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• "TEN YEARS LATER": FIRST PARTY BAD FAITH A DECADE AFTER *WHITEN v. PILOT INSURANCE CO.* •

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Whiten v. Pilot Insurance Co., [2002] S.C.J. No. 19, 2002 SCC 18, has now been with us for almost ten years. The Supreme Court of Canada's decision in *Whiten* marked a watershed in the law of first party bad faith in Canada. *Whiten* was the first case to award truly substantial punitive damages ($1,000,000). In doing so, the Court overturned the decision of the Ontario Court of Appeal, which would have reduced the jury award of $1,000,000 in punitive damages to $100,000.[1] *Whiten* itself came only a little more than ten years after what was likely the first decision to award punitive damages in a first party bad faith claim in Canada.[2] When *Whiten* was handed down, there was a great deal of discussion as to whether the decision would radically change the law of insurer bad faith, and whether *Whiten* signalled a move to a more "U.S.-style" system under which bad faith claims would be routinely made and in which punitive damage awards would skyrocket.[3]

So, ten years after the decision in *Whiten*, where are we? The purpose of this article is not to fully address all developments in the law of insurer bad faith over the last ten years. This article will consider, in some detail, four significant recent decisions involving first party bad faith, and what can be said, on the basis of those decisions, concerning the state of first party bad faith in Canada. Those decisions are *Sagl v. Chubb Insurance Co. of Canada*, [2011] O.J. No. 3974, 2011 ONSC 5233; *Wilson v. Saskatchewan Government Insurance*, [2010] S.J. No. 350, 2010 SKQB 211; *Sidhu v. The Wawanesa Mutual Insurance Company*, [2011] B.C.J. No. 1573, 2011 BCSC 1117; and *Kings Mutual Insurance Co. v. Ackerman*, [2010] N.S.J. No. 255, 2010 NSCA 39. While the trend in those cases is not entirely uniform, the overall

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message is fairly clear. Predictions that *Whiten* would result in a more liberal approach to bad faith claims against insurers and would open the floodgates to ever larger punitive damage awards have not come to pass. While the B.C. trial decision in one of the four cases, *Sidhu*, has arguably lowered the bar in terms of conduct that may be found to constitute bad faith, none of the recent decisions show a marked change in approach. Indeed, two of the recent decisions, *Sagl* and *Wilson*, show a very conservative and restrained approach, both in considering what sort of conduct should give rise to a finding of bad faith, and in determining the appropriate award of punitive damages where bad faith is found.

I. Bad Faith in First Party Policies: General Principles

Before turning in detail to the four cases, it is worth restating the fundamental underlying principles of insurer first party bad faith. In both *Sidhu* and *Wilson* the courts referred extensively to the two key decisions of the Supreme Court of Canada on bad faith, *Fidler v. Sun Life Assurance Co. of Canada*, [2006] S.C.J. No. 30, 2006 SCC 30, and, of course, *Whiten, supra*, and quoted the following language from *Fidler* (which was in turn quoted from *720535 Ontario Inc. v. Lloyd's London, Non-Marine Underwriters*, [2000] O.J. No. 866 (Ont. C.A.):

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

> *whether the denial was the result of the overwhelmingly inadequate handling of the claim, or the introduction of improper considerations into the claims process.*

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

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

In considering the principles that will apply in awarding punitive damages where bad faith is found, the *Sidhu* Court quoted the following from *Whiten* (at para. 155):

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

The following passage from *Whiten* on the factors to take into account in awarding punitive damages is also worth referring to:

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

At the risk of over-simplification, the key principles underlying the duty of good faith in a first party context can be summarized as follows.[4]

1. The insurer must undertake a proper and unbiased investigation into the claim, without a pre-determined conclusion, and must consider all reasonably available information, including information available from the insured;
2. The insurer must undertake that investigation reasonably promptly, must communicate the results to the insured reasonably promptly, and must generally communicate properly with the insured regarding the claim;
3. The insurer must not subject the insured to undue or unfair pressure or tactics in-

tended to extract a low settlement, and must not impose improper conditions on payment of claims;

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

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

II. Recent Cases

Sagl v. Chubb Insurance Co. of Canada

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

The facts in *Sagl* are well known, but bear repeating. Ms. Sagl was insured under a Chubb high net worth homeowner's policy which covered her principal residence. Not long after the policy was taken out the house was destroyed by fire. The house was a veritable museum, stuffed with sculptures and paintings by well known artists, with a value of several million dollars. Chubb denied the claim on grounds of arson; asserted that the policy was void for misrepresentation/failure to disclose and alleged fraud in the making of the claim. The matter first went to trial, on both coverage and bad faith, in 2007, [2007] O.J. No. 3311.

Sagl's bad faith claim was based, in part, on alleged failure to conduct a reasonable and unbiased investigation into the arson allegation. The Court's consideration of the arson investigation was significant, as the primary investigation was not conducted by the insurer at all, but by the fire commissioner and, to some extent, by the police. The fire commissioner was convinced, based on a number of pieces of evidence, that the fire was arson. There was no suggestion that the insurer influenced the fire commissioner's investigation. The bad faith claim was based largely on the assertion that the insurer might have "looked more closely" at the fire commissioner's investigation (para. 227), and failed to "impartially scrutinize" the investigation. As a result, the Court held, the insurer approached the arson question with "tunnel vision" (para. 231).

The finding in *Sagl* of bad faith in following, without sufficient scrutiny, an independent investigation into cause, was a significant expansion on prior cases. In *Whiten* and in *Khazzaka v. Commercial Union Insurance Co. of Canada*, [2002] O.J. No. 3110 (Ont. C.A.), insurers doggedly pursued arson investigations in the face of overwhelming objective evidence to the contrary and independent investigations which discounted the possibility of arson. Those cases are a far cry from the facts in *Sagl*.

There are prior cases where the investigation was independent but nonetheless give rise to a finding of bad faith. In *Cornhill Insurance plc v. Bay Bull Sea Products Ltd.*, [2006] N.J. No. 279, there was an allegation of arson by two groups of insurers following destruction by fire of a fish processing plant. Insurers under the building and equipment policy abandoned the arson defence before trial. Insurers under the stock policy maintained the arson defence to trial. In that case the arson defence had been carried out primarily by the RCMP and the primary experts and investigators were retained by the RCMP and the fire commissioner. The Court nonetheless found a breach of obligation of good faith of both groups of insurers in main-

taining the arson defence on the grounds that the insurers could not "hide behind the actions of the RCMP and the fire commissioner and avoid their duty" (para. 160). Insurers failed to conduct a reasonable investigation and evaluation of the claim by "readily buying into the investigator's view that there had been arson" (para. 157). However, the Court found that the insurers' conduct did not justify an award of punitive damages. The trial judge did award solicitor-client costs, essentially as a remedy for the bad faith conduct of insurers. That finding was upheld on appeal with regard to the stock insurers, but overturned with regard to the building and equipment insurers. Thus, while there was a finding of bad faith, there were no damages, and no remedy at all against one of the two groups of insurers. In that sense, the first trial decision in *Sagl* was a significant expansion of the type of conduct capable of giving rise to a finding of bad faith.

The Court also found evidence of bad faith in the insurer's underwriting of the policy in question. *Sagl* was quite an unusual case in this respect. The policy was written without any detailed application form. After the loss the insurer alleged that the policy was void for failure to disclose various material facts regarding the insured's financial condition and other matters. The trial judge found that the insurer had waived the right to further inquiries on the matters in issue by not asking any questions at the time the policy was taken out. But the trial judge went further and found that this practice of "post claims underwriting" (not a phrase used by the trial judge), combined with the allegation of misrepresentation, was evidence of bad faith. The allegations of fraud in the making of the claim were also indicative of bad faith (see paras. 231-235).

In the result, Sagl was awarded $500,000 in punitive damages. There was very little analysis of the basis for the quantum of punitive damages awarded. The only factor specifically referred to on this point was the insured's argument that Chubb, after having been successfully sued in a prior case alleging bad faith, "did not learn" from the prior case (para. 238).

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

The Court of Appeal, [2009] O.J. No. 1879, found that the trial judge had not adequately dealt with the allegation of fraud in the making of the claim and ordered a new trial on that issue. The issue of bad faith and any damages arising from bad faith were also remitted to the second trial.

The second trial proceeded in May and June 2011 and reasons were handed down September 8. With regard to the arson allegation Justice Marrocco simply reached a different conclusion on the evidence than Justice Wright had reached at the first trial. Justice Marrocco referred to the fact that the insurer had "reasonably believed" that the fire was arson (see, for example, para. 284). There are no detailed findings on this point. Justice Marrocco found that, because the investigation was an independent investigation by the fire commissioner, the insurer was entitled to rely on that investigation. No evidence was called at the second trial on the arson issues. Accordingly, Marrocco J. reached a decision on this point considering exactly the same evidence as that which was before Wright J. at the first trial.

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

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

Justice Marrocco was also very critical of the insurer's handling of the fire scene, noting that there was no proper inventory of materials removed from the site. Given the allegation of fraud in the making of the claim and the dispute over what artworks were actually in the house at the time of the fire, this was obviously a significant issue. This issue did not, however, support an award of punitive damages.

Overall, Justice Marrocco found that Chubb's conduct, while deserving of criticism, did not rise to the standard necessary to award punitive damages. Neither side has appealed.

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

Wilson v. Saskatchewan Government Insurance

Wilson involved a claim for rehabilitation benefits arising out of two motor vehicle accidents in the mid 1990s. SGI paid benefits to the insured until 2006. In 2006, a new examiner took over the file. The examiner requested an opinion from a physiotherapist as to whether the insured's ongoing problems were related to the motor vehicle accident, or were the result of a pre-existing condition (para. 25). The examiner did not ask the physiotherapist to address the specific issue required to be addressed by the applicable statutory provisions, namely whether the treatment program then in effect was "necessary or advisable" to contribute to rehabilitation or lessen the insured's disability caused by the accident. The physiotherapist, nonetheless, considered that the ongoing treatment was not beneficial (para. 126). The Court noted that this single opinion was contrary to every other opinion that had been obtained with regard to the

insured's claim over the years. This included opinions previously obtained by SGI. Nonetheless, in reliance on the new physiotherapist opinion, SGI terminated benefits. The Court noted that this was done without any consultation with the insured and without consideration of the other opinions obtained on the file.

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

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

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

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

Wilson involves a veritable catalogue of the factors that can be found to give rise to first party bad faith. The insurer failed to conduct a proper investigation as to whether there was a basis to withdraw benefits; ignored the bulk of the expert evidence, including opinions of experts it retained; failed to communicate properly with the insured; and placed improper conditions on reinstatement of the claim. Yet, despite the fairly extreme conduct of the insurer, the award of punitive damages was, to say the least, not large. The Court awarded only $7,500 in "pure" punitive damages. The Court also awarded indemnity for legal fees incurred up to the date of commencement of the action. Indemnity for these legal fees was expressly awarded as an element of the punitive damages award (making the total award $15,000). Characterizing indemnity for those costs as punitive damages was arguably an error, given the fact that punitive damages are not intended to be compensatory. However, indemnity for those costs presumably could have been awarded as special damages as a result of the insurer's bad faith. The Court also awarded solicitor-client costs for the action, in part on the basis that SGI's bad faith conduct continued throughout the litigation, with SGI having "attempted to instruct and impede" certain evidence being presented (para. 148) and essentially being uncooperative in the process. In any event, even with the award of legal fees, the award of punitive damages was very small.

Sidhu v. The Wawanesa Mutual Insurance Company

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

1. Issues of coverage and bad faith were considered at one trial. This is very unusual for a British Columbia bad faith case, as bifurcation motions are almost routinely granted in B.C.[5]
2. It was common ground that the fire was arson. Again, this is very unusual for a first party bad faith case involving an allegation of arson. The only issue in *Sidhu* was whether the insured was implicated in the arson.
3. The investigation which resulted in a charge of arson was not primarily the insurer's. As in *Sagl*, the fire department conducted an independent investigation and concluded that the fire was arson.

The facts of the case are reasonably straightforward. The initial investigation proceeded promptly. The fire department conducted the primary investigation. That investigation concluded that there was evidence of accelerants outside the house. The investigation also determined that there were accelerants inside the house. The insurer appointed its own investigator. There were meetings with the insured. Within a few months of the fire there was an internal "round table" at Wawanesa involving some more senior personnel. The result of the "round table" was that there would be some further investigation before a decision was made as to whether to deny cover. For some reason, this did not happen. It is not entirely clear why from the decision. But the fact is that the investigation was not concluded.

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

Justice Armstrong found that there was not sufficient evidence to implicate the insured in the arson. The finding was that the arson was by unknown persons. Significantly, given the bad faith analysis referred to below, the Court found that the insurer was justified in having "concerns" about the credibility of the insured (para. 125). In fact, Armstrong J. confirmed the possibility that the insured may have been untruthful with the insurer, but found this was not proven on a balance of probabilities (para. 128).

On the basis of those facts Armstrong J. considered the insured's bad faith claim. Justice Armstrong concluded that "promptness" was the key issue in terms of the bad faith claim (para. 180). The key finding appears to have been the fact that the investigation dragged on for two years without conclusion. Justice Armstrong referred to the insured as having been "left in the lurch" (para. 173) for two years.

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

Justice Armstrong referred to some additional factors as also supporting his conclusion that

there was bad faith. Justice Armstrong referred to the fact that the insurer had failed to provide a proof of loss, as required under the terms of the policy and the *Insurance Act*, RSBC 1996, CHAPTER 226. This appears to have been a pure oversight by the insurer or the adjuster. There appears to have been no basis to suggest that the proof was intentionally withheld. Nor does it appear a proof was demanded. Justice Armstrong does not expressly consider whether there was any prejudice arising from the lack of a proof.

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

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

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

On a related point, *Sidhu* is significant in awarding punitive damages for bad faith in an arson case in which there was an independent third party investigation, not primarily conducted by the insurer. In *Sagl*, as noted above, a finding of bad faith on the basis of a largely independent investigation was made at the first trial, but not at the second trial. By awarding punitive damages where there has been an independent finding of arson *Sidhu* arguably lowers the bar in terms of conduct that may be found to support a finding of bad faith.

Another interesting aspect of the decision in *Sidhu* is the Court's reference to the "round table" meeting at Wawanesa. This was a meeting at Wawanesa to consider the insured's claim in March 2005, about six weeks after the fire. The Court referred to the round table negatively, pointing out the lack of information, or correct information, in the possession of Wawanesa's claims executives. The Court also referred to the fact that the intention, at conclusion of the round table, was to carry out a further investigation, which was not done. The issue of round tabling has been referred to in a number of U.S. cases, but has received little attention in Canada. From the insurer's perspective "round tabling" is seen as a salutary practice which improves claims handling and decision making by bringing to bear all of the insurer's expertise. However, this is not always the case. A glaring example of a situation in which "round tabling" worked against the insurer was *Merrick v. Paul Revere Life Insurance Co.*, 594 F.Supp. 2d 1168 (D.Nev. 2008) at 1170-71. In that case the insurers' policy was to destroy all records of the round tables, including the identity of those attending, subjects discussed, and the basis for any decision reached at the round table.

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

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

The insurer has appealed the decision in *Sidhu*. Accordingly, a full consideration of whether *Sidhu* "lowers the bar" in terms of conduct that may support a finding of bad faith, will have to await the result of the appeal.

Kings Mutual Insurance Co. v. Ackerman

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

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

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

Matters then started to go sideways.

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

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

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

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

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

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

III. Lessons to Be Drawn

The recent cases, overall, certainly do not suggest a trend towards a more liberal approach to findings of bad faith. Nor do the cases suggest a trend towards increasing damages. Only *Sidhu* arguably suggests a lowering of the bar, in terms of conduct that may constitute bad faith. *Sidhu*, as noted above, is under appeal and full assessment of that case will have to await the result on the appeal. The decision following the second trial in *Sagl* certainly suggests a restrained approach to findings of bad faith. Indeed, the second trial found no basis for punitive damages on the same evidence that had, at the first trial in 2007, been found to support an award of $500,000. *Wilson* shows a very restrained approach to an award of damages. In a case in which the facts were arguably quite egregious, there was an award at the very low end of the spectrum. The insured in *Wilson* came out with little more than indemnity for the additional legal fees incurred as a result of the insurer's bad faith handling of the claim. *Kings* shows that even in a jury trial, where the quantum of punitive damages is much less predictable than following a non-jury trial, the award will not necessarily be high. The award in *Kings*, at $55,000, was both moderate in absolute terms and in relation to the indemnity payable under the policy.

There have, of course, been some fairly substantial punitive damage awards since *Whiten*. For example, in *Plester v. Wawanesa Mutual Insurance Co.*, [2006] O.J. No. 2139, a case involving an unwarranted allegation of arson, the jury awarded indemnity under the policy at $500,000, together with aggravated damages to two plaintiffs in the amount of $175,000 and punitive damages totalling $450,000, for a total verdict of approximately $1,200,000. On appeal, the Court set aside the award of aggravated damages as "grossly excessive" (para. 66) and reduced the award to $50,000. The award of punitive damages, however, was upheld. The Court noted that the award was at the "high end" of the range and higher than the amount the Court would have awarded (echoing the comments of Justice Binnie in *Whiten*), but was not an award with which the Court would interfere (para. 103). Obviously, where juries are involved, a greater degree of variability in punitive damage awards continue to occur, but recent cases do not indicate a trend to increasing awards, and *Whiten* remains the high water mark.

First party bad faith cases since Whiten are also notable for what they do not consider. The focus, in the four cases considered in this article, has been entirely on a detailed examination of the investigation and handling of the specific claim under consideration. None of those cases consider the sorts of allegations of "institutional bad faith" that are often made in U.S. cases. Those cases, which consider evidence of company-wide practices, and such matters as compensation schemes, bonus schemes and corporate profitability, involve a much wider-ranging enquiry than the vast majority of Canadian bad faith claims.[6] In the few instances in which such claims have been brought in Canada they have been unsuccessful,[7] and there is no indication that this will change.

Overall, almost a decade after *Whiten*, the message appears to be one of restraint. Bad faith claims continue to be fairly rare; the bar to prov-

ing bad faith remains high; and the damages awarded, in most cases, are modest.

[*Editor's note*: This article was adapted from a paper presented to the BC CBA Insurance Law Subsection, October, 2011.]

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1 See [1999] O.J. No. 237, 170 D.L.R. (4th) 280 (Ont. C.A.).

2 *Labelle v. Guardian Insurance Co.*, [1989] O.J. No. 1093, in which punitive damages of $10,000 were awarded.

3 See, for example, "Insurance Bad Faith: The Next 10 Years", Hilliker, BC CLE Insurance Law Conference May 2003; Buller, "Whiten v. Pilot: Controlling Jury Awards of Punitive Damages", (2003) 36 UBC L. Rev 357, Oakley, "Punitive Damages in Canada: Whiten v. Pilot Insurance, 'The Insurer from Hell'", (Winter 2002) 21 Advocates' Soc. J. No. 3, 14.

4 A more detailed list of specific actions or conduct that may constitute bad faith in the first party context is set out in Margolis, "The Continuing Evolution of Bad Faith Claims Against Insurers", (March 2009) 27 Can. J. Ins. L. 17 at p. 20.

5 See *Wonderful Ventures Ltd. v. Maylam*, [2001] B.C.J. No. 1144, 2001 BCSC 775; *Lawrence v. Insurance Corp. of British Columbia*, [2001] B.C.J. No. 2516, 2001 BCSC 1530; *Sanders v. Clarica Life Insurance Co.*, [2003] B.C.J. No. 596, 2003 BCSC 403; *Stevens v. Sun Life Assurance Co. of Canada*, [2004] B.C.J. No. 661, 2004 BCSC 468; *Stuart v. Manufacturers Life Insurance Co.,* [2004] B.C.J. No. 729, 2004 BCSC 501; *Rehmat v. Transamerica Life Canada*, [2009] B.C.J. No. 738, 2009 BCSC 495; *Cort v. ICBC*, [2011] B.C.J. No. 853, 2011 BCSC 586; and *Brennand v. Sun Life Assurance Co. of Canada*, [2011] B.C.J. No. 1062, 2011 BCSC 759. In all of these cases the Court found that any reasonable possibility that the insurer would rely on legal advice as a defence to the bad faith claim justified severance. Contrast the approach taken in such cases as *Sempecos v. State Farm Fire and Casualty Co.*, [2001] O.J. No. 4887 (S.C.J.) and *SNC-Lavalin Engineers & Constructors Inc. v. Citadel General Assurance Co.* [2003] O.J. No. 310 (Nfld.), in which severance was not permitted on that basis.

6 An example of this sort of decision in the U.S. is *Merrick v. Paul Revere Life Insurance Co.*, 594 F. Supp. 2d 1168 (D. Nev. 2008). *Merrick* follows and expands on earlier cases involving Unum-Providence/Paul Revere and found institutional bad faith in various corporate practices, including a procedure to target "subjective claims", a practice of attempting to extract low settlements based on "vulnerability of insureds to pressure tactics", a practice of imposing "objective evidence requirements" on insureds, a practice of shifting "the burden of claims investigation to the insured" and instructions to limit the use of IMEs., a practice of heavy reliance on in-house medical personnel who never examine the insured, setting of "targets and goals for claim terminations" without regard to claim merit, including evidence that claims units were required to meet certain net termination ratio targets and develop action plans if those targets were not met on a weekly basis.

7 For example, in *Chaplin v. Sun Life Assurance Co. of Canada*, [2001] B.C.J. No. 350, 2001 BCSC 310 and [2004] B.C.J. No. 146, 2004 BCSC 116, allegations were made concerning bad faith based on corporate bonuses, compensation plans, and related matters. The claim was not only unsuccessful, but resulted in a substantial award of costs against the insured and plaintiff's counsel.