

DENIAL OF COVERAGE UNDER THE INSURANCE POLICY
PAPER 6.1

Denial of Coverage under the Insurance Policy

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I. Introduction

There are probably few areas loaded with as many potential mine fields for counsel as advising insurers on coverage issues—particularly where the possibility of a contested denial exists. This is partly due to developments in the law in this area over the past 20 years. The most significant development is the introduction into Canada of the “bad faith” claim.¹ Insurers’ duty of good faith, and exposure to damages for conduct found to be in bad faith, is now well established. In a few cases, bad faith claims have led to substantial punitive damages awards.² The second, related development is the uncertain state of the law. There are a number of issues on which the law is uncertain, changing and in some cases in outright conflict among provinces. Such issues regularly have to be considered in connection with a denial of coverage as well as the steps that should be taken following a full or partial denial.³

The purpose of this paper is to highlight the key issues in:

1. considering whether, when and how to properly deny a claim;
2. dealing with the potential consequences of an improper denial; and
3. steps that can be taken to minimize the prospect of a bad faith claim or other problematic consequences flowing from an improper denial.

This paper covers both first party and liability policies. The two types of policies are dealt with separately where the relevant considerations differ.

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- 1 As noted in Hilliker, *Insurance Bad Faith*, 2d ed (Toronto: LexisNexis, 2009) at 12, it is only since the 1980s that the concept of insurers’ duty of good faith was first discussed in Canada and “bad faith” claims made, with early cases including *Pelky v. Hudson Bay Insurance Co.* (1981), 35 O.R. (2d) 97 (H.C.J.), *Dillion v. Guardian Insurance Co. of Canada* (1983), 2 C.C.L.I. 227 (H.C.J.), *Fredrikson v. Insurance Corporation of British Columbia* (1990), 42 C.C.L.I. 250 (S.C.), and *Shea v. Manitoba Public Insurance Corp.* (1991), 55 B.C.L.R. (2d) 15 (S.C.).
 - 2 Including, of course, a jury award of \$1 million in punitive damages in *Whiten v. Pilot Insurance*, [2002] 1 S.C.R. 595. For a full discussion of recent Canadian bad faith litigation, see Nigel Kent, *Insurance Bad Faith Litigation: Recent Development and Interesting Issues Arising from The Supreme Court of Canada Decisions in ‘Whiten’ and ‘Fidler’* (Vancouver: CLE Insurance Law Conference, 2007).
 - 3 Some of the issues touched on in this paper include: the scope of “the underlying facts exception” to the “pleadings rule” in connection with assessment of claims; basic questions regarding interpretation of exclusions; and questions concerning the role of defence counsel in defending claims subject to a reservation of rights or non-waiver agreement.

II. The Why, When and How of a Proper Denial

A. Why: Grounds for Denial

The primary grounds on which claims may be denied, under both first party and liability policies, are as follows:

1. claims or losses outside policy cover and/or excluded;
2. pre-loss breach of condition or breach of other duty owed by the insured under the policy (including misrepresentation/failure to disclose);
3. post-loss breach of conditions/breach of other duty by the insured;
4. claim brought or proceedings commenced outside an applicable limitation or notice period; and
5. existence of other insurance alleged to be primary.

Each of these grounds gives rise to somewhat different considerations in terms of how to deal with a denial of cover and its consequences, particularly under liability policies. For example, where the existence of a duty to defend is denied or where rights are reserved on the basis of an exclusion, it should be (subject to some exceptions referred to below) relatively straightforward to have the coverage issue determined promptly. In general, the court only needs to consider the policy language and relevant case law. Where a claim is denied for breach of condition/misrepresentation the situation is different. Except in the simplest cases, a full trial will be required to deal with contested issues of fact. This distinction has significant implications in terms of whether the underlying action will proceed and how it will be handled pending determination of the coverage issues (an issue also dealt with below). The key point here is that the nature of the issue giving rise to the denial is relevant to the proper course of action both in connection with and following the denial.

B. When: Timing Considerations

I. Property/First Party Policies

a. Proof of Loss

The most straight forward timing consideration, of course, is that a first party claim must be responded to within the time set out by statute or under the policy. In BC, in connection with the first party property claims, the proof of loss provisions in the *Insurance Act*, R.S.B.C. 1996, c. 226 will rarely apply. The policy itself, however, will invariably have a period from the filing of the proof of loss within which the claim must be responded to—generally 60 or 90 days.

b. Duty to Act Reasonably Promptly

The insurer has a duty to act reasonably “promptly” in considering first party/property claims.⁴ Unreasonable delay in consideration of the claim and payment under the policy may expose an insurer to liability for damages even in circumstances in which the claim is eventually paid.⁵

4 *Maschke Estate v. Gleeson* (1986), 54 O.R. (2d) 753 (C.A.) (in the context of uninsured/underinsured motorist cover); *Labelle v. Guardian Insurance Company of Canada* (1989), 38 C.C.L.I. 274 (Ont. S.C.J.) (delay in payment of the replacement claim under homeowner’s insurance).

5 See, for example, *Cross v. Canada Life Assurance Co.*, [2002] I.L.R. 1-4044 (Ont. S.C.J.). In that case, there was a lengthy delay in consideration and payment of the claim under a disability policy. A claim for punitive damages was dismissed but a claim for consequential and aggravated damages was allowed.

What constitutes reasonably prompt consideration and handling of the claim will depend on the circumstances, including the complexity and size of the loss. It will also depend, to some degree, on the situation of the insured. The standard will be different as between an insured who faces no prejudice other than delay in receipt of the funds and an insured who faces, say, foreclosure, calling of loans, or potential failure of a business if payment under the policy is not received.

The question of when a first party claim should be denied is therefore subject to competing considerations that must be considered in each case. On one hand, the coverage decision must be reached and communicated to the insured “promptly.” On the other hand, the insurer must undertake a proper investigation which will, in an appropriate case, involve substantial and potentially time consuming investigation into the facts. For example, the nature of the claim may require the insurer to seek engineering, legal and other expert advice before making a decision on coverage.

c. Good Faith Investigation

The Ontario Court of Appeal in *702535 Ontario Inc. v. Non-Marine Underwriters of Lloyd’s London* (2000), 184 D.L.R. (4th) 687 at para. 29 summarized the general duties an insurer has in making its coverage decision as follows:

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. This duty of fairness does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith.

What actions must be undertaken during the course of an investigation to achieve the requisite standard of “reasonableness” will vary on any given claim. While there is no exhaustive checklist, judicial commentary has provided some guidance.

One issue that repeatedly comes up in the cases is the insurer’s duty to maintain objectivity and an open mind in connection with its investigation and assessment of a claim. Where it appears from the court’s review of the investigation that an insurer was looking for ways to deny cover, as opposed to objectively assessing whether or not cover exists, the insurer is at risk of a finding of bad faith or improper denial.

There are many “suspicious fire” cases in which this issue has been considered. *Whiten v. Pilot*, [2002] 1 S.C.R. 595, in which an arson theory was doggedly pursued in the face of overwhelming evidence to the contrary, is an extreme example.⁶ Similarly, in *Khazzaka (c.o.b. E.S.M. Auto Body) v. Commercial Union Assurance Co. of Canada* (1999), 43 C.C.L.I. (3d) 90 (Ont. S.C.J.) at para. 10, aff’d (2002), 43 C.C.L.I. (3d) 90 (Ont. C.A.), the trial judge found that it had been open to the jury to award punitive damages, in part, on the basis that the insurer had only pursued evidence supporting its preconceived notion:

The evidence entitled the jury to find that the defendant’s adjuster, Mr. Laporte, and the fire-cause expert Mr. Szabo, had acted unreasonably and in such a way as to justify the label “bad faith” and some of the other adjectives used in describing conduct worthy of punitive damages, being attached to the defendant’s handling of the plaintiff’s claim for loss. It was, in my view, open to the jury to find that Mr.

6 Whiten is covered in detail in Kent, *Insurance Bad Faith*, *op. cit.*

Laporte, far from being a disinterested, objective adjuster, pursued his search for a suspicious basis for the fire's origin, in the face of the fire fighters' and O.P.P.'s conclusions and on little or no real basis. It was open to them to conclude that Mr. Laporte decided very early that the fire was incendiary, and doggedly pursued that conclusion, ignoring evidence that militated against him. It was open to the jury to find that Mr. Laporte, in a very partisan way, did his best to get the fire fighters and police to change their opinion about the origin of the fire and call in the fire marshal's office. Fire Chief Bennett and Deputy Chief Campbell both told the jury they got the impression that Mr. Laporte was not working in any co-operative way with them in trying to discern the cause of the fire but had concluded that it was incendiary and was looking for evidence on which to base that conclusion. When they explained the probable cause of what appeared a second origin, he ignored their explanation.

Another fire case is *Kogan v. Chubb Insurance Company of Canada* (2001), 27 C.C.L.I. (3d) 16 (Ont. S.C.J.). In *Kogan*, the insurer's arson theory was based on its expert's opinion which had overlooked evidence tending to support the insured's innocence. The Court held at para. 61:

Where the insurer and/or adjuster acts unreasonably by effectively presupposing arson as the cause of the fire and taking steps to fortify this conclusion rather than objectively assessing the evidence in order to draw a reasonable conclusion therefrom, the label of bad faith will be justified and punitive damages should be awarded.

In *Spence v. ICBC*, 2005 BCSC 1838, a non-fire case, the insured's vehicle collided with a deer and, thinking there was no damage, the insured then drove the vehicle a short distance further. The insurer denied the claim on the basis that the engine damage was not the result of the collision. The trial judge found that the insurer's investigation had focused only on acquiring evidence supporting its initial assessment. The insurer was found to have breached its obligation to perform a prompt and complete investigation.

In addition to being objective, the insurer's investigation must be reasonably thorough. For example, in *Evans v. Crown Life Insurance Co.* (1996), 25 B.C.L.R. (3d) 234 (S.C.), the insurer paid benefits under a disability policy for four years. The benefits were paid in reliance on the opinion of the insured's treating physician. The insurer decided to terminate the benefits after its medial director reviewed the insured's file and determined he was employable. The Court found that the insurer had breached its duty to the insured, *inter alia*, because it had failed to interview the insured, her doctor and employer.

d. Legal Advice

Where there is an allegation of bad faith the insurer will often defend on the grounds that the denial was based on legal advice. As has been pointed out by some writers (see Hilliker, *op. cit.*, at 134) legal advice is not, strictly speaking, a defence to a bad faith claim. Nonetheless, the fact that an insurer received and relied on legal advice in connection with a denial of cover is important to the consideration of the reasonableness of the investigation and denial.

In one recent case, the contrary proposition—that an insurer seeking legal advice was potentially evidence of bad faith—was accepted at summary trial, but overturned on appeal. The case is *Pearlman v. American Commerce Insurance Company*, 2008 BCSC 1091 rev'd (2009), 91 B.C.L.R. (4th) 267 (C.A.). There, the insurer had accepted the insured's claim for motor vehicle accident benefits, but asserted that the claim was capped at the limit shown on the face of the policy. The insurer had done so without reference to a PAU it had filed which required provision of no fault benefits equal to those available from ICBC. The insurer subsequently sought legal advice on this issue and, following receipt of that advice, changed its position. On the insurer's summary trial application to dismiss the insured's bad faith claim, the Court referred to the fact that the insurer had sought legal advice as

potentially supporting the insured's claim. The Court of Appeal overturned the summary trial decision. The Court of Appeal declined to find that the insurer having sought or obtained legal advice could be evidence of bad faith.

e. Engineering/Other Professional Advice

An insurer will generally retain adjusters and engineering or other experts in connection with the investigation and assessment of a claim. Retainer of competent and qualified adjusters/experts is an important fact in assessing the investigation, but is not sufficient in and of itself to meet the insurer's duty. As held in *Khazzaka (c.o.b. E.S.M. Auto Body) v. Commercial Union Assurance Co. of Canada* (2002), 43 C.C.L.I. (3d) 90 (Ont. C.A.) at para. 15:

The [insurer] cannot excuse itself by hiring reputable independent agents. They owe no duty to the insured. But the insurer does, and its obligation continues through trial.

In *Cornbill Insurance PLC v. Bay Bulls Sea Products Ltd.* (2006), 41 C.C.L.I. (4th) 164 (N.L.C.A.), the defendant insurers relied, *inter alia*, on investigations performed by the RCMP and the Fire Commissioner in denying a fire loss claim on the basis of arson. At paras. 157, 158 and 162, the Court held:

The trial judge's decision respecting a breach of the duty of good faith, as against both groups of insurers, is grounded primarily on the insurers' handling of the investigation of the fire. Certain points are key: the trial judge's conclusion that the investigation of the fire by the investigators was seriously flawed; his finding that the insurers had not acted promptly; and his conclusion that in readily buying into the investigators' view that there had been arson the insurers had failed to reasonably investigate and evaluate the claim, leading to an unwarranted allegation of arson, one made in the face of insufficient evidence of wrongdoing.

An insurer has a duty to reasonably investigate and evaluate the claim without undue delay. What is reasonable conduct depends on the circumstances of the case. In this case, as the trial judge acknowledged, at least by implication, the presence of the oil filter bowl on the floor of the furnace room was sufficient to make investigation of the cause of the fire, including the possibility of arson, reasonable conduct.

...

In the context of this case while the insurers cannot control the actions of officials, the existence of an official investigation does not relieve them of their duty to act in a timely manner. Further, if they choose to rely on the "official investigation" and that investigation fails to meet the standard required then the insurers cannot separate themselves from that work by saying they did not direct it. Here, the trial judge's findings that the official investigation was "seriously flawed" is supported on the evidence. Further, the delay in appointing independent investigators and raising arson with Sea Products meant that the danger of loss of evidence became a reality. The connection of Mr. Power to the insurance industry made the engagement of an independent investigator all the more critical.

Of course, an expert's investigation is only as good as the information provided. In considering an award for punitive damages in *Asselstine v. Manufacturers Life Insurance Co.* (2003), 1 C.C.L.I. (4th) 271 (B.C.S.C.) at para. 195 aff'd in part (2005), 22 C.C.L.I. (4th) 169 (B.C.C.A.), the Court took a very negative view of the insurer's failure to provide the expert with relevant information:

When Ms. MacInnes asked for an informal, "ad hoc" rehabilitation opinion from Hawthorne to determine whether there were other positions for the plaintiff, based on her education, training, medical history, and experience, many pertinent pieces of information pertaining to Ms. Asselstine, were never sent to Hawthorne; including her description of her medical condition at the relevant time, limitations on her physical and social life, her attending physician's statements and opinions, and her resumé, all of which are crucial to a determination of her suitability for other

positions in light of her condition. To rely so heavily on such a flawed report, the foundation of which was laid by Ms. MacInnes' selective disclosure, in order to reject the plaintiff's claim and appeal, was unfair to the plaintiff, and amounted to a flawed process.

f. Continuing Duty to Reassess

The insurer must, following an initial denial, continue to consider pertinent new information which might cause the insurer to reconsider its denial. A case where an insurer did not revise its initial opinion in the face of subsequently acquired contrary evidence is *Bullock v. Trafalgar Insurance Co. of Canada*, [1996] O.J. No. 2566 (Gen. Div.). In *Bullock*, the insurer's theory, based on the opinion of an engineering expert, was that the insured had deliberately caused his car to ignite by puncturing its fuel line and then accelerating. The Court summarized the insurer's investigation as follows at para. 105:

Mr. Pizzey [the adjuster] was suspicious from the mere fact of an automobile fire. Mr. Pizzey testified that he was relying upon the expertise of Mr. Byers to determine the cause of the fire. When Mr. Byers ascertained that there was a puncture to the fuel line, both he and Mr. Pizzey became fixed upon the view that the puncture was deliberate. Given the location and circumstances of the fire, they viewed the puncture as having been made by Mr. Bullock, or at the very least, at his direction. The fluid drip upon the roadway was inferentially thought to have come from the punctured fuel line. Once they adopted this position, they and Trafalgar refused to contemplate that any other explanations were possible in respect of the origin and cause of the fire. They did not pursue any other possible explanations. They did not approach General Motors or Courtesy before denying the claim. They did not pursue the reported problems relating to the functioning of the vehicle to which Mr. Bullock had alluded. They did not investigate as to whether there could be any motive for arson.

The Court found that the insurer had acted in good faith when it initially denied the claim, but breached its duty of good faith in failing to reconsider the probable cause of the fire when presented with contrary evidence.⁷

2. Liability Policies

a. Is there a Claim/Action/Suit?

The first question, in considering the appropriate time for a denial under a liability policy, is whether the policy has potentially been triggered. The policy language varies on this issue and may refer to "claims," "claims and suits," "demands" or may be restricted to claims for "damages," etc.

Where the claim is tendered only after the service of a statement of claim (or equivalent) this issue does not arise. But a claim will sometimes be tendered or the insurer provided with notice of a claim at an earlier stage—for example, where the insured has received a demand letter or, in some cases, only a verbal demand or threat to sue. A full analysis of when a policy is triggered is beyond the scope of this paper.⁸ The point for present purposes is that this issue must be considered if the "claim" is tendered before formal suit.

7 An expert opinion and a statement of an attending firefighter to the effect that the firefighters had scraped their shovels against the hot engine in order to clean them—and could have accidentally punctured the fuel line in that manner.

8 Some of the cases on this issue, on various policy wordings, are *Chamberlain v. North American Accident Insurance Co.* (1916), 28 D.L.R. 298 (Alta. C.A.); *Hilton Hotel (1963) Ltd v. Dominion Insurance Corp.* (1968), 1 D.L.R. (3d) 214 (B.C.S.C.); *Privest Properties v. Foundation Co. of Canada* (1991), 6 C.C.L.I. 23 (B.C.S.C.); *Neiman v. CGU Insurance Co.*, [2002] O.J. No. 2215 (S.C.J.); *Myers v. Simcoe & Erie General Insurance Co.*, (1994) 18 O.R. (3d) 475 (Ont. Gen. Div.); *Corporation of the Municipality of Brockton v. Frank Cowan & Co.*, [2001] I.L.R. 1/3905 (Ont. S.C.J.) (upheld 34 C.C.L.I. (3d) 1 (Ont. C.A.); *Akey v. Encon Insurance Managers Inc.*, (2001), 28 C.C.L.I. (3d) 63 (Ont. S.C.J.).

b. General Rule: Pleadings Only—No “Investigation”

Under liability policies (as first party policies) the insurer has a general obligation to consider claims reasonably “promptly” and, once a decision is made concerning coverage, to promptly communicate that decision to the insured.⁹ The ability to make a reasonably prompt coverage determination under a liability policy is assisted by the “pleadings only” rule. The general rule is that only the pleadings can be looked to in determining whether there is a duty to defend.¹⁰ Accordingly, subject to the limited and possible exceptions referred to below, no “investigation” into the facts is necessary before a coverage decision can be made. Rather, the insurer must, of course, undertake a proper assessment as to whether the pleadings, as drafted, bring the claim within potential cover.

There are some non-contentious limited exceptions to the “pleadings only” rule, and one quite contentious and potentially very significant exception—the “underlying facts exception.” We will deal with those exceptions in turn below.

c. Exceptions

i. Legal Advice

If determination as to whether the pleadings give rise to a duty to defend is not straight forward the insurer may seek legal advice. There are no Canadian cases holding an insurer has a duty to seek legal advice in connection with difficult or contentious liability claims. But, as in property/first party claims, the fact that such advice has been sought and relied on in connection with a denial is an important fact in defence of a potential claim for bad faith or improper denial. Certainly, an insurer's failure to have regard to the advice of counsel is a factor the court may consider in respect to a bad faith claim (*Fredrikson v. ICBC* (1990), 42 C.C.L.I. 250 (S.C.) at para. 87).

ii. Denial for Breach of Duty/Misrepresentation

Where the insurer considers denying cover on the basis that the policy is void or the claim forfeited for breach of condition/misrepresentation, the insurer is in a situation in which the facts have to be considered and assessed before a coverage decision can be made. Some of the issues which arise in this situation are dealt with below at section II C.

iii. Manipulative Pleadings

In some cases the statement of claim in the underlying action will be drafted in such a way as to attempt to ensure that the defendant’s liability cover is triggered. In principle, there is nothing wrong with this so long as the claims are properly framed. But where the claims are improperly pleaded in an attempt to trigger insurance cover (for example, pleading an intentional assault as negligence¹¹) the court will look to the true substance of the claims. That analysis will necessarily involve some degree

9 See, for example, *ICBC v. Hosseini* (2006), 31 C.C.L.I. (4th) 157, (B.C.C.A.). The insurer had defended the driver throughout the underlying action and settled the action. The insurer then sought to recover the settlement on the grounds that the defendant was not driving with the owner’s consent and thus was not an insured. That conclusion had been reached internally within the insurer, but not communicated to the driver until after settlement. The Court found that, in those circumstances, it was not open to the insurer to deny cover. In *Rosenblood*, the insurer had all of the information necessary to deny, but did not inform the insured and continued to defend the action. The insurer was estopped from denying cover.

10 *Nichols v. American Home Insurance Co.*, [1990] 1 S.C.R. 801. The “pleadings” in this context include (at least in some cases) documents that are expressly referred to and/or incorporated into the pleadings: *Monenco Ltd. v. Commonwealth Insurance Co.*, [2001] 2 S.C.R. 699.

11 *Unrau v. Canadian Northern Shield Insurance Co.*, (2004), 15 C.C.L.I. (4th) 189 (B.C.C.A.), 2004 BCCA 585; *Non-Marine Underwriters, Lloyd’s of London v. Scalera*, (2000) 18 C.C.L.I. (3d) 1 (S.C.C.), 2000 SCC 24.

of investigation into the underlying facts in order to determine the true nature of the claims made. Of course, this is generally an investigation that the insurer will be undertaking in its own interests as the pleadings will invariably be “manipulated” to trigger cover, not to avoid triggering cover.

iv. Possible Exception Regarding “Underlying Facts”

There is a potentially significant exception to the pleadings rule—the “underlying facts exception.” The existence and scope of an “underlying facts” exception to the pleadings rule is a matter of debate and is worth considering in some detail. Accordingly, a number of the key cases on this issue are referred to in the appendix to this paper. In summary, the existence of any “underlying facts exception” to the pleadings rule has been soundly rejected in Ontario, but has received some support in decisions from other provinces, including BC. There are some commentators who suggest there is, at least in some circumstances, a duty on the insurer to consider not simply claims as pleaded, but also the underlying facts.¹²

The question of whether there is an “underlying facts exception” to the pleadings rule is significant for an insurer considering a demand for coverage in a liability claim. If there is such an exception, then there may potentially be a concomitant obligation on the insurer to conduct an investigation of the facts underlying the claim before making a decision as to whether to deny cover.

Arguably, the better interpretation of these cases is that the “underlying facts exception” is really not a separate exception to the pleadings rule at all. The cases are best explained on either the “manipulative pleadings” rule or the rule that where the pleadings are ambiguous the insured is entitled to the benefit of the doubt in the decision as to whether a covered claim is pleaded. It is, on the basic insuring covenant of virtually every liability policy, the claims that *are made* which trigger and define the scope of the duty to defend, not claims that could have been made. The fact that the plaintiff does not make a claim against the insured which might be available to it on the underlying facts may be careless or may be intentional. But in either case, if the claim is not made, can the duty to defend be triggered?

There is one other point worth noting. All of the cases on the “underlying facts” exception make it clear that the exception applies only where the underlying facts are not in dispute. The facts are “not in dispute” in this context if they are not in dispute between the claimant in the underlying action and the insured. Whether particular facts are in dispute between the claimant and the insured is not always a straight forward matter for the insurer to determine in making an assessment of potential coverage at the outset of the action.

v. “Know the Insured”

It is generally necessary in connection with a claim under a liability policy for the position and sophistication of the insured to be considered. For example, if there will be a period of time during which litigation is ongoing, and before a decision can be made as to potential coverage, is the insured in a position to retain and instruct counsel and competently deal with the action?

C. How: Steps to Take and Matters to Consider in Denying Coverage

This section of the paper considers steps to take to preserve insurers’ rights during the period of investigation and assessment of the claim, including how to go about issuing an effective denial as well as steps to consider following a denial.

12 For example, *Hilliker, op. cit.*, at 80 includes that where the underlying facts are not in dispute the insurer should not be able to deny a defence “simply because of careless pleading on the plaintiff’s part.”

I. Possible Estoppel or Waiver

On receipt of a claim, an insurer will commence an investigation (in the case of a first party/property policy) or an assessment as to whether the pleadings potentially trigger cover (in the case of a liability policy). Both courses of action involve dealings with the insured. In the case of a liability policy, steps may have to be taken in the underlying litigation quickly. It is vital that the insurer take the proper steps to ensure that its rights are reserved during the investigation/assessment. If the insurer fails to do so, it may find itself estopped or otherwise precluded from later denying cover.

Section 11 of the *Insurance Act*, R.S.B.C. 1996, c. 266 provides some protection to an insurer during the course of its investigation. Section 11 provides:

11(1) A term or condition of a contract is not deemed to be waived by the insurer in whole or in part unless the waiver is stated in writing and signed by a person authorized for that purpose by the insurer.

(2) Neither the insurer nor the insured are deemed to have waived any term or condition of a contract by any act relating to the appraisal of the amount of loss or to the delivery and completion of proofs or to the investigation or adjustment of any claim under the contract.

There are some important limitations to the protection afforded by s. 11. Section 11 does not apply to estoppel,¹³ and thus does not apply to a situation in which the insured has relied to its detriment on representations made by the insurer. Whether s. 11 applies to all categories of election (possibly as distinct from waiver) and precisely what constitutes “waiver of a term or condition of the contract” are open questions.¹⁴ Also, it has been found that an insurer may waive s. 11 itself and that the waiver may need not be in writing.¹⁵

Generally, s. 11 should protect an insurer from an allegation that acts which are purely related to the investigation of the claim result in waiver of any rights and/or the policy. It is where the insurer begins to undertake defence of the claim under a liability policy, or makes express or implied representations to the insured regarding cover (relied on by the insured), that the insurer may be estopped from denying cover. As the Court noted in *Rosenblood Estate v. Law Society of Upper Canada* (1989), 37 C.C.L.I. 142 at para 64 (Ont. H.C.):

When a claim is presented to an insurer, the facts giving rise to the claim should be investigated. If there is no coverage then the insured should be told at once and the insurer should have nothing further to do with the claim if it wishes to maintain its off-coverage position. If coverage is questionable the insurer should advise the insured at once and in the absence of a non-waiver agreement or of an adequate reservation of rights letter, it defends the claim at its risk.

What may constitute estoppel is open-ended. Commonly cited examples include investigating the claim, defending the underlying action, accepting the payment of a premium, entering settlement negotiations or making representations to the effect that coverage will be afforded in circumstances where the insurer had knowledge of facts calling coverage into question. For an excellent discussion regarding waiver and estoppel, see Neo J. Tuytel, *Waiver, Estoppel and Causes of Action* (Vancouver: Continuing Legal Education, 1994). It is to avoid that situation that a reservation of rights/non-waiver agreement is necessary.

13 *Cadboro Investments Ltd. v. Canada West Insurance Co.* (1987), 45 D.L.R. (4th) 470 (B.C.C.A.); *Gillies v. Couty* (1994), 100 B.C.L.R. (2d) 115 (B.C.S.C.).

14 See, for example, *Bell Pole v. Commonwealth Insurance Co. et al.* (1999), 66 B.C.L.R. (3d) 79 (C.A.) in which the Court of Appeal held that, even in the absence of any allegation by the insured of reliance, a decision could not be made as to whether s. 11 applied in the absence of a full trial.

15 See, for example, Brown, *Insurance Law of Canada*, v. 1 (Toronto: Thomson Carswell, 1999) at 12-28 and cases cited therein.

2. ROR Letter/Non-Waiver Agreement

Where there may be grounds for a denial an insurer should promptly issue a reservation of rights letter or seek to enter into a “non-waiver agreement” with its insured. A reservation of rights letter is a unilateral assertion by the insurer. A non-waiver agreement is a reservation of rights that has received the express assent of the insured. A unilateral reservation of rights, consequently, may be less effective or more strictly construed as against the insurer relative to a non-waiver agreement (e.g., *Ward Estate v. Olds Aviation* (1996), 37 C.C.L.I. (2d) 154 (Alta. Q.B.); and *Allstate Insurance v. Foster* (1971), 24 D.L.R. (3d) 9 (Ont. Co. Ct.)). However, a properly drafted reservation of rights letter ought to serve the intended purpose and may be the only practical option available due to timing or the insured’s refusal to execute a non-waiver agreement.

The first purpose of reservations of rights/non-waiver agreement is to permit the insurer to undertake an investigation and take initial steps connected with the claim without suffering waiver or estoppel. The second purpose, particularly in connection with liability policies, is to permit the insurer, following the initial investigation, to continue to defend the claim under a reservation of certain rights. That purpose of the reservation of rights/non-waiver is described in *Harrison v. Ocean Accident & Guarantee Corporation Ltd.* (1948), 3 D.L.R. 445 (Ont. C.A.):

The purpose of the agreement is obvious. There is an action against the [insured] to be defended. The action may or it may not involve liability of the insured, against which the policy promises indemnity, and it may be that, whether it does or does not, there are circumstances already known, or that may be discovered, that entitle the insurer to be relieved of liability to the insured under the policy. With matters in this condition the insurer and the insured consider it the wiser course, instead of immediately fighting each other, to defend the claimant’s lawsuit and find out first whether or not there was really anything for them to fight with each other about.

Specific matters that should be considered in drafting reservation of rights letters/non-waiver agreement are referred to below at section IV. A.

3. Declaratory Action

When a claim has been denied and the denial is contested, the question becomes “what next”? Particularly in the case of liability policies, where there is an ongoing underlying action, it is often not a safe course of action for the insurer to deny and take no further steps. The possible consequences of a denial which is later found to be incorrect, and where the underlying action proceeds to judgment or settlement in the meantime, are dealt with below at section III. A.

The most common course of action by which the insurer may seek to protect its interests in this situation is a declaratory action. Where the issue is purely a question of whether the allegations against the insured fall within the coverage afforded by the policy, seeking a declaration on an expedited basis should not be difficult. However, where the issue goes to the essential validity of the policy, breach of condition, non-disclosure on the part of the insured, etc., then the matter may become more complicated.

In BC, it has been held that, under these circumstances, an insurer cannot be compelled to defend the insured in the underlying action pending the resolution of the coverage dispute.¹⁶ In *Continental Insurance Co. v. M.T.C. Electronic Technologies Co.* (1995), 32 C.C.L.I. (2d) 102 (B.C.S.C.), the Court

16 Other decisions reaching a similar result include: *Agassiz Enterprises (1980) Ltd. v. General Accident Assurance Co. of Canada* (1988), 49 D.L.R. (4th) 415 (Man. C.A.); *Carter v. Kerr* (1990), 69 D.L.R. (4th) 542 (B.C.C.A.); *Featherstone v. Zurich Insurance Co.* (1991), 6 O.R. (3d) 639 (Gen. Div.); *Laughlin v. Sharon High Voltage Inc.* (1993), 12 O.R. (3d) 101 (Gen. Div.); *Veillieux v. Chambers* (1995), 25 O.R. (3d) 538 (Gen. Div.); *Colitti v. Popp* (1998), 3 C.C.L.I. (3d) 161 (Gen. Div.); *Comeau v. Roy*, [1999] I.L.R. 1-3668 (N.B.Q.B.); and *Wade v. Wade* (2000), 25 C.C.L.I. (3d) 84 (N.S.C.).

analyzed the insured's application for an order that the insurer fund its defence in the underlying action as if it were an application for a mandatory injunction. At para. 15, the Court held:

I am of the opinion that the weight of the authority ... leads to the conclusion that where an insurer has placed at issue, in proceedings commenced for that purpose, the essential validity of the policy, the issue as to the obligations to defend or indemnify must be resolved within the action by judgment before the insurer can be compelled to either defend or indemnify with reference to separate proceedings.

There is a line of cases including *Slough Estates Canada Ltd. v. Federal Pioneer Limited* (1994), O.R. (3d) 429 (Gen. Div.),¹⁷ to the opposite effect (i.e., that a mere pleading of the invalidity of the policy by an insurer does not suspend or defeat its duty to defend). The differing approaches were considered in *Longo v. Maciorowski* (2000), 23 C.C.L.I. (3d) 1 (Ont. C.A.). In *Longo*, the Ontario Court of Appeal took the view that each case should be decided on its own merits and cited the following factors as relevant to its decision not to compel the insurer to defend pending resolution of coverage issue in that case:

1. the insurer made allegations of clear and uncontested breaches of condition;
2. the insured filed no evidence relevant to estoppel or relief from forfeiture;
3. the insurer added itself as a third party to the underlying action; and
4. as a statutory third party, the insurer contested both the liability of the insured and the amount of the claim made against him in language congruent with the interests of the insured.¹⁸

Ideally, the underlying action can be stayed pending a decision regarding the validity of the policy (e.g., *Featherstone v. Zurich Insurance Co.* (1991), 6 O.R. (3d) 639 (Gen. Div.); *Colitti v. Popp* (1998), 3 C.C.L.I. (3d) 161 (Gen. Div.)). However, if a stay cannot be obtained, the insurer is left with the risk that the underlying action will not be competently or efficiently defended. In such a situation, even if the duty to defend is not "suspended" due to an alleged breach of condition, the insurer may prefer to fund the defence in order to protect its interests while, potentially, recouping the defence costs if successful in the coverage proceeding.

4. Third Party Proceedings Against Insurer

In some situations it will be appropriate for the insured to add the insurer as a third party in the underlying litigation. In many respects that is the best course of action for both insurer and insured (assuming an acceptable reservation of rights/non-waiver agreement can not be reached). This way the claim can be properly defended without estoppel or waiver of coverage positions. But it is, of course, generally up to the insured as to whether the insurer is joined as third party. One BC case in which this course was followed is *MacKenzie v. Jevco Insurance Management* (1986), 26 C.C.L.I. 358 (B.C.S.C.), aff'd (1988), 32 C.C.L.I. 28 (B.C.C.A.).

¹⁷ Other decisions reaching a similar result include: *Canadian Linen Supply Co. v. Canadian Indemnity Co.* (1987), 27 C.C.L.I. 248 (Alta. Q.B.); *Dominion of Canada General Insurance Co. v. MacCulloch* (1991), 78 D.L.R. (4th) 593 (N.S.C.A.); *Yang v. Canadian Lawyers Insurance Association* (1997), 196 A.R. 270 (C.A.); *Griffen v. Hopey Estate* (1998), 41 O.R. (3d) 216 (Gen. Div.); and *SCS Western Corporation v. Dominion of Canada General Insurance Co.* (1998), 5 C.C.L.I. (3d) 250 (Alta. Q.B.).

¹⁸ *Longo* has been cited by the courts in *Carrozella v. Zelaya*, (2004), 18 C.C.L.I. (4th) 130 (Ont. S.C.J.); *Parlee v. Pembridge*, [2005] I.L.R. 1-4421, 2004 NBQB 38.

5. Right of Insurer to be Added to Underlying Litigation

Another potential option an insurer might pursue is an application pursuant to R 15(5)(a)(iii). Nigel Kent, in his article entitled *Preventative Paperwork: Non-Waiver Agreements, Reservation of Rights Letters and the Defence of Claims in Questionable Coverage Situations* (Vancouver, CLE, 1995), advocates the use of this procedure in situations where an insurer has concerns regarding the competent defence of the underlying action.

In *Starr Schein Enterprises Inc. v. Gestas Corp.*, [1986] B.C.J. No. 3213 (S.C.), the plaintiff judgment creditor brought an action directly against the judgment debtor's insurer pursuant to what was then s. 26 of the *Insurance Act*. The plaintiff sought satisfaction of the judgment. One argument advanced by the plaintiff was that it ought to have a right of recovery on the basis that the insurer could have added itself as a party to the prior action pursuant to R 15, but decided against it. The trial judge disagreed:

I am unable to accede to that argument. If there is merit in the plaintiff's position that R. 15(5)(a)(iii) applies, the plaintiff might have applied to have the insurers added as defendants under that Rule. I doubt that such application would have succeeded because there was no issue between the plaintiff and the defendant insurers to be tried in the action. Until judgment was obtained against the solicitor, no action could be brought against the insurers [per the terms of the subject policy].

In his dissent at [1987] B.C.J. No. 803 (C.A.), Mr. Justice Lambert disagreed with that conclusion. He found that the insurer could have added itself as a party to the prior action:

... in my opinion there would be no improper prejudice to the insurer, in this type of case, in permitting a direct action against the insurer once liability is established on the part of the insured. I consider that subrules 15(5)(a)(ii) and (iii) are broad enough to allow an insurer to apply successfully to be joined in the victim's action against the insured, if the action would not otherwise be adequately defended.

In *Bryant v. Korres Moving & Transfer Ltd.*, [1989] B.C.J. No. 1694 (Co. Ct.), the insurer applied to be added as a party in several actions brought against its insured. The plaintiffs in those actions sought damages for the destruction of goods by fire. The insurer had appointed counsel to defend the negligence claims. The insured had appointed separate counsel in respect to claims made in contract for which it appears to have been agreed there was no coverage.

The court's primary concern was in regard to a conflict of interest:

The concern arises in this way. The Elite policy has a limit of \$50,000.00 but apparently does not provide indemnity except through negligence. The defendant Korres is thereby in a conflict. While it seeks to deny any liability, if those defences fail, Korres would obviously prefer that it be indemnified under the negligence insurance, than found liable in contract.

Likewise, Elite will wish to place loss, in the cases where contract is pleaded, to that contract, rather than under the policy. In other words, they are interested in having the plaintiffs' claims, if not dismissed, then founded on a breach of contract.

The Court then considered whether an insurer could add itself as a party via R 15. The portions of the trial decision and Mr. Justice Lambert's dissent from *Starr Schein* quoted above were considered. The Court then went on to determine that the applicable test for adding the insurer was whether it would be "just and convenient." In this regard, the Court held:

It is clearly "just" that the defendant not be saddled with counsel representing potentially conflicting interests. It is clearly "just" that Elite Insurance have full answer and defence to a potential liability. It is, clearly "just" that a possible diverse finding of fact between the two trials be avoided: that is, the finding, not merely of liability but causation, one cause being insured, the other not.

The decision in *Bryant* appears to have been driven by the court's concern regarding the conflict of interest. It is not a case where the insurer denied cover and then sought to be added as a party to protect its own interests.

In *Passarell v. Taku Air Transport Ltd.*, [1988] B.C.J. No. 244 (C.A.), Taku's plane, piloted by Bond, crashed killing five passengers. Taku and Bond's insurers denied liability on the basis that previous incidents had not been disclosed and because the plane, when it crashed, had carried more passengers than insured seats. The insurers commenced an action for a declaration that the policy was void. The families of the deceased passengers were added as defendants pursuant to R 15 on the basis that they were potential future claimants against the insurers pursuant to what was then s. 26 of the *Insurance Act*.

The survivors of two of the deceased commenced their own actions against Taku and Bond. Default judgments were taken against Taku and Bond in those actions. The insurers then applied to be added as defendants to those actions, without prejudice to their ability to deny any defence or indemnity obligations, and also to set aside the default judgments. The BC Court of Appeal framed the issues as follows:

The facts indicate that the Insurers knowingly and intentionally allowed judgment to go by default against the insured, Taku and did not apply to be joined in the action before judgment was granted, whether as a representative of the defendant insured or in their own right. It is also clear that the Insurers elected to accept the alleged breach of the insurance contract by the insured Taku as a repudiation of that contract thereby relieving the Insurers of any obligation to indemnify or defend the insured and they continue to maintain that position.

The Insurers now wish, however, to avoid the consequence of their election—namely, that they have no right or status to defend the claims advanced against the insured Taku by the claimants in the *Family Compensation Act* action—and they do so by invoking the provisions of Rule 15(5)(a)(ii) and (iii)....

The insurers apparently conceded that R 15 would not allow them to be added as parties on the basis of the dispute regarding the validity of the policy (even in the face of inadequate, or non-existent, defence). The insurers also agreed that whether joinder ought to be allowed should be viewed from the perspective of the interests of the parties to those actions. The insurers argued that Taku and Bond allowing default judgments to be taken provided the justification for joinder. The BC Court of Appeal disagreed:

... having elected to rescind this contract of insurance, the insurers have no status with regard to the litigation between the Passarell and Florence families against Taku. They are strangers to that action. Accordingly, their participation in those proceedings is not necessary to ensure that all matters in the Family Compensation action may be effectually adjudicated upon. There is no "necessity" to add the Insurers to the proceedings under the *Family Compensation Act* in order to resolve the issues extant between the plaintiffs and the defendant Taku. To rule otherwise would be to enable any stranger to the issues raised in the litigation to intervene in order to set aside a default judgment or otherwise defend the action if it was in its interest to do so.

The Court of Appeal went on to find that it would not be "just and convenient" for the insurers to be added as defendants:

So far as Rule 15(5)(a)(iii) the "just and convenient" rule is concerned, the Insurers are faced with the same problem. Having elected to rescind the insurance contract, there is "no question or issue" between the insurer and the claimants relating to or connected with the liability of Taku or the quantum of damages. Accordingly, it is neither just nor convenient to permit the Insurers to intervene in the Family Compensation action. It is not convenient because the claimants now have a judgment that determines liability and are engaged in a proceeding that will determine quantum. It is not "just" to permit a stranger to their litigation to test the validity of their claims against the defendant Taku.

A broad reading of *Taku* might support the argument that a denying insurer is a stranger to the underlying action (at least to the extent of the claims denied) and ought not to be added as a party pursuant to R 15. However, *Taku* may be more appropriately confined to situations where the validity of the policy itself is disputed. Certainly *Taku* does not appear to foreclose the ability of an insurer to be added as a party in a situation involving mixed claims or pure coverage disputes. The *Bryant* decision lends support in this regard.

III. Possible Consequences of Failure to Defend/Cooperate

This section considers possible consequences to the insurer arising from improper denial of cover and refusal to defend. This section also considers potential consequences to the insured arising from failure to meet its duties under the policy, including its duty to cooperate.

A. Consequences for the Insurer

I. Potential Bad Faith/Punitive Damages

The most obvious potential result of a wrongful denial is a finding of bad faith and an award of punitive or aggravated damages. Of course, it is far from every wrongful denial that gives rise to this possibility. It is inevitable that some coverage decisions will prove to be wrong. An incorrect determination on coverage, in and of itself, is not evidence of a breach of the duty of good faith. This proposition was emphasized by the Supreme Court of Canada in *Fidler v. Sun Life Assurance Co. of Canada*, [2006] 2 S.C.R. 3:

... 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.

As held in *702535 v. Ontario Inc. v. Non-Marine Underwriters of Lloyd's London* (2000), 184 D.L.R. (4th) 687 (Ont. C.A.) at para. 37:

In some cases, the risk of being found liable for consequential damages resulting from unsuccessfully contesting a claim under a policy would constitute a substantial disincentive for insurers to deny claims, even those which they reasonably and in good faith consider to be either unfounded or inflated. In a general sense, insurers and insureds have a common interest in ensuring that only meritorious claims are paid. Increased payments by insurers lead to increased premiums for insureds. In order to effectively screen claims, insurers must be free to contest those claims which in good faith they have reason to challenge, without running the risk that if they are ultimately found to be wrong, they will be liable to indemnify the insured for losses not underwritten in the policy contracted for by the insured.

But where the insurer's conduct meets the "overwhelmingly inadequate" standard or is based on improper considerations (including a pre-determined agenda to find no cover) the possibility of a finding of bad faith exists.

2. Exposure to Unfavourable Settlement

A second potential consequence of wrongful denial, whether or not in bad faith, is the insurer's exposure to the cost of an unfavourable settlement by the insured. Where the insurer has denied cover and refused to defend the underlying claim, it will be liable to pay any "reasonable" settlement made

by the insured. In *Cansulex v. Reed Stenhouse* (1986), 70 B.C.L.R. 273 (S.C.) at para. 188, McEachern C.J.B.C. summarized the law as follows:

In my view, an insured in the position of Cansulex is entitled to settle any insured claim brought against it on any reasonable basis and for any reasonable amount, and to recover such amount from its insurers not necessarily as indemnity, as such may only be payable in discharge of a liability which may not have existed, but as damages for breach of contract. In this connection it is my view that an insured who has been abandoned by his insurer is entitled to buy peace at a reasonable price even though he denies his liability.

Other cases in which the insurer was held bound to a reasonable settlement by the insured following improper denial include *Shore Boat Builders Ltd. v. Canadian Indemnity Co.* (1974), 51 D.L.R. (3d) 628 (B.C.S.C.) and *Wright Engineers Ltd. v. U.S. Fire Ins. Co.* (1986), 19 C.C.L.I. 74 (B.C.C.A.).

Of course, where the settlement is truly “reasonable” there is little or no prejudice to the insurer if its denial is ultimately found to be wrongful. However, an insurer ought to be alive to the possibility of a “collusive” settlement. Such a settlement can involve, among other things, an agreement under which the underlying claimant takes a consent judgment (and possibly an assignment of the insured’s rights, including any bad faith claim, against the insurer), receives little or no payment from the insured, and then agrees to pursue only the insurer for the settlement amount. There is very little Canadian law on this issue.¹⁹ There is substantial US law on this issue, much of which is analyzed in *Midwestern Indemnity Co. v. Laikin*, 119 F.Supp. 2d 831 (US Dist. Court 2000). While a settlement which is collusive and/or unreasonable will not be enforceable, the risk of such a claim is obviously to be avoided.

3. Insurer Potentially Bound to Defence as Conducted by the Insured

Where the insurer denies coverage and does not participate in the defence of the claim, the insurer will be bound in any subsequent proceedings brought against the insurer by the insured or the claimant (under a direct action statute). An insurer cannot contest the liability of the insured on the grounds that the defence would have been conducted differently, so long as the defence was not collusive as between the claimant and the insured (*Stoyka v. General Accident Assurance Co. of Canada* (2000), 183 D.L.R. (4th) 424 (Ont. C.A.)). Of course, this principle applies only to findings actually made in the underlying action. The insured is free to contest, in subsequent coverage litigation, any matters which were not the subject of specific findings in the underlying action.

4. Exposure to Additional Defence Costs

The legal expense incurred by the insured in defence of the claim will generally be recoverable from the insurer where it is determined that the denial was wrongful. Where the insurer defends under a reservation of rights and some defence expenses are referable only to non-covered claims, the insured will generally be responsible for that portion of the defence expense. Where the insurer has refused to defend there are cases which suggest the court will be loathe to consider any apportionment.²⁰ In other words, the insurer may end up bearing a larger part of the defence costs than would otherwise have been the case.

19 One case giving some consideration to this issue is *Litchfield Holdings & Management Corp. v. Kingsway General Insurance Co.* (2002), 44 C.C.L.I. (3d) 238 (B.C.S.C.). There are some cases considering the enforceability of assignment in different contexts, including *Fredrickson v. Insurance Corporation of British Columbia* (1986), 17 C.C.L.I. 194 (B.C.C.A.), in which the issue was not a denial of coverage, but a judgment beyond policy limits, where it was alleged that the claim could have been settled within limits.

20 See, for example, *Bacon v. McBride* (1984), 5 C.C.L.I. 146 (B.C.S.C.) and *Modern Livestock Ltd. v. Kansa General Insurance* (1993), 11 Alta. L.R. (3d) 355 (Q.B.).

B. For the Insured

I. What Constitutes Failure to Cooperate

The insured will virtually always, under the policy conditions, have an express duty to cooperate in connection with defence and/or handling of the claim. The duty of the insured to cooperate is a precondition to the right to recover (*Travellers Indemnity Co. v. Sumner Co. Ltd.*, [1961] I.L.R. 1-179 (N.B.S.C.); *Utica Mutual Insurance Co. v. Gruzlewski*, 630 N.Y.S.2d 826 (4th Dep't 1995)). Even where an insured is in bankruptcy or having financial difficulties, it retains the duty to cooperate and provide such information as the insurer reasonably requires to defend or negotiate settlement (*Re Canada 3000 Inc.* (2004), 8 C.C.L.I. (4th) 141 (Ont. S.C.J.); *Brown v. Royal Insurance Co. of Canada*, [1994] O.J. No. 1529 (Gen. Div.)).

Thompson v. ING Halifax (2005), 28 C.C.L.I. (4th) 151 (Ont. S.C.J.) aff'd [2006] I.L.R. 1-4546 (Ont. C.A.) is a good example of an insured's lack of cooperation giving rise to a material breach. In *Thompson*, a judgment creditor brought an action against the judgment debtor's insurer directly pursuant to the relevant statutory provision. Such actions are subject to the equities between the defendant insurer and its insured. At para. 13, the insureds were found to have materially breached the policy due to their unresponsiveness to the insurer's telephone calls and letters:

... the defendant insurance company required further information from the insureds in relation to the nature of the employment of the plaintiff and the circumstances from which the claim arose. The lack of cooperation by the insureds by not responding to the letters or communicating in any other way amounts to a substantial and material breach of their insurance policy. Accordingly, the action by the plaintiff is hereby dismissed with costs.

In *Richards (c.o.b. Richards, Berretti, Jellinek) v. Continental Casualty Co.* (1993), 14 C.C.L.I. (2d) 202 (Alta. Q.B.), the insured's officer was found to have lied at his examination for discovery and falsified documents. Not surprisingly, the Court found these actions resulted in a breach of the insured's duty to cooperate. In *McConnell v. Aviva Insurance Co. of Canada Ltd.* (1996), 35 C.C.L.I. (4th) 90 (Alta. Q.B.) at para. 50, the Court appears to have considered that the failure of the insured to attend his examination for discovery alone might constitute non-cooperation. However, the Court did not directly consider the point as the insurer was found estopped from denying cover as it had continued to defend subsequent to the insured's non-attendance. In *Canadian Newspapers Co. v. Kansa General Insurance Co.* (1996), 30 O.R. (3d) 257 (C.A.), the insured failed to cooperate when it did not keep the insurer apprised of developments in an action being handled by the insured.

2. Loss of Cover

The result of the insured's failure to cooperate, if serious, is forfeiture of cover. An insignificant breach or improper compliance is insufficient; the insured's breach must be material. Even if a material breach occurs, an insured may be entitled to relief from forfeiture.

IV. Guidance for Coverage Counsel—What to Put in and What to Leave Out

This section of the paper deals with specific matters to consider in drafting a denial/reservation of rights letter/non-waiver agreement. Some of the matters referred to are appropriate for an initial denial letter or reservation of rights/non-waiver letter. Some are more appropriate for a non-waiver agreement, which may well come after the initial letter. These types of agreements ought to deal in more detail with matters concerning ongoing defence of the claim.

Exactly what should be included and what should be left out of such a letter or agreement depends very much on the particular facts and stage of the subject claim. For example, the Insurance Bureau of Canada Non-Waiver Agreement Form (copy attached) sets out very general terms regarding preservation of all defences and grounds to deny cover. Such terms may be appropriate at the very outset of the matter. But no insured who is properly advised would permit defence of the claim to proceed on the basis of a blanket and non-specific reservation for any period of time. Specific grounds for denial or reservation need to be disclosed and specific terms for conduct defence under any reservation dealt with.

This section identifies a number of underlying legal issues (without fully analyzing those issues) and considers terms of the reservation/non-waiver to deal with those issues.

A. Matters to Include and/or Consider

I. All Material Facts Known

There is no case holding that all material facts have to be set out in a denial and/or reservation of rights letters. However, it is clearly in both the insurer's and insured's interest to ensure that all material facts are known and, further, that any dispute regarding those facts becomes apparent. The best way to ensure this is the case is to set out all of the known material facts in the reservation of rights or denial letter and to invite the insured to comment on them.

2. Specific Provisions Relied On/Grounds for Denial Known

To the extent possible, a denial/reservation letter should provide reasoning for the denial of all reasonably available benefits under the policy. This issue was considered in a first party claim in *Clarfield v. Crown Life Insurance Co.* (2000), 23 C.C.L.I. (3d) 266 (Ont. S.C.J.). The insurer was found to have performed an inadequate investigation in failing to give heed to medical evidence showing that the insured was totally disabled and therefore entitled to disability benefits. However, in considering an award for punitive damages, the Court also addressed the inadequacy of the insurer's denial letter in failing to deal with other potentially available benefits:

The defendant not only failed to consider a claim for residual benefits [as opposed to disability benefits], but failed to inform the insured of its decision or of its reasoning for the decision. I find this significant because an insured who is not given notice of an adverse decision cannot contest it. If Crown Life had advised Mr. Clarfield that it had decided he was not entitled to residual benefits, he may have been prompted to look at his policy or consult a lawyer. An insured who is not advised of the reasoning for a decision cannot mount an argument against it. Whether by design or not, Crown Life's conduct had the effect of concealing from Mr. Clarfield its interpretation and application of the Prior Average Monthly Income provision of the policy.

One unresolved issue is whether the insurer is obliged to bring to the insured's attention potentially relevant matters such as an applicable limitation period. There is case law suggesting that an insurer is not under a duty to advise of an applicable limitation period (e.g., *International Movie Conversions Ltd. v. ITT Hartford Canada* (2001), 27 C.C.L.I. (3d) 102 (Ont. S.C.J.); and *Pekarek v. The Manufacturers Life Insurance Co.* (2006), 27 C.C.L.I. (4th) 190 (B.C.C.A.)). However, in *Johnston v. Wawanesa Mutual Insurance Co.*, [2006] O.J. No. 3037 (S.C.J.), the Court left open the argument that failure to advise of a limitation period could constitute a breach of the duty of good faith and did not foreclose the insured's argument that such a failure to advise might amount to a "special circumstance" allowing the court to exercise its equitable jurisdiction to relieve against the application of a limitation period.

3. Reservation Regarding Potentially Unknown Grounds

While a denial/reservation letter should identify all policy provisions forming the basis for the denial/reservation of coverage, it is also advisable to include a general statement that the insurer does not waive its right to deny the claim based on other grounds, as well as the right to amend or supplement the denial letter. A recent US case suggesting that it is advisable to include such a “catch all” phrase reserving the right to raise other coverage defences is *1804-14 Green Street Assoc., L.P. v. Erie Ins. Exchange*, No. 1763, 2008 Phila. Ct. Com. Pl. LEXIS 196, (Pa. C.P. Philadelphia County Aug. 21, 2008). Of course, if the insurer actually becomes aware of such grounds, they should be brought specifically to the attention of the insured. The “catch all” should not be relied on to permit delay in disclosure of additional grounds for denial/reservation after the insurer becomes aware of those grounds.

4. Terms Regarding Conduct of Defence/Allocation of Defence Costs

There are complex issues concerning choice and instruction of counsel as well as payment of fees where a claim is defended under a reservation. The issue of whether defence counsel, the insured and the insurer are in a “tripartite relationship” (i.e., whether defence counsel has a joint retainer and the concomitant obligations arising therefrom *vis-à-vis* the insurer and the insured) is complex and not entirely settled in BC. In *Hopkins v. Wellington* (1999), 68 B.C.L.R. (3d) 152 (S.C.), Mr. Justice Burnyeat held that the insured is an insurer appointed defence counsel’s only client. Mr. Justice Burnyeat rejected that defence counsel might also have a duty to protect the insurer.

Hopkins may conflict with the prior BC decision of *Chersinoff v. All State* (1968), 69 D.L.R. (2d) 653 (B.C.S.C.). In *Chersinoff*, it was held that communications between the insurer and defence counsel in anticipation of and during a wrongful death action brought against the insured were not privileged and ought to be produced into the insured’s subsequent action for indemnification. After determining that a solicitor-client relationship existed between defence counsel and both insurer and insured, the Court went on to hold:

The starting point now must be that the solicitors were acting as solicitors for both insurer and insured in respect to the claims for damages brought against the latter. Although the insured did not select the solicitors himself but was represented by them and became their client because of the contractual right of the insurer to conduct the defence and select the solicitors, the insured agreed as a condition of being indemnified that the insurer should have the right to select solicitors so I think the insured may properly be taken to be a party to the employment of the solicitors selected. While the employment of the same solicitors for both parties came about because of the condition, the position of the solicitors in my view is that they must be regarded as having been jointly retained to represent both parties on the issues of whether or not the insured was liable to pay damages in respect to the motor accident and the amount of the damages.

That statement of the law accords with the view of the BC Law Society. A full discussion of the legal and ethical issues surrounding the existence of the tripartite relationship is beyond the scope of this paper. For a thorough discussion of these issues see Nigel P. Kent, *Juggling Ethics: Joint Retainers and the Professional Obligations of Insurance Defence Counsel* (Vancouver: Clark Wilson, 2009) at 1-4.

In respect of who pays, the general rule in BC is that if defence costs would have been incurred in order to defend a covered claim, then the insurer is obligated to bear those costs (*St. Andrews Service Co. v. McCubbin* (1988), 31 C.C.L.I. 161 (B.C.S.C.)). Costs associated *only* with the defence of uncovered claims are borne by the insured. The insurer bears the burden of presenting the court with a workable apportionment formula for distinguishing the costs of defence of the potentially covered and not covered claims (*Sansalone v. Wawanesa Mutual Insurance Co.* (1997), 29 B.C.L.R. (3d) 297 (S.C.)). If a workable formula is presented, then the court may order the parties to each pay a “fair” proportion of the defence costs pending reallocation at the conclusion of the action (*Continental*

Insurance Co. v. Dia Met Minerals Ltd. (1996), 20 B.C.L.R. (3d) 331 (C.A.); *Sommerfield v. Lombard Insurance Group* (2005), 20 C.C.L.I. (4th) 301 (Ont. S.C.J.)). If allocation of the defence costs is not possible, the insurer is generally required to pay for the defence (*Daher v. Economical* (1996), 31 O.R. (3d) 472 (C.A.); *R.W. Hope Limited v. The Dominion of Canada General Insurance Company*, [2000] I.L.R. 1-3845 (Ont. S.C.)).

In respect to who acts, the insurer's ability to control the defence is not unconditional. The seminal decision of *Laurencine v. Jardine* (1988), 30 C.C.L.I. 187 (Ont. H.C.J.), which followed the once leading US decision in this area, *San Diego Navy Federal Credit Union v. Cumis*, 208 Cal. Rptr. 494 (1984), determined that the test for removal of counsel appointed by an insurer was whether there was "an appearance of impropriety." In *Jardine*, the insured refused to sign a non-waiver agreement. The insurer then refused to defend the action. As a result, the insured brought a motion and received an order permitting him to choose and instruct counsel at the insurer's expense. The insurer was also permitted to appoint counsel, but he or she was to be subject to the control of the insured's counsel. The court's concerns that lead to those orders included: 1) that insurer's counsel might take actions contrary to the insured's coverage interests; and 2) the insurer might use confidential information communicated by the insured to insurer's counsel in order to deny cover.

The reasoning in *Jardine* has been largely confined by subsequent decisions. In *Brockton (Municipality) v. Frank Cowan Co.* (2002), 34 C.C.L.I. (3d) 1 (Ont. C.A.) at paras. 42 and 43, the Court held:

In coming to this conclusion, LeBel J.A. noted that American jurisprudence had moved towards a similar position and away from the broader basis for shifting control of the defence to the insured that was articulated in *Cumis*. For example, after *Cumis*, in *Foremost Insurance Co. v. Wilks*, 253 Cal. Rptr. 596, (1988), the California Court of Appeal made clear that not every case where the insurer elects to defend the insured under a reservation of rights creates a conflict of interest requiring the insurer to furnish independent counsel. If the reservation of rights arises because of coverage questions which depend upon an aspect of the insured's own conduct that is in issue in the underlying litigation, a conflict exists. On the other hand, where the reservation of rights is based on coverage disputes which have nothing to do with the issues being litigated in the underlying action, there is no conflict of interest requiring independent counsel paid for by the insurer.

I agree with the approach taken in *Zurich* and *Foremost*. The issue is the degree of divergence of interest that must exist before the insurer can be required to surrender control of the defence and pay for counsel retained by the insured. The balance is between the insured's right to a full and fair defence of the civil action against it and the insurer's right to control that defence because of its potential ultimate obligation to indemnify. In my view, that balance is appropriately struck by requiring that there be, in the circumstances of the particular case, a reasonable apprehension of conflict of interest on the part of counsel appointed by the insurer before the insured is entitled to independent counsel at the insurer's expense. The question is whether counsel's mandate from the insurer can reasonably be said to conflict with his mandate to defend the insured in the civil action. Until that point is reached, the insured's right to a defence and the insurer's right to control that defence can satisfactorily co-exist.

Brockton's approach has been followed by numerous Canadian courts, including *Parlee v. Pembroke Insurance Co.*, [2005] I.L.R. 1-4421 (N.B.C.A.), *Co-Operators General Insurance Company v. Morrison* (2004), 12 C.C.L.I. (4th) 171 (N.B.C.A.), *Roman Catholic Episcopal Corp. of St. George's v. Insurance Corp. of Newfoundland* (2003), 6 C.C.L.I. (4th) 83 (N.L.C.A.), and *Appin Realty Corporation Ltd. v. Economical Mutual Insurance Company* (2008), 57 C.C.L.I. (4th) 187 (Ont. C.A.). For excellent discussions regarding the duty to defend and defence counsel's ethical obligations, see Judith P. Kennedy, "Coverage Disputes: The "Duty" and "Right" to Defend" (Vancouver, BC, CLE, 2006), L. Anderson and P. Walker, "The Duty to Defend Partially Covered Claims" (Vancouver: PBLI, 2008), and Nigel P. Kent, *Juggling Ethics: Joint Retainers and the Professional Obligations of Insurance Defence Counsel* (Vancouver: Clark Wilson, 2009).

To avoid uncertainty these matters are best dealt with by specific agreement. Among the key terms to consider are the following:

1. Provision that defence counsel report fully on the merits of the action and will not give coverage advice to either the insured or the insurer.
2. Provision regarding allocation of fees on an ongoing basis, with defence counsel to identify and segregate fees that are incurred only in connection with certain identified claims. It is also common for the insurer and insured to bear cost of defence of mixed claims in agreed “ballpark” percentage; i.e., 50/50 or 75/25. Such terms probably produce about the same results as an item by item allocation and is much more efficient. Consider adding a provision to the effect that the percentages are subject to prospective adjustment by agreement or arbitration at the instance of either party. This deals with the situation in which one aspect of the claim begins to loom much larger partway through the underlying action.
3. Provisions for joint reporting on all matters concerning the defence to insured and insurer. No unilateral communications by defence counsel with either party.
4. Terms giving one party (insurer or insured) sole authority to instruct regarding day-to-day matters, with a procedure involving joint instruction or consultation regarding more significant matters. More significant matters can be specifically defined and could potentially include such issues as decisions to bring summary judgment motions, retainer of particular experts, material amendments to pleadings, trial conduct and strategy, etc.
5. A “deadlock breaking” term under which the one party (insurer or insured), after consultation, would have final authority to make decisions on significant matters. The alternative would be a dispute resolution process for such matters (referred to below).

5. Terms Re Recovery of Costs/Settlements

Where the claim is defended under a reservation of rights the insurer may agree to make initial payment of settlement or judgment, with a right to recover from the insured if it determined, in subsequent coverage litigation determines that all or part of the claim was outside cover. If the right to recover settlement or judgment is to be preserved, this must be expressly dealt with.

The same principle applies to recovery of defence costs. If the insurer wishes to preserve the right to recover defence costs where it is determined, in subsequent litigation, that all or part of the claim was outside cover, this must be dealt with expressly. In a case where the insurer is bearing all of the legal expense, such a term should generally be included.

It is also common, where costs are split on an ongoing basis, to seek specific agreement that both insurer and insured will not seek reassessment of defence costs. In other words, liability for judgment or settlement may be determined at the end of the day, but no reallocation of defence costs will be sought.

6. Settlement Authority

It is advisable to have as much certainty as possible concerning authority to settle and decision making in connection with settlement. In a “traditional” full non-waiver agreement the insurer is given authority to settle the claim as it sees fit and then seek recovery from the insured. In most circumstances, a properly advised insured potentially at risk for the settlement would not agree to those terms.

There may be major changes in the settlement picture over the few weeks, or even days, leading up to mediation or trial. It is important to minimize the prospect that a dispute concerning the offer/counter-offer to be made will frustrate a settlement that could have been achieved. It is, therefore, common to see a term that provides process for consultation and agreement regarding settlement decisions.

7. Dispute Resolution

A full blown arbitration where there is a dispute between insurer and insured on instruction of counsel would be too unwieldy. But it is not uncommon to see some provision for expedited dispute resolution decision making by a neutral third party and such a provision can be useful in avoiding deadlock between the insurer and the insured regarding conduct of the case and, possibly, settlement.

B. Matters to Avoid

I. Overly Broad Reservations

Avoid general or blanket reservations. Such a reservation may be fine during the very early period where investigation of the matter is at a preliminary stage, but maintaining an overly broad reservation may do nothing other than give a false sense of security. An overly broad and general reservation will not be effective where specific grounds to potentially deny cover subsequently become known.

2. Unenforceable or Unreasonable Terms Regarding Conduct of Defence

A term that gives the insurer sole authority to make all decisions concerning defence, sole authority to settle and an unfettered right to seek recovery of all settlements and defence costs from the insured if it turns out the claim was outside cover, is not one that a well-advised insured would agree to. The goal here is to make certain that the role of the insurer and insured in conduct of the defence and decision making is commensurate with their risk and exposure.

V. Appendix A—Cases on “Underlying Facts Exception”

- (1) *Cansulex v. Reed Stenhouse Ltd.* (1986), 70 B.C.L.R. 273 (S.C.)

A cargo of sulphur became wet while being loaded under wet-weather conditions, resulting in corrosion damage in the hold of the third parties ship. The third party claimed against the insured for negligence. One of the insurers refused to defend as it argued the claims fell outside the coverage provided by the policy by virtue of an exclusion.

McEachern C.J.C. reviewed the law on duty to defend, and noted (at 294-95):

I do not disagree in any way with the judgment of Wallace J. in *Bacon v. McBride*, 51 B.C.L.R. 228, 5 C.C.L.I. 146, [1984] I.L.R. 1-1776, 6 D.L.R. (4th) 96 (S.C.), upon which both Mr. Altridge and Mr. Gouge relied, but that was a case where claims were advanced against the insured in pleadings, some of which were clearly covered by the policy. In such circumstances there is no doubt the obligation to defend arose and the insurer was accordingly found liable for all the costs of defence, which is all that was an issue. When one is concerned with indemnity, however, and claims are advanced for which the insured may be liable and for which he is entitled to indemnity on one ground or another, it is not always possible to determine upon which theory the insured may be liable or, if there is a settlement, on which ground he may have been found liable if the case had gone to judgment.

It is quite different, in my view, when considering just the liability of an insurer for the costs of defence. If a claim is pleaded which is covered, then the insured is unquestionably entitled to succeed on that narrow ground. Most cases are not so simple, but I have the view that *neither the insured nor the insurer are always in the hands of the third party pleader, and it is open to an insured to show he is covered for the claim even if it is not correctly pleaded, and it is equally open to an insurer to show that a claim, however pleaded, is not one for which indemnity is furnished or, if covered, is excluded by another provision of the policy.*

This was the view of Devlin J. in *West Wake Price & Co. v. Ching*, [1957] 1 W.L.R. 45, [1956] 3 All E.R. 821 (Q.B.), as stated in the headnote, at p. 822, which appears accurately to state his Lordship’s views. It states:

PER CURIAM: underwriters were not bound by the way in which a claimant chose to formulate his claim, but could properly invite the court to ascertain the true nature of the claim and to make such inquiry as might be necessary for that purpose.

In this respect, see also *Fidelity & Casualty Co. of New York v. Envirodyne Engineers Inc.*, 461 N.E. 2d 471, 122 Ill. App. 3d 301, 77 Ill. Dec. 848 (1983), although I think the declaratory action has mercifully fallen into disuse in Canada. I have the view that is always open to an insured or an insurer to show that a claim is or is not covered or excluded, subject, of course, to situations such as *Bacon*, supra, and other circumstances following a denial of coverage such as occurred in this case and which will be discussed later. [emphasis added]

It is the emphasized portion of McEachern C.J.S.C.’s reasons in *Cansulex* that has since been cited as authority for the proposition that the court may examine underlying facts.

- (2) *Bathurst (City) v. Royal Insurance Co. of Canada* (1994), 154 N.B.R. (2d) 86 (C.A.)

A number of claims were made against the insured for damage to property caused by flooding. The flooding was allegedly caused by improper functioning of a water and sewage drainage system, resulting from the negligence of the insured. The insurer refused to defend on the ground that the claim fell within an exclusion in liability policy for “expected or intended” property damage, due to the insured’s experiences with previous floods.

At trial, Deschênes J. found that the statement of claim contained allegations which, if true, triggered the duty to defend under the policy. Deschênes J. noted that the traditional view was that the pleadings governed the duty to defend. The insurer argued that although the “pleadings rule” was the traditional view, it was possible to go behind the pleadings where a strict application of the rule would bring about an unjust result. In this case, the insurer claimed that the underlying facts gave rise to an exclusion in the policy.

Deschênes J. relied heavily on *Nichols v. American Home Ins. Co.*, [1990] 1 S.C.R. 801 and *Opron Maritimes Const. Ltd. v. Can. Indemnity Co.* (1986), 19 C.C.L.I. 168 (N.B.C.A.). In particular, the Court noted that in *Opron* the rule that the pleadings governed and that any doubt was resolved in favour of the insured was adopted.

Deschênes J. went on, however, to interpret above emphasized words of McEachern C.J.S.C., in *Cansulex, supra*, as indicating that it should be open to the parties to go behind the pleadings in appropriate case where a strict adherence to the “pleadings rule” would bring about an unjust result. Deschênes J. declined to apply the “underlying facts exemption” to the case at bar however, as the underlying facts were too contentious and it was unclear whether or not the exclusion applied. Further, the allegations by the insurer that the insured was reckless to the extent that the damage caused was “expected” were materially identical to the allegation of the third party claimants that the insured was negligent. Thus, it would be “patently unfair” to the insured to allow the issues between it and the insurer to be dealt with first, as such a process would seriously impair the insured’s capacity to defend itself against the claims (para. 20).

The Court noted (paras. 21-22):

This decision should not be taken as endorsing the “pleadings rule” to the exclusion of the “underlying fact exception” in every instance. I make this point because there are surely instances where the application of the “underlying fact exception” is the only solution in order to reach an equitable result. In other words, there may well exist circumstances “where the difficulties inherent in investigating and assessing the facts underlying the claim” simply cannot be avoided in order to achieve a just result. (See Hilliker page 62 and the case of *American Motorist Ins. Co. v. South Western Greyhound Lines Inc.* referred to at page 63)

This is not such a case as I believe that the difficulties which would be brought about as a result of not adhering strictly to the “pleadings rule” are such that it would, in my view, be most unfair to the City of Bathurst not to adhere to it.

Deschênes J. held that the insurer had to defend.

Deschênes J.’s decision was upheld on appeal. The Court of Appeal also referred to *Opron* and *Nichols*, and cited *Nichols* as follows (para. 4):

Furthermore, the duty to indemnify against the costs of an action and to defend does not depend on the judgment obtained in the action. The existence of the duty to defend depends on the nature of the claim made, not on the judgment that results from the claim. The duty to defend is normally much broader than the duty to indemnify against a judgment.

...

In that case [*Prudential*] it was unclear whether the insurer might be liable to indemnify under the policy, so the duty to defend was held to apply. In the court’s view it would have been unjust for the insurers to be able to assert that “the claim is probably groundless, or will probably end up falling outside of the indemnity coverage. Since we have no proof that we owe the indemnity in this case, we take the position that we owe no duty to defend.

The Court of Appeal noted the insurer's contention that the underlying facts rule ought to be applied, and cited the above portion of Deschênes J.'s decision (which stated the decision should not be taken as endorsing "pleadings rule" over the "underlying fact exception" in every instance).

The Court of Appeal found that Deschênes J. correctly concluded that because the underlying facts relied on by the insurer were in serious dispute, the pleadings rule applied and, for that reason, the insurer must undertake the insured defence of the two actions.

(3) *Privest Properties Ltd. v. Foundation Co. of Canada* (1992), 6 C.C.L.I. (2d) 15 (B.C.S.C.)

The claim in *Privest Properties Ltd.* against the insured arose from its use of asbestos during a major renovation construction project for a third party. The insured joined six of its CGL insurers as third parties to the action, and applied for a declaratory order to compel one or more of them to pay the legal costs of defending the action. One of the insurers, Allstate, applied for a determination of whether the duty to defend was governed solely by the pleadings and the relevant policies or whether the parties could adduce evidence of the nature of the plaintiffs' claims beyond the allegations contained in the pleadings.

Drost J. referred to *Nichols, Bacon, and Cansulex*, and held (at 22):

I conclude that, as a matter of law, it is open to a court on an application of this nature to go beyond the pleadings and to consider evidence. However, I also conclude that in the circumstances of this case, one in which many complex and novel issues arise and which, at that time, was still in its early stages, it would be wrong to admit evidence which counsel considered contentious and which would likely require the court to trench upon the very issues to be resolved in the main action.

For those reasons, I held that on the duty to defend application I would allow counsel to adduce only such evidence as they could all agree was not contentious and would be of assistance in the determination of that application.

Thus, while Drost J. does not reject the "underlying facts exception," he does limit it to a very narrow application.

In fact, in *Privest Properties Ltd. v. Foundation Co. of Canada* (1991), 6 C.C.L.I. (2d) 23 (B.C.S.C.), Drost J. refers to his above decision as refusing the application of Allstate for introduction of evidence. Drost J. describes the "key question" in this related application to be whether there have been "alleged in the pleadings such facts as would, if proved, fall within the scope of the 'property damage' coverage provided in any of the insuring agreements" (at 50).

(4) *Heck v. Prudential Assurance Co.* (1991), 5 C.C.L.I. (2d) 138 (Man. Q.B.)

A third party claimed against the insured Heck for injuries sustained when he was shot by the insured (which resulted in the insured being convicted of assault with a weapon). The insurer refused to defend as the allegations in the statement of claim involved intentional conduct, which was excluded from coverage under the liability policy.

Glowacki J. articulated the principals of the standard pleadings rule, referring to several cases including *Nichols* and *Opron*. The Court then referred to the above-emphasized passage from *Cansulex*. Glowacki J. held (at 143):

When one examines the allegations in the statement of claim, it appears that they involve intentional acts on the part of Heck. Further, Heck has been found guilty of assault with intent to commit bodily harm, an offence which clearly requires intent on the part of Heck ... When one considers the material before the court, it appears that the action is for damages suffered as a result of an intentional act of Heck. There has been nothing filed by or on behalf of [the plaintiff] which indicates that Heck's acts were anything but intentional and, accordingly, [the insurer's] policy does not provide coverage. Heck's application is therefore dismissed.

As the statement of claim involved allegations of intention acts, it is perhaps arguable that even if the court did refer to extrinsic evidence, it was unnecessary.

(5) *Marjak Services Ltd. v. Insurance Corp. of British Columbia* (2004), 32 B.C.L.R. (4th) 206 (C.A.)

The chambers judge found that the insurer had a duty to defend the insured against a third-party claim. The insurer appealed on the ground, among others, that the chambers judge had erred in refusing to consider a written statement made by the general manager of the insured.

Ryan J.A., delivering the judgment of the court, cited *Monenco* for the “pleadings rule,” and *Non-Marine Underwriters, Lloyd’s of London v. Scalera*, [2000] S.C.R. 551, for the three step process to be undertaken in determining whether a duty to defend arose in a particular case (para. 15):

To state the test briefly, the court should first determine which of the plaintiff’s legal allegations are properly pleaded. The court is not bound by legal labels chosen by the plaintiff. The question is not whether the claims have merit, but what the true nature of the claims might be. Second, the court must determine whether any of the claims are derivative in nature. Where a policy, such as those issued in the case at bar, excludes liability for intentionally caused injuries, there will be no duty to defend. If the pleadings allege negligence based on the same harm as the intentional tort, the court will not allow the insured to avoid the exclusion clause for intentionally caused injuries. Thus the court must determine whether the claims are derivative in nature. Finally, the court must decide whether any of the property pleaded claims could potentially trigger indemnity under the policy. This requires analysis of the policy.

Ryan J.A. cited the ruling of the chambers judge regarding the admissibility of the general manager’s statement the chambers judge ruled (para. 16):

... It would seem to me that the weight of authority at this point favours not looking at extraneous material because of the recent decision in *Scalera*. However, in *Scalera* the direct point as to whether or not extraneous material should be looked at was not before the court. That was a case dealing primarily with the nature of the action.

To err on the side of caution I think that I should rule at this time that there may still, in appropriate cases, be an option available to the court of looking at extraneous material. However, I feel that in the case that is before me, the material that is sought to be introduced is really evidence which directly or indirectly goes to the very heart of the decision to be made in the ultimate trial in Washington.

The Court noted that the statement of the general manager was attached to the affidavit of a lawyer and was self-serving, likely inadmissible and not made under oath. Ryan J.A. found it was “difficult to accept that on the duty to defend application the court should examine a statement which [might] never achieve the status of evidence” (para. 31).

Ryan J.A. referred to *Monenco* for the proposition that the court would not advocate an approach that caused a duty to defend application to become a “trial within a trial” and that a court considering such an application must not look at “premature” evidence which, if considered, would require findings to be made before trial that would affect the underlying litigation.

Ryan J.A. concluded:

In any event it would have been necessary for the chambers judge at the duty to defend application to find that the statement was true for him to have acted on it. Without the benefit of cross-examination, he could not have done that.

Thus, quite apart from all the other problems associated with this statement, to admit it on a duty to defend application would create a trial within a trial requiring the chambers judge to make findings of fact. This is not permitted by case law.

Scalera involved a claim for sexual assault against the insured. The policy covered “bodily injury” excluding intentional or criminal acts. Iacobucci J., delivering the unanimous judgment on this issue, held that the courts should “look beyond” the legal allegations used pleadings to determine what the “real” legal claim was (para. 50):

... A plaintiff cannot change an intentional tort into a negligent one simply by choice of words, or vice versa. Therefore, when ascertaining the scope of the duty to defend, a court must look beyond the choice of labels, and examine the substance of the allegations contained in the pleadings. This does not involve deciding whether the claims have any merit; all a court must do is decide, based on the pleadings, the true nature of the claims.

What is of note regarding *Scalera* is its use of language similar to that used in *Cansulex* (see emphasized passage above) (para. 79):

The appellant notes that the plaintiff's statement of claim alleged the non-intentional torts of negligence and breach of fiduciary duty. He therefore argues that the respondent has a duty to defend because the exclusion clause does not apply to these claims. However, these bare assertions alone cannot be determinative. *Otherwise, the parties to an insurance contract would always be at the mercy of the third-party pleader. What really matters is not the labels used by the plaintiff, but the true nature of the claim.*

Iacobucci J. went on to state (para. 84):

Conversely, a plaintiff may draft a statement of claim in a way that seeks to turn intention into negligence in order to gain access to an insurer's deep pockets ... A court must therefore look beyond the labels used by the plaintiff, and determine the true nature of the claim pleaded. *It is important to emphasize that at this stage a court must not attempt to determine the merit of any of the plaintiff's claims. Instead, it should simply determine whether, assuming the verity of all of the plaintiff's factual allegations, the pleadings could possibly support the plaintiff's legal allegations.* [emphasis added]

Thus, Iacobucci J. emphasised that the analysis is done on the facts alleged in the pleadings, and not an examination of underlying facts.

(6) *Axa Pacific Insurance Co. v. Elwood* (2000), 20 C.C.L.I. (3d) 168 (B.C.S.C.)

Another BC case that refers to the underlying facts exception is *Axa Pacific Insurance Co. v. Elwood*. This case involved a single car accident in which the insured was a passenger, and admittedly grabbed the steering wheel which allegedly resulted in the accident.

Chamberlist J. held that an insurer's duty to defend was governed by the pleadings, and an insurer was only required to defend against those claim, which if proven, would fall within coverage of the policy (para. 45). Chamberlist J. continued (para. 47):

In relation to the ‘pleadings test’ as set out in *Nichols, supra*, concern has been expressed by some courts that the insured, in seeking coverage under a policy of insurance, is at the mercy of the individual who drafted the pleadings. As a result the so-called ‘underlying facts exception’ has been developed as a means to allow the court to look beyond the pleadings and consider additional evidence when deciding the issue of whether a defence is owed to an insured under the policy in question.

Chamberlist J. looked at what could be categorized as some fairly non-controversial extrinsic evidence, including the police department's motor vehicle accident information sheet, the signed statement provided by the insured and answers given by the insured at her discovery. The Court found this evidence “confirm[ed] that the material facts pled by the plaintiff in the negligence action [were] true, namely that while riding as a passenger...[the insured] intentionally grabbed the steering wheel” (para. 48). Thus, it appears Chamberlist J. is exercising the “underlying facts exception” for the unnecessary purpose of confirming that the material facts pled in the underlying claim are true.

Chamberlist J. found that the insurer was not obligated to defend the insured as coverage was excluded under the policy.

(7) *Douglas Symes & Brissenden v. LSBC Captive Insurance Co.* (1999), 13 C.C.L.I. (3d) 228 (B.C.S.C.)

The “underlying facts exception” is also referred to in *Douglas Symes & Brissenden v. LSBC Captive Insurance Co.* The facts of this case, in brief, arose from a joint venture agreement entered into between a number of companies. A lawyer, “Milne,” who had a beneficial interest in one of the companies, “Pilot Pacific,” was retained to provide legal services to the joint venturers. At the time he performed the services he had an interest in Pilot Pacific, and so also had interest in the joint venture. The joint venture companies brought an action against Pilot Pacific, Milne, and the law firm the lawyer was with (Milne left the firm part way through the circumstances that gave rise to the claim) in negligence and fraud, as well as other causes of action. There was also a third party proceeding brought against the lawyer and the law firm by a company in a related action, based on essentially the same grounds as the original action.

The law firm (represented by G. Hilliker) brought a petition for an order that its insurer defend it against the third party claim. The insurer refused to defend the action based on an exclusion in the policy which excluded coverage for all claims “arising out of, or in connection with” any organization in which the insured had a beneficial ownership of 10% or more.

Cohen J. noted that (para. 14-15):

As well as the allegations contained in the pleadings, there are some additional facts, not in controversy, which, it is agreed, fall within the “underlying facts exception” as expressed in *Cansulex* ... These uncontroverted facts are, as follows:

- (i) Milne was a partner of petitioner from February 1, 1993 to July 31, 1995, at which time he left the petitioner ...
- (ii) During the time that Milne was at the petitioner, either Milne or his immediate family held a 30% interest in Pilot Pacific ...
- (iii) During the time that Milne was at the petitioner, he held less than a 10% interest in the Project referred to in the underlying actions ...

Based on the allegations contained in the pleadings, and the uncontroverted facts set out above, both respondents have refused to defend the petitioner on the basis of Exclusions clause 6 of the LSBC Policy.

Cohen J. then referred to *Nichols* as the leading authority on the issue of duty to defend.

Counsel for the insured contended that upon a “close review of the allegations contained in the pleadings, and on the basis of the unconverted facts” the court should find the action commenced against the petitioner fell within an exclusion clause in the policy.

Cohen J. found that the exclusion clause applied until the time Milne left the insured, meaning that the insured no longer had an interest in the organization. The insurer thus had to defend all claims that related to the time after July 31, 1995. Cohen J. seemed to suggest that a finding of liability on the remaining claims was unlikely, but found it was possible, and that was sufficient to find a duty to defend existed with respect to that narrow band of potential liability.

Douglas Symes was appealed at (2000), 24 C.C.L.I. (3d) 178 (B.C.C.A.). Between the time of the chambers application and the appeal, counsel for the plaintiffs in the underlying action had changed and the new counsel had given notice of their intention to entirely revise the statement of claim. The allegations of fraud had also been abandoned.

Esson J.A. described the petition as follows (para. 13):

... It is an unusual type of proceeding in that it involves a person against whom an action for damages had been brought making an application at the outset of the underlying action for a declaration that its liability insurer is obligated to defend the action. It is well established that, in such a proceeding *the pleadings filed by the plaintiff in the underlying action are the primary, perhaps sole, source of the facts upon which the application must be decided.* [emphasis added]

Esson J.A. noted that one of the difficulties in the case was that the pleadings that the Chambers Judge had to consider were “sadly deficient” (para. 14). Esson J.A. noted that the chambers judge had found that the Pilot Pacific allegations were at the “centre” of the whole claim and that the whole of it was therefore caught by the exclusion.

Esson J.A. found that applying for a declaration by way of petition may have been a misconceived process. The facts alleged in the petition said nothing useful about the issue which the court was asked to decide, as the issue to be decided was not solely or principally a matter of construction of documents (para. 25):

It is not, because all the facts on which the issue of the insurer’s obligation to indemnify and to defend, which are coextensive, are not known. In this context, the word ‘facts’ does not mean facts as determined by the trial judge on the trial of the underlying actions. It means the gravamen of the claim made in them. Here the pleadings in the underlying actions, as they stood at the time of the hearing below, are so muddled that one cannot tell what the gravamen is. Furthermore, the exclusion to put it as politely as possible, is difficult of construction. No doubt it would apply if, for instance, Pilot Pacific had brought an action against the respondent, but what else does it mean?

Esson J.A. referred to *Nichols* and *Scalera* regarding the necessity of looking beyond the “labels” used by the plaintiff in pleadings to determine the true nature of the claim. Esson J.A. stated he was not aware of any previous case in which the court had, because of an absence of an adequate factual basis for deciding the issue, refused to do so. Esson J.A. held, however, that in his view this was such a case for a number of reasons, including (paras. 35-36):

- (a) the fact that the pleadings in the underlying action were “hopelessly vague” and that the exclusionary clause was “difficult to understand”;
- (b) the exclusionary clause potentially affected every lawyer in British Columbia, and within the action the interpretation of the exclusion clause on an inadequate factual basis could bind the parties in the ultimate question of indemnity for liability;
- (c) a decision on the present pleadings could prove meaningless due to the anticipated changes; and
- (d) it was highly doubtful that the insurer could succeed in the appeal based on the above factors, but on the other hand the argument of the insured was based on the dicta in *Nichols* and took no count of the refinement of the applicable principles to be found in *Scalera*.

Esson J.A. held that the declarations that the insurer was required to defend the action should be set aside and the petition should be dismissed.

(8) *Karpel v. Rumack* (1994), 19 O.R. (3d) 555 (Gen. Div.)

Karpel v. Rumack cites all of the cases (including *Kates*) referred by Hilliker in *Insurance Bad Faith*. The claim in this case arose under a professional liability insurance policy that excluded “any dishonest, fraudulent, criminal or malicious act of the Insured”, and the insurer refused to defend on that basis.

After referring to *Nichols* as the leading authority on how the duty to defend is determined, the court went on to cite additional Ontario authorities on that point. The Court noted:

I have been referred to a number of decisions in which courts outside of Ontario have admitted evidence as to underlying facts. Those cases include: *Cansulex...*; *Shragie...*; *Kates...*; *Heck...*; *Privest Properties...* I have not been referred to any Ontario case, not involving the statutory condition, to which the underlying facts exemption allowed in the last-mentioned cases has been applied. It is my understanding of the Court of Appeals decisions in *Picken* and *Longarini*, *supra*, that the underlying facts exemption is not recognized in Ontario. [emphasis added]

(9) *Alie v. Bertrand & Frère Construction Co.* (2000), 30 C.C.L.I. (3d) 166 (Ont. S.C.)

Karpel was relied on by the trial judge in *Alie v. Bertrand & Frère Construction Co.* for the proposition that “evidence of underlying facts is not admissible in connection with the question of the insurer’s obligation to defend. Whether that obligation exists is to be determined solely on the basis of the allegations in the pleadings, and on a clear exclusion in the policy” (para. 472).

Alie was appealed at (2002), 1 C.C.L.I. (4th) 166 (Ont. C.A.). The Court of Appeal made no direct reference to the underlying facts exemption, but after reviewing *Nichols*, as well as some additional cases, the court held (para. 182):

As these cases demonstrate, where a policy provides a duty to defend, the operation of that duty will be determined prospectively by reference to the allegations made in the claim unless the policy expressly indicates to the contrary. If the insurer is potentially liable to indemnify under the terms of the policy, the insurer will be obligated to defend ...

It thus appears that the court of appeal upholds the trial judge’s rejection of the “underlying facts exemption.”

(10) *Halifax Insurance Co. of Canada v. Innopex Ltd.* (2004), 15 C.C.L.I. (4th) 159 (Ont. C.A.)

The Ontario Court of Appeal referred to the admissibility of extrinsic evidence in *Halifax Insurance Co. of Canada v. Innopex Ltd.* (2004), 15 C.C.L.I. (4th) 159 (Ont. C.A.). The claim against the insured arose from its alleged distribution of “knock off” Gucci watches in the US. Gucci brought suit against the insured in New York, alleging trademark infringement. The policy covered liability arising from “advertising liability.” Trademark infringement was excluded, excepting infringement that arose from the use of a title or slogan.

Counsel gave an opinion to the insurer that it had a duty to defend upon the pleadings. Counsel went on to opine, however, that the insurer would not have a duty to defend on what he referred to as the “known facts,” which were not substantially in dispute, as the insurer had not really engaged in any advertising (at 167). Counsel’s opinion was that the lawsuit by the third party was “a strategic manoeuvre” on the part of Gucci to try and determine the entity responsible for the alleged trademark infringement (at 168). Counsel also noted that U.S. courts would likely find that use of the alleged trademark infringement would fall within the “title” exception to the exclusion.

The insurer applied for a declaration that it did not have a duty to defend, framing its application to emphasize the underlying known facts. The motion judge held, based on the extrinsic evidence that the insured had not “advertised,” that the insurer did not have a duty to defend. The motion judge further found that the exclusion applied, and the title exception did not.

Borins J.A., delivering the judgment of the court of appeal, cited a lengthy passage from *Monenco* as “helpful in reviewing the legal principles and the test governing an insurer’s duty to defend and for the admonition against admitting extrinsic evidence on a motion or application to determine this issue” (at 173). Borins J.A. interpreted *Monenco* only as allowing the consideration of documents referred to in the pleadings and of documents referred to in the underlying statement of claim (at 176):

As Iacobucci J. made it clear in *Monenco*, so long as the facts as pleaded, within the coverage in the policy, the insurer is under a duty to defend even though the actual facts may differ from the pleadings. That is why extrinsic evidence going to the truth of the allegations pleaded, as occurred in this case, is not receivable. Moreover, as the motion judge did in this case, the court must avoid findings that would compromise or affect the underlying litigation. This is not to say that evidence is never permissible on a duty to defend application. Indeed, as in this case, it is not uncommon that expert evidence is helpful to the court in the interpretation of the insurance coverage and, on occasion, in interpreting technical language in the underlying claim.

What the insurer did in this case, by the procedure it followed, was to turn a duty to defend application into a duty to indemnify application by introducing extrinsic evidence pertaining to what it termed ‘the true facts.’ It is well-recognized that the insurer’s duty to defend is broader than its duty to indemnify. The time to determine the insurer’s duty to indemnify, if at all, is at the conclusion of the underlying litigation.

Borins J.A. found, referring to *Monenco*, that a determination on duty to defend was to be made on the pleadings, even though the “actual facts may differ from the allegations pleaded” (at 177).

Borins J.A. found that the motion judge correctly appreciated the threshold issue was whether the insured had been engaged in advertising when it sold and distributed the watches. The motion judge had incorrectly, however, relied on the extrinsic evidence to make a factual finding that the insured was not engaged in advertising, instead of making the determination on the basis of the allegations in the complaint. This application of extrinsic evidence was contrary to the procedure outlined in *Nichols*. Borins J.A. found it was implicit in Gucci’s complaint, although the word “advertising” did not appear, that the allegations included this offence (at 177).

The Court of Appeal overturned the decision of the trial judge and held that the insurer had a duty to defend against the complaint.

VI. Appendix B—IBC Non-Waiver Agreement Form

IBC CLAIM FORM NO. 6

IMPORTANT NOTICE: Your insurance company does not have enough information to make a decision whether or not the loss or occurrence you have reported to it is covered under the insurance policy. The purpose of having you sign this form is to allow the insurance company to continue investigating the loss or occurrence, to make investigations about your coverage under the policy, and to settle and pay any claims against you without giving up its rights to deny that the occurrence or loss is covered under the policy once its investigations are completed. You are not giving up your rights under the policy by signing this form. If the insurance company determines that there is no coverage for the occurrence or loss, it can require you to repay the amount of any settlement or judgment it has paid on your behalf, plus its costs of handling and defending any claim against you.

NON WAIVER AGREEMENT

IN THE MATTER OF
(Describe Nature of Claim or Loss)

which is reported to have occurred on or about the

day of 20 at or near
(Place of Occurrence)

involving the undersigned

and claim made by

AND IN THE MATTER OF a Policy of Insurance No.

issued by, hereinafter called the Insurer, under which policy the Insured alleges the insured has coverage, which the insurer does not admit, and whereas the Insurer requires further information to determine if the Insured is entitled to coverage under the policy, whether for defence or indemnity.

The undersigned hereby covenants and agrees with the Insurer, as follows:-

1. The Insurer may make such investigations of the loss or occurrence and claims arising there from as it deems necessary. In the event that issues relating to coverage arise as a result of such investigation, the Insurer will not be estopped from relying on such facts to make a decision on the coverage available to the insured under the terms and conditions of the Policy.
2. The Insurer may appear and defend all actions arising from the occurrence in the name of the undersigned.
3. The Insurer may carry on negotiations toward possible settlement in respect of claims or actions arising from the loss or occurrence without Judgement against the undersigned or without the further consent of the undersigned.
4. The Insurer may negotiate, settle and pay any claims arising from the occurrence or loss without a Judgement having been obtained against the undersigned. The undersigned realizes that this means that he has made himself liable to the Insurer to the extent of the payment made by the Insurer under the policy should the undersigned be found in breach of the policy.
5. Any action taken by the Insurer shall be without prejudice to the respective rights of the Insurer and the undersigned under the designated policy of insurance.