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Errors & Omissions Insurance

An Update on Legal Issues

by

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A. INTRODUCTION

The prudent professional would be well-advised to secure professional liability insurance as the risks and potential liability associated with the practice of professions continue to grow. Professional liability insurance, or E&O (errors & omissions) as it is more commonly known, can be obtained in addition to general liability insurance policies and seeks to protect professionals from the financial loss and civil liability they can incur as a result of negligent acts, errors and omissions during the performance of professional services. E&O policies also cover costs associated with defending an action which can become quite hefty, even where liability is not established. Only professionals are eligible for E&O coverage; non-professionals, such as technicians, labourers, and employees do not qualify.

The purpose of this paper is to provide an update on the issues raised in recent case law on E&O coverage and related issues, and to discuss the implications of these cases on the insurance industry.

B. WHAT CONSTITUTES A "CLAIM"?

E&O policies are "claims-made" policies, as opposed to "occurrence-based" policies. While the latter type of insurance policy focuses on the time when the negligent act or damage occurred in order to determine coverage, insurers who underwrite claims-made policies are liable to indemnify the insured for claims that are made *during the policy period*, regardless of when the negligence giving rise to a claim may have occurred.

By its very nature, claims-made policies allow the insurer to better assess its risk for any given year. That factor is particularly important for insurers in assessing the risks of insuring a professional as claims arising from professional services may not be known until may years after the negligent act. With a claims-made policy, insurers are able to ask appropriate questions and gather information about a potential insured's business and any circumstances that may give rise to a claim in a particular year before deciding whether or not to insure them and what risks to assume. The ability of insurers to better assess their risk typically results in more affordable insurance coverage for the professional.

The concept of claims-made policies appears to be simple enough – when a claim is made, the insurer shall indemnify. But is it that simple? What constitutes a "claim" under the policy? The answer to that

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oft-asked question may be found both in the policy itself and in the case law which has developed surrounding this legal issue.

No doubt, from years of risk management wisdom, and probably incessant advice from coverage counsel, most insurers now define what is meant by the term, "claim", in the policy itself. However, as the case law has revealed, this step alone does not give full security of what will or will not constitute a claim in all circumstances.

There are some general interpretive principles of insurance law that can be of assistance in determining whether there is a "claim". First, *contra proferentum* is the notion that where there is ambiguity in the policy, insuring provisions are to be read broadly and exclusions are to be read narrowly. In the absence of ambiguity, this interpretive tool is not to be used and the policy should be simply read as a whole and the ordinary meaning applied[1]. Second, courts should try to give effect to the reasonable expectations of the parties without reading in windfalls to either party's benefit. Finally, the context of the particular risk should be taken into account[2].

The Supreme Court of Canada has provided some meaning to the term "claim". Madam Justice McLachlin noted the authorities and established a general rule that:

> For a 'claim' to be made there must be some form of communication of a demand for compensation or other form of reparation by a third party upon the insured, or at least communication by the third party to the insured of a clear intention to hold the insured responsible for the damages in question…[3]

Her Ladyship went on to note that the authorities distinguish between a communication of a demand and an assertion of liability sufficient to trigger coverage under a claims-made policy and:

[1] *Jesuit Fathers of Upper Canada v. Guardian Insurance*, 2006 SCC 21 at para 28.
[2] *supra*, para 29 and 30.
[3] *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.* (1993) 99 D.L.R. (4TH) 743 affirming (1991) 47 C.C.L.I., reversing (1990) 45 C.C.L.I. 172 (Man. Q.B.)

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1. mere requests for information,

2. filing a law suit without serving it on the insured or otherwise advising them of the claim within the suit[4], and

3. expressions of dissatisfaction that are clearly not meant to convey a demand for compensation for damages[5].

The words of the policy and the factual background serve as determining factors in making these distinctions. Madam Justice McLachlin later gave a more general definition of the word "claim" for a policy where there was no definition of the word "claim". In this scenario, Madam Justice McLachlin not surprisingly defined "claim" broadly as "a *form* of demand or assertion of liability, not a *formal* demand or assertion of liability".

In an effort to alleviate this confusion as much as possible and to have some predictability in outcomes, many E&O policies today make ardent efforts to define a "claim" under a policy. Notwithstanding such efforts, and the case law which broadly interprets what may be a "claim" in the eyes of the law, issues still surround the triggering of the insurers' duty to defend in claims-made policies. Most recently, the following issues were considered by the court:

(i) When do allegations of negligence become claims? and

(ii) Can notice of an event from which a claim is expected give rise to a duty to defend?

1. <u>When do allegations become a claim?</u>

The duty to defend under claims-made policies is triggered by a "claim" being made, and not by an allegation. Deciding whether a particular communication is an allegation or a claim can be a difficult

[4] *Peacock v. Roberts* (1990) 42 C.C.L.I 196 (B.C.C.A.), affirming (1986) 15 C.C.L.I. 36 (S.C.)
[5] Tuytel, Neo "Design Professionals' Errors & Omissions Insurance Coverage: A Survey of Canadian Cases Involving Architects, Engineers and Their Liability Insurers" (2004), pg. 7.

choice to make, and one that could have costly consequences for an insured or an insurer. The Supreme Court of Canada recently discussed the distinction between allegations and claims in *Jesuit Fathers of Upper Canada v. Guardian Insurance Company of Canada*, 2006 SCC 21, and, in a unanimous decision, stated what factors must be present for an allegation to become a claim.

(a) *Jesuit Fathers of Upper Canada v. Guardian Insurance,* 2006 SCC 21

The Jesuits operated a residential school in Ontario from 1913 to 1958. In 1991 a former student alleged that he was sexually abused by one of the school priests while he was a student at the residential school. After several internal and external investigations, by 1994 the Jesuits were aware of the general and specific allegations of abuse and also had names of possible victims and perpetrators. From September 30, 1988 to September 30, 1994 the Jesuits had a Comprehensive General Liability policy which included E&O coverage on professional services for "claims which are first made against the insured during the policy period". Unlike many E&O policies, this policy did not contain a definition of "claim".

During the policy period, only one clear-cut claim was made – the Cooper claim. This claim came in the form of a written demand letter from a former student's lawyer and was brought to the Jesuits' and insurer's attention during the policy period. In an attempt to secure coverage for impending claims, the Jesuits' lawyer, Mr. Zimmerman, wrote to the insurer on March 18, 1994 notifying them of nine additional sexual abuse claims they could face. The allegations in this letter were specific and included names of offending Jesuits, dates and locations of the acts in question and provided names of the anticipated claimants. After the policy expired on September 30, 1994, the Jesuits received approximately 100 additional sexual abuse claims; notice of these was forwarded to the insurer. The insurer took the position that with the exception of the Cooper claim, no "claims" had been made during the policy period and that its duty to defend had not been triggered.

The court was faced with deciding whether the allegations in the Zimmerman letter were sufficient to trigger the duty to defend, and more generally, to decide under what circumstances an allegation becomes a claim.

This case was first considered at the Ontario Superior Court in 2003. The trial judge held that notice of a general belief that claims would be presented did not amount to a "claim" made during the policy

period and would not trigger the duty to defend. The Ontario Court of Appeal endorsed the decision of the trial judge in 2004, stating that "the appellant's knowledge of circumstances or prior events that could give rise to claims against the appellant for compensation at some point in the future could not be equated with a claim for the purposes of the insuring agreement provisions in the policy".

After considering the judicial history, the Supreme Court of Canada concluded that there was a clear distinction in the policy between an occurrence and a claim, and further, that there was a suggestion that a claim had to involve an actual demand or other legal process received by the insured. The court turned to common law and held that a claim required, at the very least, a third party representative such as a lawyer, teacher or friend, to communicate an intention to hold the insured responsible for damages; that representative must be "accurately communicating the intent of the claimant and that [the communication] be done with the claimant's full knowledge and approval". The communication must be within the policy period.

Justice Lebel found, on behalf of a unanimous court, that the insurer's duty to defend was not triggered with respect to the allegations in the Zimmerman letter or by the 100 claims made after the policy had expired. An intention to hold the Jesuits responsible for damages was not communicated by the claimants in either of these categories during the policy period. As a result, the insurer did not have a duty to defend.

(i) Implications for Insureds

Although information developed or discovered by the insured about potential, even likely, claims may give rise to an obligation under the policy to give notice of an occurrence, this is typically insufficient to trigger coverage. In order for a claim to be made which will trigger coverage, a clear communication must be made by the claimant or their representative to the insured within the policy period expressing an intention to hold the insured liable for damages. The insured must disclose this claim to the insurer at once.

The legal requirement for a "claim" to occur within the policy may pose a problem for the insured, even if E&O coverage is obtained consecutively. Despite being continually insured, there can be gaps in coverage and claims that will not fall within the purview of any policy. For example, the next policy may exclude from coverage any negligence of which the insured is aware prior to the coverage period even if

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no claims have been made. A problem could arise where the underlying damages (and related negligence) are discovered in the prior policy period but the claim is not made by the claimant or their representative third party until a subsequent policy period. The current insurer may then be off the hook (as no "claim" has yet been made), while a new insurer will require an exclusion of the potential claims in its policy. This leaves the insured exposed to liability.

In those circumstances, the insured must consider additional coverage that may be available on the market to deal with the potential gaps in coverage. The insured may obtain an "Extended Reporting Period" "Discovery Period" or "Tail Coverage" clause, which would cover claims made for a specified period of time after the expiry of the policy. These clauses protect the insured against the possibility of an insurer refusing to renew a policy after becoming aware of circumstances that may give rise to many future claims. Another option for an insured may be to obtain the "Notice of Circumstance Clause", which permits the insured to report during the policy period circumstances that may give rise to future claims. Any claims related to those circumstances made after the expiry of the period are deemed to be made during the policy period. While such a clause is not a complete solution for the insured (see discussion below on the *MWH* decision), depending on the wording of the policy, it may allow the insured to claim coverage for an event from which it expects a claim could be made.

(ii) Implications for Insurers

Insurers would be wise to put "an occurrence-based restriction on the claims made coverage" so that they do not have to provide coverage for any claim arising out of circumstances known by the insured prior to the coverage period. This limits the liability and risk assumed by the insurer, and clarifies what will constitute a "claim" under the policy. A thorough background check should be done by the insurer for all potential insureds so as to assess the risk that may arise during the policy period. If any potential sources of liability are found, the insurer can include exclusion provisions in the policy for assumption of that risk.

The decision in *Jesuit Fathers* amplifies the basic interpretive principles of insurance law and, most notably, it affirms *contra proferentum*, the notion that insuring provision are to be read broadly and exclusions are to be read narrowly when there is ambiguity in the policy. This decision also reinforces the principle that the policy should be read as a whole and ordinary meaning applied in the absence of ambiguity.

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Accordingly, it is important that when drafting policies, insurers be clear, include definitions where possible, and try to avoid conflict. Failure to take these steps may result in the court interpreting the insuring provisions broadly and in favour of the insured, and contrary to the original intent of the insurer. In that instance, the risk underwritten will be greater than that which was expected by the insurer.

2. Can notice of an event from which a claim could be made trigger the duty to defend?

Not all claims will satisfy the requirement of being a "claim" as defined in the policy, nor will all claims be sufficient to trigger the insurer's duty to defend. In *MWH International, Inc. v. Lumbermens Mutual Casualty Co.* 2006 BCSC 219, and in *MWH International, Inc. v. Lumbermens Mutual Casualty Co.* 2007 BCCA 164, the court considered this issue in depth.

(a) *MWH International, Inc. v. Lumbermens Mutual Casualty Company,* 2006 BCSC 219, overturned 2007 BCCA 164

The plaintiff, MWH, was a firm of consulting engineers. The firm believed it was entitled to coverage afforded by the E&O policy which its corporate predecessor had obtained with the insurer for a specific project. This policy provided insurance for professional services rendered in respect of the design and construction of a power plant project.

During the policy period, the named insured partnership was restructured to a company and renamed to MWH. MWH was not a named insured on the policy.

During the policy period, a major part of the structure of the project failed and was largely destroyed. The plant that housed the structure had to shut down and the plant owner suffered a loss of approximately $50 million. MWH's lawyer wrote a letter to the insurer giving notice of potential claims against MWH that *may* arise as a result of the failed structure. No formal proceedings for the claim had yet been advanced by the plant.

MWH took the view that the insurers duty to defend was triggered by notice of potential claims and, specifically, that the insurer was responsible for covering the costs associated with MWH retaining a lawyer to investigate their legal liability and to prepare a defence. The insurer disagreed and argued that

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it had no obligation to defend under the policy unless and until a claim against the insured was actually made and that no claim was yet made in that case.

The following were the relevant provisions of the insurance policy governing this dispute:

> II. DEFINED TERMS
>
> B. CLAIM means "a demand received by the INSURED for money or services, including the service of a suit or institution of arbitration proceedings against the insured.
>
> F. DAMAGES means "a monetary judgment, award or settlement and does not include…"
>
> VII. DEFENSE, SETTLEMENT AND COOPERATION:
>
> A. With respect to the insurance afforded by this Policy, the Company shall **defend any CLAIM against the INSURED seeking DAMAGES to which this insurance applies**, even if any of the allegations are groundless, false, or fraudulent. It is further agreed that the Company may make such investigation of any CLAIM as it deems expedient, but the Company shall not be obligated to pay DAMAGES or to defend or to continue to defend any CLAIM after the applicable limits of the company's liability have been exhausted by payment of DAMAGES and/or CLAIMS EXPENSE.

Endorsement 6 of the policy modified the definition of CLAIM and stated: "The definition of CLAIM shall include CIRCUMSTANCE. CIRCUMSTANCE means an event reported during the Policy Period from which the insured reasonably expects that a claim could be made."

In light of the additional endorsement expanding the definition of "claim" to include a "circumstance", as defined, is giving notice of claims that exist but have yet to be pursued sufficient to trigger an insurer's duty to defend?

At trial, the judge found that since a "claim" includes a "circumstance", all the plaintiff must establish is that an event has been reported to the insurer from which the plaintiff reasonably expects that a claim for damages could be made to which the policy applied. Since the plaintiff insured in this case had given notice of a "circumstance", and therefore a "claim", the trial judge reasoned that the insurer had a duty

to defend the insured "against the INSURED seeking DAMAGES to which this insurance applies." The trial judge made this finding despite the lack of specific details of the "claim" or the "circumstance" in the notice letter, and did so, it would appear, ignoring the actual wording of the insurer's obligation to defend under Section VII of the policy.

The trial decision was overturned at the Court of Appeal. The insurer's duty to defend the insured was thus not triggered by the notice of a "circumstance". Even if there was a "claim" because there was a "circumstance", there was no "claim" against the insured whereby "damages" were then being sought. In what may be considered an unusual turn of events, our Court of Appeal strictly interpreted the policy wording in favour of the insurer.

The Court of Appeal went further. In coming to its decision, the Court of Appeal questioned the intention of the parties to the policy that the word "claim" should really be read to include "circumstance". The court found, when looking at the surrounding words and context where the term "circumstance" was used in the policy, that a "claim" could not have been intended to include a "circumstance". To do so would stretch the common usage of the term to suggest that a circumstance or an event can be defended, when realistically only claims against insureds can be defended. The court thought it was not sensible to speak of settling or defending a circumstance or an event.

In conclusion, the Court of Appeal found that the insurer's duty to defend was not triggered by the letter giving notice of the "circumstance".

Leave to appeal the decision to the Supreme Court of Canada was refused.

(i) Implications for Insureds

Interesting questions arise from our Court of Appeal's decision in *MWH*. If Endorsement 6 does expand the definition of "claim" to include "circumstance", then what could be the purpose of including Endorsement 6 but to alter the insured's ability to make a "claim"? Could Endorsement 6 be limited to the notice requirements of an insured for an event when the endorsement itself contains no words limiting its applicability? Why would sophisticated commercial parties include a useless clause?

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The *MWH* decision is a good reminder for insureds that in the current state of the law, notice of a "claim", as traditionally defined by law to mean some form of communication of a demand for compensation or at least a communication by the third party to the insured of a clear intention to hold the insured responsible, is likely required to trigger an insurer's duty to defend. Even with an express attempt to broaden an insured's ability to give notice of a "claim" before a demand is actually made, the court, as we have seen in the *MWH* decision, may strictly interpret the policy to limit the insured's rights in this regard.

(ii) Implications for Insurers

Pursuant to *MWH*, insurers will not be liable to indemnify insureds for legal defence costs incurred to defend against *potential* claims. An insurer's obligation to defend will be triggered only where there is an actual claim that falls within the scope of the policy and where damages are being sought.

Arguably, the Court of Appeal in the MWH decision resolved ambiguities in the policy in favour of the insurer and, if so, then the Court did not apply the principle of *contra proferentum*, which states that ambiguities in polices are to be resolved against the drafter of the policy.

Keeping in mind that decisions often "go the other way" when ambiguities arise, insurers should make a concerted effort to ensure the terms of their policies are clearly defined. For example, greater clarity could be given in a policy as to what circumstances will trigger an insurer's duty to defend and what constitutes a claim for the purposes of triggering the duty to defend. Indeed, the *MWH* decision underscores the need to have coherent policies. If the policy was clear in the first place, the insurer in that case would not have had to try the issue in not only our trial court but also our Court of Appeal.

C. SCOPE OF E&O INSURANCE

(a) *Cassels Brock & Blackwell LLP v. LawPro*, 2007 ONCA 122

Cassels Brock & Blackwell, a law firm, sued its provider of E&O insurance after the insurer had failed to defend the firm in an action brought by one of the firm's clients. The firm was sued for providing negligent advice relating to the client's investments. The E&O policy covered "all sums which the INSURED shall become legally obligated to pay as DAMAGES arising out of a CLAIM, provided the liability of the INSURED is the result of an error, omission or negligent act in the performance of or the failure to perform PROFESSIONAL SERVICES for others". 'Professional Services' was defined as "the practice of the

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Law of Canada ... and specifically, those services performed, or which ought to have been performed, by or on behalf of an INSURED in such INSURED'S capacity as a lawyer and as a member of the Law Society of Upper Canada ... and ... include ... those services for which the INSURED is responsible as a lawyer arising out of such INSURED'S activity as a trustee". The key issue on appeal was whether investment advice provided as a direct consequence of the performance of legal services was covered by the E&O policy. The Ontario Court of Appeal found that the investment advice offered was not covered, and that the insurer was therefore under no obligation to defend the law firm.

(i) Implications for Insureds

Although E&O insurance provides coverage for professional services, it only does so to the extent the policy outlines. Services associated with a professional's business may not be covered. It is important for professionals insured under E&O policies to appreciate the extent to which they are covered, and conversely, the extent to which they are uninsured for their actions.

D. FAILURE TO DISCLOSE AND DUTIES OF THE INSURED

Insureds owe insurers a duty to cooperate and a duty to disclose. A failure to disclose information in an application for insurance does not render an insurance contract void or voidable unless the failure to disclose is material to the contract. Whether such a failure is material is a question of fact (s. 13 of the *Insurance Act*, R.S.B.C. 1996, c. 226).

The test for determining materiality is an objective one. The question is whether, if the information had been disclosed, it would have influenced the judgment of a reasonable or prudent insurer in fixing the premium or accepting the risk [*Surrey (District) v. General Accident Assurance Co. of Canada* (1994), 92 B.C.L.R. (2d) 115 (S.C.), aff'd (1996), 19 B.C.L.R. 186 (C.A.)].

The onus is on the insurer to prove both the failure to disclose and that the failure was material (*Surrey*).

1. What constitutes a failure to disclose? What are the effects of failing to disclose?

If an insured fails to disclose material information about a potential claim to its insurer when applying for liability coverage, then coverage under the insurance policy is excluded and the insurer will be under no duty to defend the insured in the action. The following case serves as a useful example.

(a) *Agresso Corporation v. Temple Insurance Company et al.*, 2007 BCSC 19

Agresso, the insured, designed and installed computer software systems. They applied for liability insurance on January 14, 2002 and were granted insurance on February 28, 2002 for a period of one year. When applying for insurance, Agresso had already been doing work for a particular client since 2000 and there were potential problems with their contract. On February 21, 2003, Agresso applied for a new policy. When making the application they did not disclose to the insurer the potential claims that could arise from the contract with their client. Eventually, a claim did arise with respect to that client and the insurer denied coverage on the basis that Agresso failed to disclose. Agresso brought an action claiming that the insurer had a duty to defend them in this claim against the client.

The court here upheld the insurer's decision not to defend Agresso. They were satisfied that Agresso knew there was a reasonable likelihood of a claim against them arising at the time they applied for the insurance policy and that they deliberately failed to disclose this information to the insurer. The court also found that had the insurer known of this impending claim, they would have acted differently and either refused to accept the risk or imposed special conditions on the policy.

(i) Implications for Insureds

This case affirms insureds' duty to disclose material information to insurers, and that the consequences for failure to disclose will either be that the insurance policy becomes void or is voidable. To ensure the most protection for themselves, insureds must report to the insurer any information that could reasonably result in a claim. If the insured fails to disclose any material information (ex. information about a potential claim) to the insurer that they had prior to entering into the policy for insurance, they could be left without any protection from liability. This can become a very costly risk.

Insureds should note that the duty to disclose applies from term to term of an insurance policy, even if you are with the same insurer throughout. For example, if you enter into Policy A for one year on January 1, 2006, learn information about a potential claim in November 2006 but fail to disclose this to the Insurer and later attempt to renew your insurance on January 1, 2007, your previous failure to disclose (should a claim arise from that information) will result in your insurance contract being void or voidable. You could be completely exposed to liability.

(ii) Implications for Insurers

Agresso is an important case for insurers because it affirms an exclusion to coverage - insurers are excluded from providing coverage and from their duty to defend where an insured does not provide them with material information about a potential claim when applying for liability coverage. It is important for insurers to know that whether such a failure is "material" is a question of fact, and that the test for determining materiality is objective. Insurers should also note that the burden to prove there has been a failure to disclose on the part of the insured and that the failure was material lies with the insurer.

E. AGENTS & BROKERS LIABILITY

Determining the coverage included in an insurance policy can often include more parties than just the insured and the insurer. Third parties such as insurance agents or brokers are often involved in the process of negotiating the terms of the policy and with informing potential insureds of what their most suitable coverage options are. In carrying out their services, agents and brokers assume certain risk as they owe a duty of care to insureds and in some cases to the insurer.

The purpose of this section is to provide an overview of recent cases on the duties owed by agents and brokers, and the resultant liability when their duties are not met.

1. Brokers' Standard of Care

(a) *McIntosh v. Royal & Sun Alliance Insurance Co of Canada*, 2007 FC 23

This case concerns whether the broker in question met the standard of care of a reasonably prudent marine insurance broker by asking relevant questions about the insured's plans for their boat.

Upon purchasing a boat, the insured contacted a brokerage firm to obtain insurance coverage for the boat. The brokerage firm was aware that the insured planned to use the boat for commercial purposes in the near future, but suggested that the boat could be insured for personal use until such time as the insured was ready to take paying customers on the boat.

The insured obtained a personal insurance policy on the boat that specifically stated the boat would be used solely for private pleasure purposes and would not be "chartered or leased or used for any

commercial purpose". This was an absolute warranty and applied to the entire policy period. The policy was renewed on the same coverage terms. The broker did not communicate with the insured about his use of the boat at the time of renewal.

After the renewal, despite failing to obtain commercial insurance, the insured began to use the boat for commercial purposes. The boat was then stolen and the insured tried to claim on their policy. The insurer denied the claim in respect of the theft, and found that the insured had used the boat for commercial purposes in contravention of the policy. In response, the insured argued that the broker failed to properly advise them and failed to meet the standard of care that was necessary.

The court agreed with the insurer - the insured had taken paying customers on the boat without having commercial insurance and knowing that his policy specifically prohibited use for commercial purposes. The insured knowingly breached his policy.

With respect to the insured's claim against the broker for failing to advise him fully about the effect of not obtaining commercial insurance, the court held that while the brokerage firm failed to meet the standard of care required of a reasonably prudent marine insurance broker, there was no causal link between the broker's actions and the insured's loss. The insured had not relied on the advice of the brokerage firm and instead had consciously chosen to take paying customers on his boat despite being aware that this would amount to commercial use, contrary to the terms of the policy.

In this case, the broker failed to meet the standard of care required of a reasonably prudent broker because of two reasons:

1. Knowing that the insured intended to soon take paying customers on his boat for charters, the broker had an obligation to explore the insured's business plans with him in greater detail and, if necessary, to discuss these plans with the underwriter, in order to ensure that the insured obtained adequate insurance coverage; and

2. The broker's advice on the ability of the insured to obtain coverage for commercial use when the insured actually commenced commercial use was incorrect and inconsistent with the policy wording and requirements. The underwriter had a right to know of an

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> insured's current and intended future use of the boat. The broker failed to discuss this issue with the insured.

Generally, insurance brokers owe a duty of care to the insured to make sure they have adequate coverage in place in the event of a loss. This duty involves an insurance broker asking the necessary questions of an applicant for insurance in order to assess the foreseeable risks and insure the client against them. The broker also has a duty to explain the limitations of the coverage to the insured. Accordingly, the broker in this case did not meet the standard of care required by a reasonably prudent insurance broker.

Failure of a broker to meet their standard of care, however, is not sufficient to establish their liability. A causal link must also be found between the broker's failure to meet the standard of care and the insured's loss. Here, McIntosh did not rely on the broker's bad advice to his detriment; he chose to disregard the broker's advice knowing full well that his insurance coverage could be affected by his actions. Reliance on the advice provided by the broker is necessary for the insured to be able to establish a causal link between the breach of duty owed to them by the broker and the brokerage firm, and their loss (see Linden and Feldthusen, *Canadian Tort Law*, 8th Ed., at p. 467).

(i) Implications for brokers and agents

Brokers are required by law to be proactive about the questions they ask to assess the risks to be insured against, and to be accurate about the advice they give to insureds. Brokers have a duty to advise the insured on the limitations of coverage. Where possible, brokers should try to document such advice. As we can see from the McIntosh decision, communication with the underwriter about the scope of coverage is good risk management.

Care by brokers must be given not only at the initial policy application, but also at the time for renewal. Brokers should review the insured's file fully, ask necessary questions to establish the risks and advise on coverage.

Similar to other professional standards of care, perfection is not required by agents and brokers. A potential defence for claims against brokers, even if they have not met the standard of care expected of a reasonably prudent broker, is the lack of a causal link or reliance by the insured on the broker's advice.

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(b) *CIA Inspection Inc. v. Dan Lawrie Insurance Brokers*, 2010 ONSC 3639

In this case, the plaintiff, a global company that inspected oil refinery coke drums, sued the brokerage firm that arranged for its insurance. The action was brought for damages for negligence, breach of fiduciary duty, and breach of contract. The plaintiff historically carried insurance covering property, liability and office contents. When it came time to renew its insurance, the plaintiff contacted the defendant brokerage firm with a list of its insurance needs based on its prior coverage. The defendant arranged for insurance. Subsequently, a drill stem operator accidentally caused a sensor to fall to the bottom of a coke drum at a Venezuelan refinery. The plaintiff's claim for insurance proceeds was denied on the basis that the policy issued was for cargo coverage and only covered the sensor while in transit. The policy excluded job site risks. The plaintiff had assumed it had been insured against such risk and blamed the defendant for the gap in coverage. The plaintiff claimed damages representing the value of the lost equipment, the economic impact of the loss of one of its two sensors, and restructuring costs it incurred following the loss.

The defendant brokerage firm was eventually found liable and ordered to pay $297,500 based on its negligence. The defendant was found to have failed to provide the insurance coverage requested, and to have failed to communicate the gap in coverage to the plaintiff. The actual policy was never given to the insured by the defendant. Unlike the *McIntosh* case, the court in this case found a causal link between the negligence of the defendant and the loss suffered by the plaintiff. This finding was based on the fact that the policy requested by the plaintiff would have covered the loss suffered, and that had the plaintiff been aware of the gap in coverage, it would have sought other coverage or modified its business to reduce exposure to uninsured risk.

(i) Implications for brokers and agents

Brokers must carefully review the instructions of insureds to ensure that the policy they provide matches the needs and desires of the insured. Where there are gaps in coverage that pose risks to the insured, those gaps ought to be communicated to the insured by the broker. Providing the insured with a full and complete copy of the actual insurance policy, as opposed to simply the cover notes, is a key component of effective communication of the limits of the policy.

(c) *Beck Estate v. Johnston, Meier Insurance Agencies Ltd.*, 2010 BCSC 719

This case entailed a claim by the estate of the insured against the defendant insurance brokers. The insured had separated from her husband and moved out of the matrimonial home that she owned. There was evidence that the insurance brokers were aware that the insured no longer lived in her home, but did not suggest that she change her coverage. The coverage on the home was a homeowners' policy that excluded intentional acts of the insureds. The insured's husband was still a named insured even after the separation of the couple. Tragically, the husband killed his wife, himself, and set fire to the matrimonial home. Insurance coverage for the destruction of the home was denied because the fire was an intentional act of the husband, a named insured.

The court in this case found the brokers to be negligent on the basis that they had failed to ask questions of the insured when it was known that she had moved out of her home. Her insurance needs had changed because of that move, and other policies would have provided more appropriate coverage. The defendant brokers never asked the necessary questions to determine which policy was most suitable for the insured given her new circumstances. It was found that the insured would have purchased a different type of insurance, namely: a rented-dwelling policy that covered the intentional acts of the tenant (the insured's husband). This finding was key to the determination that the brokers' negligence caused the loss suffered by the insured.

(i) Implications for brokers and agents

Like the cases above, this case highlights the duty of brokers to ask questions of insureds in order to better understand their insurance needs. The particular implication of this case is to stress the importance of taking a proactive approach when a broker learns of a change in an insured's circumstances. If a broker learns of such a change, he or she ought to ask questions in order to determine if a change in insurance coverage is appropriate.

2. Fiduciary Duty of a Broker

(a) *National Crane Services Inc. v. AON Reed Stenhouse*, 2007 SKQB 31

This case is an example of a successful action against an agent and brokerage firm for breach of fiduciary duty, negligent misstatement and negligence resulting from the broker's failure to advise the insured of a gap in coverage for a crane on-the-hook policy.

The insured was a crane operator whose services were contracted by the owner of a printing press to transport a printing press from one building to another. The value of the press was estimated at $200,000. The insured was concerned that this was in excess of the rider for "on-the-hook" property covered by their policy. Accordingly, the insured contacted their broker and requested an increase in the coverage for "on-the-hook" property to ensure the press would be insured in case of any damage during the move. Damage was done to the press during the move and the owner of the press made a claim against the insured for property damage and for loss of profits. In order to settle the claim, the insured contributed $35,000 in excess of the cost required to fix the printing press. It was later discovered that there were no insurers in the marketplace that would insure against "loss of profits" or consequential losses suffered by third parties. The broker was unaware that this type of insurance was not available and therefore did not disclose this fact to the Insured.

The insured claimed that the brokerage firm failed in their duty to warn him of a "hole" in the policy and that, but for the brokerage firm's breach of duty, the insured would have had no exposure to loss beyond the amount for which it was insured.

The Saskatchewan Court of Queen's Bench held that the broker breached his fiduciary duty and was negligent. The broker had a duty to advise clients on insurance coverage based on his knowledge of his client's needs. The broker was negligent in not knowing about the lack of coverage for business interruption and the broker breached his duty when he failed to advise the insured of this fact.

(i) Implications for brokers and agents

Brokers have a fiduciary duty towards the insured. A fiduciary duty requires that the broker act in the best interest of the insured. This duty includes being aware of the insurance the insured requires, warning the insured of any "holes" in their policy and advising them accordingly. Where there is a causal link between a breach of fiduciary duty by a broker and the loss suffered by an insured, the broker will be held liable for that loss. A breach of a fiduciary duty is another manner in which a broker may be liable to an insured.

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3. Brokers and Agents Duties to the Insurer

(a) *Scottish & York Insurance Co. v. Metrix Professional Insurance Brokers Inc.*, 2006 BCSC 970

This case concerns the failure of a broker to ensure warranties were incorporated into a jeweller's interim policy. The issue raised is whether the broker in these circumstances owes a duty to the insurer and if so, what the scope of that duty is.

The owner of a jewellery store purchased a jeweller's block of policy insurance from her local agent. This local agent bought the policy from a jeweller's block broker. The insurer did not require the warranties to be sent out with quotes or binders, and the insurer knew blank-form warranties were not sent out before the policy was issued. The insurer's own procedures never required warranties to be sent out before the policy was issued. The law is clear that a warranty would not be binding on the insured or enforceable by the insurer until the insured had agreed to the warranties.

Shortly after the purchase of insurance, the jewellery store was robbed. The store was closed for the day but exterior doors were not locked. Jewellery had been removed from the display cases and was collected in trays on a trolley in preparation for night time storage in the vault. The robbers entered through an unlocked back door and stole jewellery worth $2 million.

The policy contained a warranty that stipulated store closing procedures, which required the owner to lock exterior doors prior to removing jewellery from display cases. This owner had not been provided with a copy of the warranties by the date of the robbery and was unaware that her business practices breached the warranties. As such, these warranties were not enforceable by the insurer against the insured.

The insurer paid the loss and sued the broker for failing to advise the insured of the content of the warranties and failure to obtain the owner's acceptance of the warranties by the time the insurer was bound. The insurer argued that the broker owed a duty of care to act as a prudent professional

insurance broker, and breached its duty and was negligent in failing to ensure the warranties were communicated to, and accepted by, the insured.

The broker argued that its obligations were governed by the contract it had with the insurer and that it was never an express or implied term that brokers were obliged to send warranties to the insured in the quotation or within the interim binder.

The issues considered by the court were: does the jeweller's block broker owe the insurer a concurrent duty of care in tort that is broader than its contractual duty? Is the jeweller's block broker liable in tort for failing to do what the insurer did not bother to do itself, knew the broker was not doing and did not rely on the broker to do?

The court held that the broker was not liable for the insurer's loss. The insurer and broker were on equal footing regarding the underwriting procedures that flowed from taking an insurance application, issuing a quote and binding insurance. There was nothing in their contractual relationship and there was no common law duty to require the broker to advise the insurer that its underwriting procedures were deficient, or to do anything further to ensure that the insured was aware of the subject warranties.

The broker did owe a duty of care to the insurer to communicate the content of the standard warranties to the sub-broker and breached its duty by failing to do so, but this breach was not found to contribute to the loss. The insurer failed to prove causation against the broker. The court found that it was the insurer's deficient underwriting procedures, mismanaged by its agent, that caused the insurer to be on risk without enforceable warranties.

(i) Implications for brokers and agents

A broker's duty of care to the insurer may extend beyond its contractual obligations to the insurer. However, in the *Scottish & York* decision, we see that this was not the case with respect to risk assumed and caused by the insurer as a result of deficient underwriting practices. The broker does not owe a duty to the insurer to advise them of the deficiencies in their underwriting practices. A broker also does not owe the insurer a duty of care to communicate the content of the standard warranties to the insured, but the broker does owe such a duty of care to the sub-broker.

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(ii) Implications for insurers

To avoid the liability faced by the insurer in the *Scottish & York* decision, insurers should ensure that they have proper underwriting procedures in place to ensure that the substance of a warranty is known and agreed to by an insured in the interim period between the issuance of a binder and the issuance of a policy. Reliance on agents, without such proper procedures, could result in significant loss. In the interim period, a claim arising will be adjudicated by reference only to the contract as expressed in or evidenced by the cover note. This is important where the insurers have the right to introduce conditions into the policy which were not applicable to the cover note, and which might bar a claim under the policy that would succeed on the preliminary contract of insurance.

If the insured accepts the warranty in a covering letter, then the parties have contractual certainty about all terms of the contract. If the insured does not have the opportunity to read and accept the full warranty before the loss, the warranty will be unenforceable. An insurer can achieve certainty of terms by including warranties in the initial proposal or by treating the warranties as a counter-offer and issuing them to the insured speedily. Simply referring to a warranty in a covering letter is insufficient to bind an insured; the full wording of the warranty must be included in order for it to be enforceable. In *712914 B.C. Ltd. v. Aviva Insurance Co. of Canada*, 2007 BCSC 163, it was held that mere reference to a warranty, even if coupled with a broker's explanation of the warranty to the insured, was insufficient to bind the insured to the terms of that warranty. The implication of this case to insurers is that it is necessary to be thorough when describing a warranty in the interim binder. It is also important not to rely on the oral descriptions of brokers.

F. CONCLUSION

Insurers and insureds alike must keep in mind the duties governing their relationship and the circumstances under which they will limit or expand their risk. It is important for all parties involved, including brokers and agents, to know, understand, and adhere closely to their obligations in order to best position themselves and limit their liability.

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While courts have typically interpreted insurance coverage in favour of the insured, we are seeing, especially in recent years, that this is not always the case. The best safeguard for insurers against unforeseen risk is to have a properly drafted, coherent policy. The best way for a broker to manage its risk is to understand the proactive nature of its duty to the insured, to give accurate advice and to ask questions when required. An insured must understand their obligations to the insurer under the policy and carry them out when required, including the requirement to give continuing full disclosure to the insurer under the policy.

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