doubtful claims is consistent with this duty. The insurer is *not* permitted, however, to treat the insured as an adversary whose interests may be disregarded. Rather, *the insurer 'must take into account the interest of the insured and give it at least as much consideration as it does to its own interest'*. Thus, the insurer is free to give the interest of its insured great weight than its own interest, but the insurer is not required to do so. *The insurer's obligation is only that 'of protecting the interests of the insured equally with his own'*. (Finch, J.'s emphasis)

Finch, J. then, starting at para. 191 summarized his view of the duty to the insured, particularly in connection with settlement. The insurer had a duty "of good faith and fair dealing" that included an obligation to "give at least as much consideration to the insured's interests as it does to its own interest" and required the insurer to disclose promptly to the insured all material information touching on the insured's position in the litigation and the settlement negotiations. The insurer was entitled to "assert or defend interests which are opposed to, or are inconsistent with, the interests of the insured" but the insurer had to advise the insured of such conflicting interest and of the nature and extent of such conflict. The insurer was obliged to instruct defence counsel to treat the interests of the insured equally with its own. All defence preparations and settlement must take place in a timely way and where negotiations are required advance planning must be made to ensure that the insured's interest are given equal protection with those of the insurer.

Finch, J. concluded that MPIC breached its duties to the insured. MPIC failed to identify the nature and extent of the interest which it had in conflict with the insured's. Here, Finch, J. was not referring to the general conflict between insured and insurer but to the specific conflict, namely, the insured's interest in arguing that no fault benefits and court order interest were payable in addition to limits and the insurer's interest in arguing to the contrary. Failure to advise the insured of this specific conflict and to deal with it was a breach of duty. The insurer was liable for the excess judgment.

Fredrikson and *Shea* illustrate the opposite ends of the spectrum. In *Fredrikson* there was obviously the potential for conflict between the interests of the insured and the insurer, given the possibility of an excess judgment. But as there were no coverage issues, there was no conflict as to the manner in which the defence ought to be conducted. In *Shea*, on the other hand, there was a direct conflict between the interests of the insured and the insurer, given the question of deduction of the first party benefits from liability limits. In *Fredrikson* the defence was conducted competently, and on the basis of the insured's evidence. In *Shea*, given the conflict issue, the question was not whether the defence was conducted with due diligence. The fact is the defence was conducted in a manner which intentionally sacrificed the interests of the insured to those of the insurer.

Another British Columbia case worth referring to, as it considers delay in connection with the duty of good faith in the context of a liability policy, is *Insurance Corporation of British Columbia v. Hosseini*, 2006 BCCA 4; 31 C.C.L.I. (4^{th}) 157. In 1992 H crashed a stolen motorcycle. His passenger, C, sued. A defence was tendered by ICBC and the claim settled. In 1998, six years after the accident, ICBC asserted that H was not insured (para. 66). ICBC had internally decided that H was uninsured shortly after the accident, but never took that position with H (para. 68). ICBC had delayed taking the position that H was uninsured while it settled

C's claim for a substantial amount, without any notice H that it would seek to recover from him the entire settlement. H was prejudiced by the delay as there was a legitimate factual issue as to whether he had believed he was operating the motorcycle with the consent of the owner (paras. 85-89).

In those circumstances, the Court found that ICBC was not entitled to claim indemnity from H for monies paid in settlement of C's claim. Thackray, J.A. quoted Windt, *Insurance Claims & Disputes* (1982), (para. 70) noted that once an insured was on notice of the claim it ought to promptly respond, notify the insured of preliminary coverage positions, and promptly notify the insured of any decision to deny coverage.[1]

Summary of Key Principles

In broad summary, in considering bad faith in liability policies, the following principles apply:

1. The insurer is at risk of a finding of bad faith only where there is a potential for an uninsured or partly uninsured judgment, either because there is a claim over limits, or because there is a coverage dispute.

2. As with first party policies, the insurer must carry out a diligent and reasonably prompt investigation into the insured's claim and communicate its conclusions to the insured promptly. Note that "investigation" in the context of a liability policy has a different meaning than in a first party policy, in connection with the initial investigation into potential coverage. There is no duty to "investigate" the underlying facts in a liability claim. The duty is to properly determine, on the basis of the pleadings, and very limited admissible extrinsic evidence, whether a duty to defend is owed.

3. As with first party policies, the insurer may be wrong in determining whether a duty to defend is owed, but its position must be reasonable or "fairly debateable".

4. The defence must be reasonably competent and undertaken with due diligence.

5. The insurer must undertake the defence in a way that does not sacrifice the insured's interests to those of the insurer. In some cases, depending on the facts and degree of conflict this requires steps such as appointment of *Cumis* counsel.

6. Where there is a potential uninsured claim, the insurer is not bound to settle within limits, but must consider doing so, and in considering that issue, must give the insured's interests as much weight as the insurer's, and must act as a prudent insurer would in the absence of limits or coverage issues. A decision as to whether to settle must be based on a reasonable assessment of the case.

[1] Smith, J.A. gave short concurring reasons agreeing in the result but not considering the allegations of bad faith. Smith, J.A. based his decision on ICBC's breach of certain provisions of the *Insurance (Motor Vehicle) Act,* which precluded ICBC from seeking to recover indemnity for a settlement it had paid. Newbury, J.A. concurred with Smith, J.A.. Accordingly, it was only Thackray, J.A. who expressly dealt with the bad faith issue.

II. RECENT CASES

Sidhu v. The Wawanesa Mutual Insurance Company, 2011 BCSC 1117

Sidhu, handed down August 17, 2011, is certainly the most significant recent BC decision considering bad faith. The case involved a fire at the insured's residence. The family were home at the time of the fire. There were a number of unusual features in *Sidhu*, as follows:

1. Issues of coverage and bad faith were considered at one trial. This is very unusual for a British Columbia bad faith case (a point considered in more detail below under the heading "Bifurcation"). There was apparently no application to sever coverage and bad faith. This is presumably on the basis that no evidence concerning legal advice was led at trial.

2. It was common ground that the fire was arson. Again, this is very unusual for a first party bad faith case involving an allegation of arson. The only issue in *Sidhu* was whether the insured was implicated in the arson.

3. The investigation which resulted in a charge of arson was not primarily the insurer's. The fire department conducted an independent investigation and concluded that the fire was arson.

The facts of the case are reasonably straightforward. The initial investigation proceeded promptly. The fire department conducted the primary investigation. That investigation concluded that there was evidence of accelerants outside the house. The investigation also determined that there were accelerants inside the house. The insurer appointed its own investigator. There were meetings with the insured.

Within a few months of the fire there was an internal "round table" at Wawanesa involving some more senior personnel. The result of the "round table" was that there would be some further investigation before a decision was made as to whether to deny cover.

For some reason, this did not happen. It is not entirely clear why from the decision. But the fact is that the investigation was not concluded.

In the meantime, the insured purchased another house, and appears to have waited patiently for a response from the insurer. Eventually, when no response came, the insured commenced an action. The insurer's response, after becoming aware of the action, was a denial of the claim, through counsel, on grounds of arson by the insured.

Armstrong J. found that there was not sufficient evidence to implicate the insured in the arson. The finding was that the arson was by unknown persons. Significantly, given the bad faith analysis referred to below, the Court found that the insurer was justified in having "concerns"

about the credibility of the insured (para. 125). In fact, Armstrong J. confirmed the possibility that the insured may have been untruthful with the insurer, but found this was not the case on a balance of probabilities (para. 128).

In that context Armstrong J. considered the insured's bad faith claim. Armstrong J. concluded that "promptness" was the key issue in terms of the bad faith claim (para. 192). The key finding appears to have been the fact that the investigation dragged on for two years without conclusion. Armstrong J. referred to the insured as having been "left in the lurch" (para. 173) for two years.

Armstrong J. found that Wawanesa may well have been entitled to deny cover based on the expert investigations carried out by the fire department and its own investigator. The fact that Wawanesa had intended to conduct a further investigation and failed to do so, was fatal to such a position. The partially completed investigation was evidence of bad faith (para. 177).

Armstrong J. referred to some additional factors which also supported his conclusion that there was bad faith. Armstrong J. referred to the fact that the insurer had failed to provide a proof of loss, as required under the terms of the policy and the *Insurance Act*. This appears to have been a pure oversight by the insurer or the adjuster. There appears to have been no basis to suggest that the proof was intentionally withheld. Nor does it appear a proof was demanded. Armstrong J. does not expressly consider whether there was any prejudice arising from the lack of a proof.

Armstrong J. also referred to the fact that the denial letter referred to above from counsel for the insurer was "accusatory" in its tone (para. 168). Armstrong J. was clearly concerned by the 'tone' of the insurer's denial letter.

Punitive damages in the amount of $50,000 were awarded. In setting this figure the Court referred to the level of conduct, which rose to blameworthiness, but which did not require a "large penalty to reflect the denunciation required" (para. 192). The Court also referred to the measure of actual loss and calculated the punitive damages at just under 50% of the known loss (certain elements of the loss remained to be determined).

Sidhu is a significant case and a warning to insurers in terms of the level of conduct that can give rise to punitive damages. The facts relied on by the Court in *Sidhu* lay in miscommunication and are undoubtedly evidence of poor claims handling. The fact that the investigation went unfinished for a lengthy period of time is obviously evidence of an investigation falling below the standard of good claims handling practice. The question is whether that conduct should support a claim of punitive damages.

On a related point, *Sidhu* is significant in awarding punitive damages for bad faith in an arson case in which there was an independent third party investigation, not primarily conducted by the insurer. Consider prior cases in which punitive damages have been awarded following an unwarranted allegation of arson. In cases such as *Whiten v. Pilot* [2002], 1 S.C.R. 595 and *Khazzaka v. Commercial Union Insurance Co. of Canada* (2002), 43 C.C.L.I. (3d) 90

(Ont. C.A.) the insurers doggedly pursued arson investigations in the face of overwhelming objective evidence to the contrary and independent investigations which discounted the possibility of arson. Those cases are a far cry from the facts in *Sidhu*.

There are prior cases where the investigation was independent but nonetheless give rise to a finding of bad faith. Thus, in *Cornhill Insurance plc v. Bay Bull Sea Products Ltd.*, 2006 NLCA 56; 41 C.C.L.I. (4th) 163 there was an allegation of arson by two groups of insurers following destruction by fire of a fish processing plant. Insurers under the building and equipment policy abandoned the arson defence before trial. Insurers under the stock policy maintained the arson defence to trial. In that case the arson defence had been carried out primarily by the RCMP and the primary experts and investigators were retained by the RCMP and the fire commissioner. The Court nonetheless found a breach of obligation of good faith of both groups of insurers in maintaining the arson defence on the grounds that the insurers could not "hide behind the actions of the RCMP and the fire commissioner and avoid their duty" (para. 160). The Court found that the investigation was "seriously flawed". Insurers had failed to conduct a reasonable investigation and evaluation of the claim by "readily buying into the investigator's view that there had been arson" (para. 157). However, the Court found that the insurers' conduct did not justify an award of punitive damages. The trial judge did award solicitor-client costs, essentially as a remedy for the bad faith conduct of insurers. That finding was upheld on appeal with regard to the stock insurers, but overturned with regard to the building and equipment insurers. Thus, while there was a finding of bad faith, there were no damages, and no remedy at all against one of the two groups of insurers.

In *Sagl* (discussed in detail below), a finding of bad faith on the basis of a largely independent investigation was made at the first trial, but not at the second trial.

By awarding punitive damages where there has been an independent finding of arson *Sidhu* arguably lowers the bar in terms of conduct that may be found to support a finding of bad faith.

Another interesting aspect of the decision in *Sidhu* is the Court's reference to the "round table" meeting at Wawanesa. This was a meeting at Wawanesa to consider the insured's claim in March 2005, about six weeks after the fire. The Court referred to the round table negatively, pointing out the lack of information, or correct information, in the possession of Wawanesa's claims executives. The Court also referred to the fact that the intention, at conclusion of the round table, was to carry out a further investigation, which was not done. The issue of round tabling has been referred to in a number of US cases, but has received little attention in Canada. From the insurer's perspective "round tabling" is seen as a salutary practice which improves claims handling and decision making by bringing to bear all of the insurer's expertise. However, this is not always the case.

A glaring example of a situation in which "round tabling" worked against the insurer was *Merrick v. Paul Revere Life Insurance Co.*, 594 F.Supp. 2d 1168 (D.Nev. 2008) at 1170-71. In that case the insurers' policy was to destroy all records of the round tables, including the identity of those attending, subjects discussed, and the basis for any decision reached at the round table.

The issue of "round tables" was considered in a recent article, Richmond, "Defining and Confining Institutional Bad Faith Insurance" 46 Tort Trial and Insurance Practice Law Journal 1 (Fall 2010). Richmond[2] states:

> From the insurers' perspective, round tables serve to focus its claim department's collective expertise in serious claims. To the insurer, round tables are a sound business practice that balances legitimate cost concerns with policyholders' expectations. If anything, round tables ensure that claims are not *under*-valued. But for plaintiffs alleging institutional bad faith, round tables are intended solely to maximize the insurer's profit at the insured's expense. In plaintiffs' eyes, round tables frustrate individual adjuster's efforts to pay legitimate claims by conjuring up ways to cheat insureds and lowball innocent third parties.

The insurer has appealed the decision in *Sidhu*.

***Sagl v. Chubb Insurance Co. of Canada,* 2011 ONSC 5233**

The lengthy saga of *Sagl v. Chubb* recently came to an end. Reasons for judgment on the second trial were handed down September 8, 2011.

Ms. Sagl was insured under a Chubb high net worth homeowner's policy. Not long after the policy was taken out the residence was destroyed by fire. The residence was a veritable museum, stuffed with sculptures and paintings by well known artists, with a value of several million dollars. Chubb denied the claim on grounds of arson. Chubb also sought to void the policy for misrepresentation and failure to disclose and alleged fraud in the making of the claim.

The matter first went to trial in 2007 ((2007), 54 C.C.L.I. (4^{th}) 236). The first trial, dealing with both coverage and bad faith, was heard in 2007 and reasons were handed down September 2007. The manner in which the trial judge, B.P. Wright J., dealt with Sagl's bad faith claim was significant.

There were multiple aspects to Sagl's bad faith claim.

The claim was based, in part, on alleged failure to conduct a reasonable and unbiased investigation into the arson claim. As noted above, the primary investigation was not Chubb's, but was conducted by the fire commissioner and, to some extent, the police. The fire commissioner was convinced, based on a number of pieces of evidence, that the fire was arson. There was no suggestion that Chubb influenced the fire commissioner's investigation. The bad faith claim against Chubb in connection with the investigation was based largely on the assertion that Chubb might have "looked more closely" at the fire commissioner's investigation (para. 227), and failed to "impartially scrutinize" the investigation, resulting in Chubb approaching the matter with "tunnel vision" (para. 231).

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The trial judge also found evidence of bad faith in Chubb's approach to underwriting of the policy. *Sagl* was quite an unusual case in this respect. The policy was written without any detailed application form. After the loss Chubb alleged that the policy was void for failure to disclose various material facts regarding the insured's financial condition and other matters. The trial judge found that Chubb had waived the right to further inquiries on the matters in issue by not asking any questions at the time the policy was taken out. But the trial judge went further and found that this practice of "post claims underwriting" (not a phrase used by the trial judge) was evidence of bad faith.

In the result, Sagl was awarded $500,000 in punitive damages.

Chubb appealed and in the course of the appeal abandoned the arson allegation. Accordingly, by the time the matter went to the Court of Appeal the key issues were the finding of bad faith and Chubb's position that there was fraud in the making of the claim.

The Court of Appeal found that the trial judge had not adequately dealt with the allegation of fraud in the making of the claim and ordered a new trial on that issue. The issue of bad faith and any damages arising from bad faith were also remitted to the second trial.

The second trial proceeded in May and June 2011 and reasons were handed down September 8. Marrocco J. at the second trial dealt with the allegations of bad faith both in connection with the arson allegation and other aspects of the investigation.

With regard to the arson allegation Marrocco J. simply reached a different conclusion on the evidence than Wright J. Marrocco J. referred to the fact that Chubb may well have "reasonably believed" that the fire was arson (see, for example, para. 284). There are no detailed findings on this point. Marrocco J. found that, because the investigation was an independent investigation by the fire commissioner, Chubb was entitled to rely on that investigation. No evidence was called at the second trial on the arson issues. Accordingly, Marrocco J. reached a decision on this point considering exactly the same evidence as that which was before Wright J. at the first trial.

Marrocco J. also considered arguments concerning the investigation into values. Marrocco J. was very critical of some aspects of the investigation, including failure to disclose to Sagl certain key documents and facts, either in the context of the claim under the policy or the litigation. The most significant evidence here was a memorandum of a meeting between insurer's representatives and an art dealer who had sold some pieces to Ms. Sagl, which had not been disclosed and the existence of which was discovered only during cross examination of one of Chubb's witnesses. The memo was then ordered disclosed. The facts set out in the memo directly contradicted certain positions taken by Chubb. While critical of the insurer on this point, Marrocco J. found that this did not support an award of punitive damages. Marrocco J. held that the 'remedy' for this conduct was essentially to make assumptions in favour of the insured as to ownership or value of the pieces in question.

Marrocco J. also found that Chubb "abused its right" to conduct examinations under oath of Ms. Sagl. There were numerous such examinations. This did not support a finding of bad faith however, at least in part, as Ms. Sagl was competently represented and could have objected to the continuing examinations.

Marrocco J. was also very critical of Chubb's handling of the fire scene, noting that there was no proper inventory of materials removed from the site. Given the allegation of fraud in the making of the claim and the dispute over what artworks were actually in the house at the time of the fire, this was obviously a significant issue.

Essentially, Marrocco J. found that Chubb's conduct, while deserving of criticism, did not rise to the standard necessary to award punitive damages.

Neither side has appealed.

The *Sagl* case sounds a somewhat more cautious note in terms of the circumstances in which bad faith will be found and punitive damages will be awarded. Many cases stand for the proposition that the insurer is not exposed to a claim for punitive damages simply because a denial turns out, in hindsight, to be incorrect. *Sagl* shows that, even where the insurer engages in conduct which can, in certain respects, be subject of harsh criticism, this will not necessarily result in a finding of punitive damages. *Sagl* indicates that there is a wide gap between the standard of a proper, thorough and diligent investigation, and one which falls so far below that standard that it attracts a finding of bad faith and punitive damages.

***Kings Mutual Insurance Co. v. Ackerman*, 2010 NSCA 39; 84 C.C.L.I. (4th) 1**

Kings is another fairly recent significant case, handed down by the Nova Scotia Court of Appeal in May 2010. *Kings* is particularly significant in that it involves an allegation of bad faith in a first party claim without any assertion of dishonesty or policy breach on the part of the insured.

The issue arose under a property policy covering the insured's farming operation. Following hurricane Juan in the fall of 2003 the insured made a claim under the policy for "windstorm" damage to a barn. It was alleged that the hurricane caused structural damage to the barn which required extensive repair.

The insurer retained an adjuster who retained an engineering expert. The engineer inspected the premises promptly and wrote a report concluding that there was no structural damage due to the hurricane. The insured then engaged its own structural engineer who wrote a contrary report. The reports were exchanged. The adjuster arranged for a meeting at the site. All of this occurred promptly and, to this point, the claim appears to have been handled properly.

Matters then started to go sideways.

At some point it was discovered that the insurer had a prior safety inspection report, less than a year before the hurricane, indicating that the barn was then in good condition. This report, by an in-house inspector on behalf of Kings, was never given to the insured. Nor was it given to the insurer's engineer and adjuster. The same inspector issued a second report, in the year following the loss and while the claim was under way, concluding that the barn now needed substantial repairs. Again, this report was not given to the insured, the insurer's engineer or to the adjuster.

By the time the second report was written there was no dispute that the barn required substantial repairs. This was conceded by the insurer's engineer. The only issue was whether the cause of the damage was Hurricane Juan. Given the inspection reports in the insurer's file asserting a cause other than Hurricane Juan would obviously be extremely problematic.

The insured produced various statements from contractors and other who had worked on the building attesting to the damage and as to the cause. The insurer made no attempt to contact any of them.

The matter went to an 8-day trial on both coverage and bad faith. The compensatory award was $265,000. $55,000 in punitive damages were awarded. The insurer appealed the finding of bad faith. The finding was upheld by the Court of Appeal.

The Court confirmed that the standard necessary to find bad faith and award punitive damages was "overwhelmingly inadequate" handling of the claim (para. 37). The Court found that, in the circumstances, the insurer had a basis to find that the investigation was overwhelmingly inadequate, to find that the insurer had "tunnel vision" and engaged in a "partisan" investigation which ignored relevant evidence and was intended to reach a pre-determined result.

The Court also referred to the phraseology of some of the adjuster's notes and correspondence, which indicated "disdain" for the insured. The adjuster, in his notes and reports, referred to the extent of the costs that the insured must be running up in retaining experts, etc. This was criticized and found to be evidence of the insurer taking "economic advantage" of the insured.

Kings is a significant case. Successful bad faith claims in the context of property insurance, and absent an unwarranted allegation of arson are very rare. For example, in *Spence v. ICBC*, 2005 BCSC 1838 the issue was whether the insured's vehicle was damaged in a collision with a deer, or through some other cause. The Court made express findings the insurer pre-determined cause early and without a proper investigation, was provided with substantial evidence in favour of the insured's theory of causation, all of which was ignored. The Court made an express finding that the insurer failed to assess the claim "objectively and fairly" (para. 21) and that "this investigation, such as it was, appears not to have been calculated to fairly and objectively assess the claim, but rather to support the denial …" (para. 25). The Court expressly found that the insurer failed to meet its duty of good faith. Nonetheless, the Court found that the insurer's conduct was not sufficient to justify an award of punitive damages (para. 39). *Kings* shows that, on the appropriate facts, an allegation of bad faith may succeed in a first party property policy, outside the context of a finding of arson or other misconduct of the part of the insured.

***Wilson v. Saskatchewan Government Insurance*, 2010 SKQB 211; 87 C.C.L.I. (4th) 65**

Wilson involved a claim for rehabilitation benefits arising out of two motor vehicle accidents in the mid 1990s. SGI paid benefits to the insured until 2006. In 2006, a new examiner took over the file. The examiner requested an opinion from a physiotherapist as to whether the insured's ongoing problems were related to the motor vehicle accident, or were the result of a pre-existing condition (para. 25). The examiner did not ask the physiotherapist to address the specific issue required to be addressed by the applicable statutory provisions, namely whether the treatment program then in effect was "necessary or advisable" to contribute to rehabilitation or lessen the insured's disability caused by the accident. The physiotherapist, nonetheless, considered that the ongoing treatment was not beneficial (para. 126). The Court noted that this single opinion was contrary to every other opinion that had been obtained with regard to the insured's claim over the years. This included opinions previously obtained by SGI. Nonetheless, in reliance on the new physiotherapist opinion, SGI terminated benefits. The Court noted that this was done without any consultation with the insured and without consideration of the other opinions obtained on the file.

Following the denial, the insured's counsel wrote a number of times asking for reinstatement and withdrawal of the termination. SGI gave no response whatsoever to these "repeated requests" (para. 128).

The insured sued. After the proceedings were underway SGI determined that the withdrawal of benefits was not sustainable. However, SGI (through its counsel) made its offer to reinstate benefits condition on the insured dropping her action, including a claim for aggravated damages and solicitor-client costs. That offer was not accepted and the case went to trial.

In those circumstances, the Court found that SGI breached its duty of good faith. The Court found that the examiner "misconstrued the purpose" of the investigation (para. 130). On that point, the Court quoted from Hilliker, *Insurance Bad Faith* (2004) at p. 34 to the effect that the insurer's role "is not to look for a putative basis to deny the claim and, having found one, to then abandon the investigation and leave it to the insured to present evidence to the contrary". The Court found that the examiner was "looking for a basis" to deny the claim (para. 130). The insurer failed to consider other available evidence, and relied on only a single opinion in the face of the other medical evidence. The insurer failed to interview the insured or ask other medical practitioners who had been involved in the file for their input. In those circumstances, the Court found that the insurer did not investigate and assess the claim on objective and proper grounds and with due diligence.

After the initial wrongful denial, SGI did not respond in a timely way, placed unwarranted conditions on reinstatement of the benefits and declined to pay undisputed portions of the claim.

Wilson involves a veritable catalogue of the factors that can be found to give rise to first party bad faith, rolled into one case. The award of punitive damages, however, was not large. The Court awarded only $7,500 in 'pure' punitive damages. This may be explained, in part, by the fact that the Court also awarded indemnity for legal fees incurred up to the date of

commencement of the action. Indemnity for these legal fees was expressly awarded as an element of the punitive damages award (making the total award $15,000). Characterizing indemnity for those costs as punitive damages was arguably an error, given the fact that punitive damages are not intended to be compensatory. However, indemnity for those costs presumably could have been awarded as special damages as a result of the insurer's bad faith. The Court also awarded solicitor-client costs for the action, in part on the basis that SGI's bad faith conduct continued throughout the litigation, with SGI having "attempted to instruct and impede" certain evidence being presented (para. 148) and essentially being uncooperative in the process.

III. MISCELLANEOUS ISSUES

1. Bifurcation

In What Circumstances Will Bifurcation be Ordered?

The issue of bifurcation in bad faith claims continues to generate cases. Cases out of BC reach a different result than cases out of Ontario and some other provinces. While there are arguably differences in the underlying rules and statutory provisions which could justify this result, the difference in treatment of these cases is stark. The issue may wind up in front of the Supreme Court of Canada at some point.

The relevant Rule of Court in British Columbia is Rule 22-5:

> (1) Subject to subrule (6), a person, whether claiming in the same or different capacities, may join several claims in the same proceeding.
>
> …
>
> (6) If a joinder of several claims or parties in a proceeding may unduly complicate or delay the trial or hearing of the proceeding or is otherwise inconvenient, the court may order separate trials or hearings or make any order it considers will further the object of these Supreme Court Civil Rules.

The leading case in British Columbia is *Wonderful Ventures Ltd. v. Maylam*, 2001 BCSC 775; 31 C.C.L.I. (3d) 298. The plaintiff owned a house in Whistler which was destroyed by fire. In the course of investigating the fire the insurer, Canadian Northern Shield Insurance Company ("CNS"), determined that the property had been used for commercial, not residential, purposes. CNS voided the policy and declined coverage. The plaintiff filed an action against CNS for coverage and breach of duty of good faith.

CNS applied to sever the bad faith claim as prejudicial, resulting from it being forced to disclose what would otherwise be privileged communications in the trial of the coverage claim in order to defend itself properly against the bad faith claim. The plaintiff opposed bifurcation of the claim on the grounds of delay, economic expense, multiplicity of proceedings (including pre-trial procedures), duplication of evidence, potential for inconsistent findings of fact and also that the two claims were inextricably linked.

Garson J. found that the protection of privileged communications was fundamental to the legal system and should not be interfered with lightly. If the action proceeded with both claims being heard at the same time, CNS could well be in the position of having to disclose its privileged legal opinions regarding its denial of coverage in order to defend effectively against the bad faith claim (p. 325). The two grounds of defence being advanced by CNS in the contract claim were that the use of the premises was mis-described on the application and that the dwelling was being used for business purposes at the time of the loss and was therefore excluded from coverage. Garson J. took note of the evidence of CNS that it had obtained legal advice in respect to those grounds of defence, and held(p. 326):

> …In my view, the subject matter of the legal advice is the very issue that is before the court. CNS should not be put in a position of defending the contract claim, which it would apparently do, on the basis set out in the Statement of Defence, and at the same time having to disclose the legal opinions which it obtained on those very same defences. The amended Statement of Claim does not limit allegations of bad faith to conduct of CNS to the May 29, 1998, denial of coverage, but alleges bad faith over the course of the continued subsequent handling of the claim. Therefore legal opinions subsequent to May 29, 1998, would similarly be evidence that CNS might wish to rely upon in defending against the bad faith claim, but also at risk to its defence against the contract claim.

Garson J. reviewed several U.S. authorities which found that a bad faith claim should not proceed until the underlying contract action was completed, and held (p. 327):

> I am satisfied based on the material before me, that there are privileged communications in the files of Mr. Goepel and CNS, which CNS ought not to be in a position of having to disclose in the defence of the contract claim.
>
> I find that the prejudice to CNS of having the contract claim and the bad faith claim tried together overrides any inconvenience, cost or expense which may be suffered by Wonderful Ventures as a result of my severing paragraphs 67 to 70 of the Amended Statement of Claim. As noted in *R. v. McClure* (*supra*) the protection of privileged communications is fundamental to the legal system and in my view should not be interfered with lightly.
>
> If there is any prejudice to Wonderful Ventures that would arise from having two trials, it is on balance less significant than the prejudice to CNS in having to disclose privileged communications. With severance, if Wonderful Ventures does not succeed on the contract claimed, there will be no subsequent trial on the bad faith claim. If Wonderful Ventures succeeds on the contract claim, it will recover the insurance moneys found due under the contract, and possibly, damages. Wonderful Ventures will not have to await the outcome of the subsequent bad faith trial before being made whole, at least in respect to pecuniary losses.

Garson J. ordered that the claim be severed, and further ordered that discovery regarding the bad faith portion of the claim be delayed until the conclusion of the trial of the contract claim.

Wonderful Ventures has been followed several times in British Columbia.

Lawrence v. Insurance Corp. of British Columbia, 2001 BCSC 1530, 34 C.C.L.I. (3d) 99 involved a claim for payment of benefits under Part VII of the *Insurance Motor Vehicle Act* and damages for breach of the duty of good faith. The plaintiff applied for production of documents relating to the bad faith portion of the claim and ICBC brought a cross-application for severance

of that portion of the claim. ICBC also applied for an order that production of any documents relating to the bad faith claim be stayed until there was a determination of the Part VII claim.

Taylor J. noted that the advancement of the bad faith claim would be complicated and lengthy, and would involve an examination of a vast amount of documents that would otherwise be protected by solicitor-client privilege. Taylor J. noted the decision of the SCC in *R. v. McClure* that solicitor-client privilege was a fundamental right. Taylor J. also referred to *Whiten v. Pilot* and noted that counsel who advanced the bad faith case could have to be difference from those who dealt with the Part VII benefits claim (p. 105).

Taylor J. found that the claim for bad faith was an ongoing claim until it was determined whether the plaintiff was entitled to benefits at which point the claim for bad faith crystallized (p. 105). Regarding the defendant's submission that it would be prejudiced if the two claims were heard together, Taylor J. held (p. 105):

> In my view, there is merit to the submission of prejudice if these claims remained joined. This is because the respect of the concept of solicitor/client privilege is fundamental to the proper conduct of litigation. The disclosure of matters within solicitor/client privilege will unquestionably affect the nature of the action in this case.
>
> There is a further consideration in terms of efficiency and economics. If the two claims remain joined and the plaintiff does not succeed in her Part VII action, then the bad faith action cannot succeed. By that point in time, given counsels' concession that the latter action will be long and complex, much time will have been spent for naught since the resolution of the entitlement claim would have involved a fraction of the time and process required for the bad faith claim.
>
> Further, should the plaintiff fail in her application, she would be at risk for substantial costs. If the plaintiff succeeds in her Part VII action, she will only recover, after much delay, the benefits that the Court concludes she is entitled to albeit she might succeed in the bad faith action. Her financial need, especially because of the passage of time since July 2000, needs to be resolved sooner rather than later.
>
> Any success in the Part VII action would not impair the quality of the bad faith claim. As I have previously observed, an early successful resolution of the Part VII benefits argument will limit the damages assessed in the bad faith claim to those arising up to the resolution of the benefits claim.

Taylor J. also observed that if the plaintiff was unsuccessful in her entitlement claim then the bad faith claim would not go forward, but if she was successful on coverage she would then be able to pursue the bad faith claim (p. 106). Taylor J. adopted paragraph 34 of Garson J.'s judgment in *Wonderful* Ventures, *supra*, and concluded there should be severance of the Part VII benefits claim and the bad faith claim, with the Part VII benefits claim being determined first. Following on that, Taylor J. held that production of all documents relating to the bad faith claim would be stayed until the plaintiff's entitlement to benefits was determined (p. 107).

Wonderful Ventures and *Lawrence* were cited by Hutchison J. in *Sanders v. Clarica Life Insurance Co.*, 2003 BCSC 403; 47 C.C.L.I. (3d) 285. In *Sanders*, Hutchison J. ordered that a claim for entitlement to disability benefits be severed from a claim for bad faith, and that discovery and production of documents regarding the bad faith claim be stayed until the plaintiff's entitlement to benefits under the insurance policy were determined (para. 10).

Similarly in *Stevens v. Sun Life Assurance Co. of Canada*, 2004 BCSC 468; 9 C.C.L.I. (4th) 245, Allan J. followed the above line of authority to sever a bad faith claim from a coverage claim without any benefits. Allan, J. specifically noted that the test applied in Ontario and Newfoundland was different than the test applied in B.C. as in the former jurisdictions severance was granted only in "exceptional circumstances". Hutchinson J. held that the production of documents and examination for discovery relating to the bad faith claim was stayed until the contractual claim was determined (para. 44), as if the contract claim was resolved in the defendant's favour it would render unnecessary the discovery of all documents relating to the bad faith claim (para. 45).

Another similar case is *Stuart v. Manufacturers Life Insurance Co.,* 2004 BCSC 501; 10 C.C.L.I. (4th) 142, in which Master Groves considered a bifurcation application for the severance of a bad faith claim and a benefits coverage claim. Master Groves reviewed the above case law and found that the cases stood for the general proposition that in this type of claim, concerning both coverage and bad faith under an insurance policy, bifurcation could be considered and ordered through weighing a number of factors (pp. 145-146):

> The factors seem to be as follows:
>
> 1) Would a continuation of the proceeding as one require the breach of privileged communications.
>
> 2) Would the advice of counsel be raised as a defence to the breach of duty of good faith claim. Would counsel essentially have to be a witness.
>
> 3) Is there an allegation of breach of good faith which is alleged to have its origin in post filing of the writ conduct by the defendant.
>
> 4) Would the defendant have to retain new counsel.
>
> 5) Is the delay associated with the bifurcation of significant inconvenience, cost or expense to the plaintiff to outweigh any prejudice that the defendant might suffer, specifically in having to disclose privileged communications.
>
> Frankly, it seems to me that once the post-litigation conduct of the defendant is raised in a claim for damages resulting from a breach of duty of good faith claim, logic suggests that the conduct of counsel and the advice of counsel will likely come into play by the defence.
>
> These cases, in my view, stand for the proposition that in balancing the prejudice considerable weight must be given to the very real danger that a breach of confidential communication between client and counsel could result if the case is continued to be tried as one.
>
> The end result, in my view, these cases suggest that the plaintiff, perhaps unfortunately, has a considerable hill to climb to tip the prejudicial balance in his favour.

Master Groves ordered that the proceedings be bifurcated, as all of the factors favoured the defendant (pp. 147-148).

These authorities have also been applied in the case of a property policy; see *Kursar v. BCCA Insurance Corp.*, 2004 BCSC 1006; 17 C.C.L.I. (4th) 65. In *Kursar* the plaintiff made a claim for theft of property which was denied by the insurer. The insurer cross-claimed for return of

monies previously paid out to the plaintiff. Crawford J., following *Wonderful Ventures, supra*, severed the bad faith claim and stayed the proceedings regarding that portion of the claim until the end of the coverage claim and cross-claim were heard (para. 25). Crawford J. did take note of the likelihood (which is also noted in some of the above cases), that the failure to sever the bad faith claim would result in the trial date being lost (para. 21).

The relevant Rule of Civil Procedure in Ontario is Rule 5.05:

> 5.05 Where it appears that the joinder of multiple claims or parties in the same proceeding may unduly complicate or delay the hearing or cause undue prejudice to a party, the court may,
>
> (a) order separate hearings…
>
> …or
>
> (e) make such other order as is just.

The leading case in Ontario is *Sempecos v. State Farm Fire and Casualty Co.*, [2001] O.J. No. 4887 (S.C.J.). The coverage claim in *Sempecos* arose out of a fire which severely damaged the plaintiffs' residence. The defendant applied for severance of the coverage and bad faith claims under Rule 5.05.

Killeen J. noted the argument of the defendant that prejudice, convenience and fairness were in favour of bifurcating the proceeding, and the argument of the plaintiffs that they had the right to one complete trial and severance should only be ordered in the clearest of cases. Killeen J. referred to some older Ontario cases as well as *Wonderful Ventures, supra*, which Killeen J. noted was factually very similar to the case at bar. Killeen J. also noted that the relevant B.C. rule was substantially similar to the relevant Ontario rule. Regarding Garson J.'s judgment in *Wonderful Ventures*, Killeen J. held (para. 35):

> With great respect, I believe that Garson J. has overemphasized the significance of the privileged communications principle within the framework of this kind of action and motion and I choose not to follow her ruling.

Killeen J. then referred to *Whiten v. Pilot* as also being remarkably similar to the case at bar, and cited its finding that breach by an insurer of its obligation to act in good faith constituted an independent wrong and probably an independent tort. Killeen J. found (para. 37):

> The unavoidable by-product of this paradigm shift in the substantive law regarding claims against insurers is that, now, otherwise privileged communications, including client/solicitor communications, become potentially relevant and admissible in these cases.

Killeen J. held that the defendant had failed to mount a clear case for severance, in particular as the jury would be able to address the issues put before it impartially and fairly even if that included privileged communications (paras. 39-43).

Sempecos was followed in *SNC-Lavalin Engineers & Constructors Inc. v. Citadel General Assurance Co.* (2003), 46 C.C.L.I. (3d) 281 (Master). The claim in *SNC-Lavalin* arose from the

costs of repairing a defective reservoir in a gold mine in Peru under a wrap-up liability insurance policy.

Master Dash reviewed several Ontario cases where issues of liability were severed from issues of damages and found those cases were specific to their facts. Master Dash took note of several U.S. decisions and the decision of Garson J. in *Wonderful Ventures*, *supra* and also referred to *Sempecos*, *supra*. Master Dash found that although *Sempecos* involved a fire loss there were many similarities to the case at bar (p. 294):

> *Sampecos* [sic] is binding authority on me for the principle that in Ontario there should be no automatic bifurcation of the bad faith claims from first party coverage claims, and that normally coverage and bad faith claims should be tried together. Even if it were not binding I would adopt its reasoning which I find persuasive…

Master Dash also referred a number of factors set out in an Ontario case which he had adapted to considering bifurcation of coverage and bad faith rather than bifurcation of liability and damages, and Master Dash held they confirmed there should be no bifurcation in *SNC-Lavalin* (pp. 294-295).

In Newfoundland it appears that the *Sempecos*, *supra,* approach is favoured (see *Lundrigan v. Non-Marine Underwriters, Lloyd's London* (2002), 36 C.C.L.I. (3d) 263 (S.C.)) and in Alberta and Prince Edward Island the *Wonderful Ventures, supra,* approach appears to be favoured (see *Sovereign General Insurance Co. v. Tanar Industries Ltd.*, 2002 ABQB 101, 36 C.C.L.I. (3d) 225 and *Collings v. Prince Edward Island Mutual Insurance Co.*, 2003 PESCTD 104; 9 C.C.L.I. (4^{th}) 138.

Recent Cases

A number of recent BC decisions have focused on attempt to "get around" the privilege barrier to permit a combined trial on coverage and bad faith. Those attempts have been largely unsuccessful.

In *Rehmat v. Transamerica Life Canada*, 2009 BCSC 495 McEwan J. had to consider a motion to strike a jury notice and an application to bifurcate a coverage action from a bad faith claim. McEwan J. referred to the two lines of authority. After referring to the Ontario authority, McEwan J. found that he was bound by the decision in *Wonderful Ventures*.

McEwan J. noted the fact that the insurer had filed a "very brief" affidavit from the insurer's solicitor (para. 29) to the effect that the solicitor believed it would be necessary to reveal "confidential communications" in defence of the bad faith claim. The insured asserted that this evidence was insufficient. The insured argued there must be some level of specificity as to the nature of the advice and the privilege that would be breached. McEwan J. rejected that argument, stating that it brought matters "full circle". In other words, to require the insurer to reveal the nature of the advice and the details of the advice would itself potentially breach privilege.

Contrast this with *Wonderful Ventures*. There, the evidence was to the effect that the insurer had an investigator's report and that there had been advice on coverage in connection with the report from trial counsel. Trial counsel had direct dealings with the investigator. It might well be necessary that trial counsel be a witness at the bad faith portion of the trial, which would require trial counsel to resign if the bifurcation order were not granted.

In *Cort v. ICBC*, 2011 BCSC 586, the insured brought a bad faith claim in conjunction with a first party vehicle fire loss claim. The Court noted that the evidence was "less compelling" than that in *Wonderful Ventures*. There was simply evidence that the adjuster discussed the claim with counsel retained to conduct an examination under oath and trial counsel and that certain otherwise privileged documents may exist. The Court referred to the evidentiary basis for the order sought as "underwhelming". Nonetheless, the Court decided in favour of bifurcation. The Court accepted that it would be necessary to at least call some evidence from adjusters, investigators and possibly counsel at the bad faith portion of the claim, and that some of this may be privileged. The Court also found that it may be more efficient to try the claims separately on the grounds that if there were no coverage, the bad faith claim would "disappear".

Another aspect of the privilege issue was raised recently in *Brennand v. Sun Life Assurance Co. of Canada*, 2011 BCSC 759. That case concerned claims of bad faith and coverage under a disability policy. The insured amended its claim to limit the allegation of bad faith to a particular time period in order to insulate the matter from any claim of solicitor-client privilege. Essentially the inured argued that, as the only claim of bad faith related to a time prior to retainer of counsel, there could be no privilege issue. The Court found however that this was not the end of the matter (para. 36). The insurer asserted that it may have to rely, at the bad faith portion of the trial, on legal advice it received concerning drafting of the policy terms at issue. Thus, despite the fact that no legal advice concerning handling of the insured's claim could potentially be in dispute, there was still the prospect of a need to waive solicitor-client privilege, so as to justify severance.

The Court in *Brennand* also referred to the fact that there would be little in the way of overlapping evidence. On the entitlement claim, the issue would be whether the insured was "disabled" within the meaning of that term in the policy, whereas at the second trial, evidence concerning handling of the claim, the insurer's understanding of the policy and other matters would have to be led. While there might be some overlapping evidence, there was not a material risk of inconsistent findings of fact or an inconsistent verdict. It would be taken as a given in the second trial that the insured was disabled and contractually entitled to benefits. While severance might delay the ultimate resolution, there was also the prospect that severance would shorten the litigation process and render it less time consuming, if the plaintiff should fail to establish entitlement (para. 48).

The Court also referred to the fact that *Brennand* involved "institutional" bad faith type claims.[3] To allow the bad faith claim to proceed "would result in an expansive, time-consuming, expensive, intrusive and potentially irrelevant discovery process" (para. 53). The Court noted

[3] This phrase was not used by the Court. Institutional bad faith claims are referred to below.

that the bad faith as pleaded did not put in issue only this particular policy and the way it has been interpreted, but any other policies containing the same term or policies dealing with the same type of disability. This would put into issue the insurer's "internal practices and policies, as well as the administrative of hundreds if not thousands of other claims" (para 53).

This is consistent with treatment of the bifurcation issue in earlier institutional bad faith claims. *Stevens v. Sun Life Assurance Co. of Canada*, 2004 BCSC 468; 9 C.C.L.I. (4th) 245 is an example of an earlier "institutional" bad faith claim in which the scope of document production would have been truly massive. Also, in *Ennis v. RBC Life Insurance Co.*, 2007 BCSC 1131; 53 C.C.L.I. (4th) 270, the Court considered an application to bifurcate in the context of an institutional bad faith claim. The insured sought an order for production of all documents concerning the insurer's "bonus plan or performance bonuses paid to the adjudicators" (para. 2). The Court referred to *Stevens v. Sun Life* (*supra*), in dismissing the documents application and granting the insurer's cross application for severance, with production of documents on the bad faith issue to be postponed following determination of entitlement.

2. Costs

Making an unsustained allegation of bad faith, even one which "had little merit" does not justify an award of special costs, along the lines of costs that may be awarded where there is an unsupported allegation of fraud. In *More Marine Ltd. v. Axa Pacific Insurance Co.*, 2010 BCSC 88; 88 C.C.L.I. (4th) 129, the Court found, notwithstanding the making of unsustained allegations of bad faith, that an award of special costs should not be made.

3. Applicable Limitation Period

In *Whorpole Estate v. Echelon General Insurance Co.*, 2011 ONSC 2234, the Court confirmed that the limitation period in an action for bad faith is a separate and independent limitation period from that which runs in terms of indemnity under the policy. The case involved an "own damage" claim under a motor vehicle policy. The limitation with regard to the basic coverage claim was one year and ran from the date of the accident. Accordingly (subject to an estoppel argument) the limitation had run. The Court found, however, that the limitation period with regard to the bad faith claim was two years and would only have been triggered at a later date when the conduct in question occurred. That conduct included the dumping by the adjuster of the "blood-stained wreck" of the insured's vehicle in the insured's driveway after the claim was concluded.

4. Dismissal of Bad Faith Claim Before Trial

There are not many instances of a bad faith claim being dismissed before trial, particularly where the underlying coverage claim is permitted to continue. However, that can happen in an appropriate case. In *Wadhwani v. State Farm Mutual Automobile Insurance Company*, 2010 ONSC 2479; 86 C.C.L.I. (4th) 288, the Court permitted certain aspects of the insured's disability claim to continue. However, the Court dismissed the bad faith claim on the insurer's summary

judgment motion on a finding that the evidence in support of the claim was "too thin" (para. 77). Insurer denials were based on medical opinions and the Court was prepared to find, on the facts as set out in the affidavits, that there was "no misconduct" on the part of the insurer.

5. Quantum of Damages

Quantum of damages awarded in bad faith claims continue to cover a wide range. *Whiten v. Pilot* remains the high water mark, with a $1 million punitive damages award. Recent cases such as *Sagl* (no punitive damages award in the face of conduct heavily criticized by the Court) and *Wilson* (punitive damages of $7,500) show that US-style runaway punitive damages awards have certainly not come to pass.

It remains difficult to assess the quantum of damages likely to be awarded in any particular case.

One decision which gave fairly detailed consideration to damages principles in a case involving claims of both punitive and aggravated damages is *Plester v. Wawanesa Mutual Insurance Co.* (2006), 39 C.C.L.I. (4th) 44. There the Court of Appeal considered an appeal from a jury verdict in a case involving an unwarranted allegation of arson. The total compensatory damages were approximately $500,000. In addition the jury awarded aggravated damages to two plaintiffs in the amount of $175,000 and punitive damages totalling $450,000, for a total verdict of approximately $1.2 million.

The Court noted that aggravated damages are compensatory. They must be based on a finding that the defendant's actions were motivated by actual malice, and on such matters as causing mental distress and humiliation for the plaintiff. The Court found that the unwarranted allegation of arson, which became publicly known, could support an award of aggravated damages. However, the Court found that the award of $175,000 was "grossly excessive" (para. 66) and reduced the award to $50,000.

The award of punitive damages, on the other hand, was upheld. The Court noted that the award was at the "high end" of the range and higher than the amount the Court would have awarded, but was not an award with which the Court would interfere (para. 103).

6. Institutional Bad Faith

One question that arises from time to time is whether Canada will ever see institutional bad faith claims of the kind that have proliferated in the US. An example of this sort of decision in the US is *Merrick v. Paul Revere Life Insurance Co.*, 594 F.Supp. 2d 1168 (D.Nev. 2008). *Merrick* follows and expands on earlier cases involving Unum-Providence/Paul Revere finding institutional bad faith in various corporate practices, including the following:

1. A procedure to target "subjective claims" which included a practice of attempting to extract low settlements based on "vulnerability of insureds to pressure tactics".

2. The practice of imposing "claim objectification" and imposing "objective evidence requirements" on insureds.

3. The use of "round table reviews", combined with an intentional practice of destroying all records of such meetings (and attempting to "cloak the round table discussions with the attorney-client privilege").

4. The practice of shifting "the burden of claims investigation to the insured" and instructions to limit the use of IME's.

5. The practice of heavy reliance on in-house medical personnel who never examine the insured and a practice of preferring those opinions of either treating physicians or IME physicians.

6. The practice by in-house medical personnel of "cheery picking records" to find grounds for denial.

7. The setting of "targets and goals for claim terminations to obtain financial gain and without respect to claim merit". This included evidence that claims units were required to meet certain net termination ratio targets and develop action plans if those targets were not met on a weekly basis.

There has, to date, been little in the way of attempted institutional bad faith litigation in Canada. Whether that situation continues remains to be seen. Attempted institutional bad faith claims to date have been remarkably unsuccessful. For example, in *Chaplin v. Sun Life Assurance Co. of Canada*, 2001 BCSC 310; 27 C.C.L.I. (3d) 70 and 2004 BCSC 116; 7 C.C.L.I. (4th) 277, allegations were made concerning bad faith based on corporate bonuses, compensation plans, and related matters. The claim was not only unsuccessful, but resulted in a substantial award of costs against the plaintiff insured and plaintiff's counsel.