CLARK WILSON LLP

"THE CHANGING ENVIRONMENT OF DENIALS AND BAD FAITH CLAIMS"

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Clark Wilson LLP

I. INTRODUCTION

Over the course of the past two decades, the notion of what exactly is deemed to be appropriate conduct in the context of insurance claims has been refined by repeated challenges in Canadian courts. This has resulted in a more comprehensive scheme of rules that better define the extent of an insurer's duty of good faith to the insured. The breach of this duty can expose insurers not only to damages above policy limits but to punitive damages that have no direct relation to an insured's loss, but rather, that are caused by the insurer's conduct in responding to the loss. Insurers continue to face bad faith allegations in relation to their conduct in handling their respective insured's claims, which can negatively impact insurers not only by way of punitive damages themselves, but by tarnishing their reputations with the negative publicity surrounding such actions.

Whiten, the leading case from the Supreme Court of Canada from 2002, sent a shockwave throughout the insurance industry when the highest court in our country awarded $1 million for punitive damages in the context of what could be described as egregious behavior on the part of Pilot Insurance in the handling of a coverage claim. Perhaps motivated to avoid a similar award, only seldom did insurers allow bad faith claims to reach our courts until two decisions in B.C. some nine years later, when our court appeared to open the floodgates on what is considered bad faith conduct on the part of an insurer, and when punitive damages may be awarded.

It is a critical part of risk management for insurers to keep themselves apprised of key court decisions regarding bad faith and the resulting punitive damage awards in order to understand which behaviors will not be tolerated by our courts. This paper is intended to provide insurers with an overview of the legal landscape in respect of bad faith claims and resulting punitive damage awards in Canada since the 2002 ***Whiten*** decision. As coverage counsel, we often have to refer our courts to case law in other jurisdictions for guidance given the relatively scant case law on the issue of bad faith claims in Canada. As such this paper will also consider the external treatments of bad faith in the context of insurance contracts by the courts of the United States and the United Kingdom.

II. OVERVIEW OF BAD FAITH

Bad faith in the insurance context occurs when an insurer or insured acts contrary to the duties owing to each other to act in good faith. The Canadian common law has established that insurance contracts give rise to a fundamental and reciprocal obligation on the part of insurers and insureds to deal with one another in "utmost good faith".[1] This is because parties to an insurance contract are uniquely vulnerable to each other.

At one end, the insurer is vulnerable to the insured because the information which dictates the assessment of the insured risk - and ultimately the decision to provide coverage or not - is obtained primarily from the insured. The insurer depends upon the insured not only to provide information to inform the investigation and payment of a loss, but also to minimize the risk of a loss materializing.[2]

At the other end, the insured is particularly vulnerable to the insurer because, in the instance of a loss, the insurer makes the decision as to whether the insured will be covered for the loss and the amount to which they will be paid. Insurance policies also serve to provide peace of mind

[1] *Coronation Insurance Co. v. Taku Air Transport Ltd.,* [1991] 3 S.C.R. 622 (S.C.C.) at para 24.
[2] Barbara Billingsley, *General Principles on Canadian Insurance Law*, 2nd ed (Toronto: Lexis Nexis Canada, 2014) at 50 [*Canadian Insurance Law*].

to the insured in the context of an unintended loss, on the basis that the insured will be treated in a fair and reasonable manner.[3]

Thus, in order to address the mutual vulnerabilities of parties involved in insurance relationships, insurance contracts are characterized by the common law as being contracts of *uberrima fides* or utmost good faith.[4] Most recently, the Supreme Court of Canada in ***Bhasin v. Hyrnew*** reiterated the concept of the duty of good faith as an implied term in every insurance contract.[5]

The duty of good faith is owed throughout the entirety of the insurance relationship, and exists apart from the express terms of the contract.[6] A breach of the duty of good faith occasions a separate cause of action commonly referred to as a "bad faith claim" which, in practice, does not arise until the insurer has either denied coverage, delayed payment, or refused to pay the amount owing under the policy.[7] The circumstances giving rise to a bad faith claim will also depend on the type of insurance policy, as these claims can be grounded in both first party and third party coverage. Each will be discussed in turn below.

III. BAD FAITH IN THE CONTEXT OF THIRD PARTY CLAIMS

Instances of a breach of the duty of utmost good faith by an insurer in the context of third party liability coverage are less common than first party claims. Third party insurers have a duty to defend an insured. Bad faith claims typically arise between an insurer and an insured with respect to either the manner in which the claim is defended or whether the claim should be settled. Bad faith claims against a third party insurer typically occur where a third party's claim for damages exceeds or *has potential to exceed* the policy limits. In this scenario, an insurer can

[3] *Ibid.*
[4] *Supra* note 1.
[5] *Bhasin v. Hyrnew,* 2014 SCC 71 at para 55.
[6] *Ferme Gerald Laplante & Fils Ltee v. Grenville Patron Mutual Fire Insurance Co.,* [2002] O.J. No. 3588 (O.N.C.A.) at para 78.
[7] Gordon G. Hilliker, *Insurance Bad Faith*, 2nd ed (Markham, ON: LexisNexis Canada, 2009) at 44 [*Insurance Bad Faith*].

be in breach of its duty of good faith where it fails to settle a claim within the policy limits before going to trial, or failing to adequately defend the insured, exposing the insured to the financial risk of the uninsured portions of the claim.[8]

The leading case in Canada on bad faith in the third party context is ***Shea v. Manitoba Public Insurance Corp***.[9] In *Shea,* the British Columbia Supreme Court explained that where a third party action may result in a judgment over policy limits, the insurer defending the action is required "to give at least as much consideration to the insured's interests as it does to its own interests".[10] This means that the insurer must make reasonable efforts to settle the third party action within the limits of the liability policy because it is in the legitimate interests of the insured to have the third party action "settled at or within the third party policy limit" if possible.[11] The Court explained that this imposes a positive obligation on the insurer to pursue settlement offers within policy limits if a liability finding against the insured is likely.[12]

Although a third party insurer owes these duties to the insured, cases involving the failure to settle within limits typically do not result in punitive damages. Rather, the insurer becomes liable for the amount of the excess judgment.

For claims on which there is *the potential* for a finding of liability against the insured at trial that will exceed the policy limits, there is a positive obligation on the insurer to settle the claim within policy limits before trial. Where this risk is likely, the decision for an insurer is actually simpler – tender the limits at mediation or during negotiations before trial, in exchange for settlement terms that will protect the insurer and insured. An insurer's decision is actually more difficult when the risk of exceeding the policy limits is less clear, or when the insured has strong defences available, but nonetheless still has risk.

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[8] *Ibid* at 1.
[9] *Shea v. Manitoba Public Insurance Corp.,* [1991] B.C.J. No. 711.
[10] *Ibid* at para 61.
[11] *Ibid* at para 76; *Canadian Insurance Law* at 263.
[12] *Ibid* at para 256.

As defence counsel on complex claims, the writer has often seen an insurer's struggle of balancing risk management with appropriate defence considerations. We as defence counsel can advise based on our experience and the factors inherent in the claim, but we cannot ever provide guarantees of outcome. In this context, the inherent risks of proceeding to trial must also be a factor considered by an insurer so as to not expose the insured beyond policy limits.

It is also important for an insurer to send out a limits letter to the insured in a timely manner when it becomes clear that the insured's liability exposure may exceed policy limits. As defence counsel, we cannot and should not advise insurers of any coverage related issues. If coverage counsel is not already involved, an insurance examiner or adjuster must be aware that when you receive a risk report from your defence counsel that opines that the insured's risk may exceed policy limits, that is the time to send the limits letter to the insured, which should also recommend that the insured obtain independent legal advice on personal exposure and on any coverage issues. Many experienced examiners on a defence file will send out a limits letter at the outset of the claim simply based on an exorbitant quantum, well before the liability landscape becomes clearly defined.

IV. BAD FAITH IN THE CONTEXT OF FIRST PARTY COVERAGE CLAIMS

Bad faith claims are more commonly litigated in the context of first party insurance coverage claims such as property and disability policies. Typically, a first party insurer is exposed to bad faith claims when it denies coverage without reasonable investigation and assessment of the circumstances of the loss or fails to evaluate the insured's claim in a timely manner. The following passage from the Ontario Court of Appeal decision of ***702535 Ontario Inc. v. Non-Marine Underwriters of Lloyd's London*** is often cited by the courts to describe an insurer's duty of good faith when responding to an insured's claim:

> The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer

> investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith.[13]

The principal rationale underlying these duties is that, by failing to conduct an adequate investigation, an insurer may wrongly deny benefits that are owing to the insured, potentially causing the insured to suffer inconvenience, financial loss or mental distress.[14]

Although the extent of the investigation required will depend upon both the nature of the claim and the basis for denial of coverage, historically the courts will only award punitive damages for bad faith where the insurer's conduct is "malicious, oppressive and high-handed" and markedly departs from "ordinary standards of decent behavior".[15] In more recent years, however, our Canadian courts have found bad faith in the context of poor handling and delay, which arguably was not "malicious, oppressive and high-handed", although the quantum of punitive damages awarded in that context was significantly lower than the $1 million in punitive damages awarded in ***Whiten***.

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[13] *702535 Ontario Inc. v. Non-Marine Underwriters, Lloyd's London, England* (2000), 184 DLR (4th) 687 (O.N.C.A.) at para 29.

[14] *Insurance Bad Faith* at 2.

[15] *Whiten v. Pilot Insurance Co.*, 2002 SCC 18 at para 155.

V. KEY CANADIAN CASE LAW ON BAD FAITH SINCE *WHITEN*

In order to deter and punish bad faith conduct, our Canadian courts have awarded significant punitive damages against insurers for breaching the duty of utmost good faith.

A. WHITEN v. PILOT INSURANCE CO.

The seminal case for bad faith claims against an insurer, ***Whiten,*** is now almost seventeen years old. Decided in 2002, ***Whiten*** was the first case in which Canada's highest court awarded significant punitive damages against a first party insurer for breaching its duty of good faith in responding to its insured's claim.

In ***Whiten,*** the insured's family home was destroyed by a fire and the insurer denied coverage on the basis of a suspected arson. As a result of the fire, the insured was left without shelter or possessions. The insurer made a single payment to the insured for $5000 for living expenses, and covered the cost of a rental home for two months. Without notice, the insurer cut off the rental payments and refused to pay the claim. The insurer denied the claim because it suspected that the loss was caused by arson, however, this reason was not initially explained to the insured.

The insurer based its contention of arson entirely on speculation, primarily due to the fact that the insured was apparently having financial problems when the fire loss occurred. Despite having been informed by a number of experts that the evidence did not support a finding of arson, the insurer persisted in this allegation throughout the trial, in the hope of forcing the insured to accept a reduced settlement.[16]

The Supreme Court of Canada, in a very detailed and reasoned decision, reinstated the trial judge's award of $1,000,000 in punitive damages, finding that the insurer had acted egregiously in clearly taking advantage of the insured's vulnerabilities and poor financial circumstances in

[16] *Canadian Insurance Law* at 238.

an attempt to settle for much less than the insured's entitlement under the policy. The evidence overwhelmingly showed that the insurer handled that insured's claim unfairly in deliberately ignoring any opinion, even of its own adjusters and experts, that it comply with its obligations under the policy to pay the claim.[17] Notably, the Supreme Court of Canada explained that the insurer had acted in bad faith by failing to respond to the insured's claim in a "fair and diligent manner".[18] The Supreme Court of Canada discussed an insurer's duty of good faith in responding to a claim as follows:

> Insurance contracts, as Pilot's self-description shows, are sold by the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim. Deterrence is required. The obligation of good faith dealing means that the appellant's peace of mind should have been Pilot's objective, and her vulnerability ought not to have been aggravated as a negotiating tactic. It is this relationship of reliance and vulnerability that was outrageously exploited by Pilot in this case. The jury, it appears, decided a powerful message of retribution, deterrence and denunciation had to be sent to the respondent and they sent it.[19]

The ***Whiten*** decision was a great wake up call to insurers, as it demonstrated the potential range of punitive damages that could be awarded against an insurer, which, in ***Whiten,*** amounted to three times the policy limit. The decision also impressed upon insurers the importance of compliance with good faith obligations in dealing with insurance claims. Although the dissenting judges claimed they would not have awarded as high of damages as the majority, they nevertheless indicated that it was not "irrational" under the circumstances.[20]

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[17] Canadian Insurance Law at 239.
[18] *Ibid* at para 159.
[19] *Ibid* at para 129.
[20] *Ibid* at para 140.

The sort of behavior seen in *Whiten* is rare. More common is the conduct at issue in the more recent B.C. decisions.

B. SIDHU & MACDONALD – 2011 & 2012 B.C. SUPREME COURT DECISIONS

After ***Whiten***, there continued to be relatively few decisions dealing with bad faith and punitive damages against an insurer. Nine years after ***Whiten***, two significant British Columbia decisions clarified what the courts characterize as bad faith conduct. These decisions also established a range of damages much lower than the Supreme Court of Canada's award in ***Whiten,*** but arguably opened the flood gates to the sort of conduct that may be found as bad faith.

In 2011, the British Columbia Supreme Court in ***Sidhu v. The Wawanesa Mutual Insurance Company***, awarded $50,000.00 in punitive damages against the insurer for failing to deal "fairly and promptly" with the insured's claim.[21]

This case involved a fire at the insureds', Hardip and Lakwinder's, family home in January 2005. On the night of the fire, two of the insureds' children were sleeping in the living room allegedly because they were frightened by an incident three weeks earlier when someone broke a window in one of the children's bedroom. Hardip's mother was also sleeping in the living room. The third child was sleeping in the master bedroom with the insureds. At some point in the night, the child interrupted the insureds' sleep and Lakwinder took the child out of the bedroom and to the living room. Hardip then heard a loud noise coming from outside of the house which he thought came from the master bedroom window. He got out of bed and walked toward the living room where the rest of the family was. The insureds then spent several minutes looking outside to see if anyone was there, after which they heard the smoke alarm go off. The insureds then saw smoke at the top of the hallway near the master bedroom. Hardip woke the children and took everyone outside. He then returned inside the home and used a phone in the kitchen to call 911.

[21] *Sidhu v. The Wawanesa Mutual Insurance Company*, 2011 BCSC 1117 at para 179.

Before exiting the house, Hardip noticed that that the lights went out. He could not be sure where he was when this happened. In partial contradiction, Hardip indicated that he was in the room where the holy book was kept, next to the sundeck, when he saw the lights go off. This indicated that Hardip had moved his family from the living room into the next room on the way to the outside deck when he noticed the lights.

Shortly after the fire, the insureds provided multiple inconsistent statements to the insurer which, when compared to fire investigation reports, led the insurer to believe that the insureds were not being truthful and reasonably gave rise to suspicion that the insureds were involved in starting the fire. The insureds were previously involved in two fire related incidents; one at Hardip's automobile repair shop and one car-fire in the driveway of the insureds' home. Moreover, the fire investigators reported the presence of an accelerator outside of the master bedroom window and in the daughter's bedroom.

The insurers deliberated the claim, and eventually decided that it warranted further investigation before a decision was made on coverage. *Two years* elapsed before any further investigations were conducted, and the insureds eventually filed pleadings against the insurer for coverage under the policy. The only communication to the insureds after March 2005, was a letter from defence counsel to the insureds' lawyer in January 2007 in response to the service of the statement of claim. The letter was accusatory in nature and communicated to the insureds that coverage was being denied on the basis that the fire was intentionally started by the insureds. The insureds then commenced an action seeking damages on the basis that the insurer did not act in good faith and did not act reasonably or promptly in investigating their claim under the policy.

The Court held that the insurer was entitled to investigate the claim thoroughly and extensively. However, the insureds were entitled to have their claim dealt with fairly, including timely

investigation and resolution of their claim, and to be informed of the insurer's decision on coverage.[22]

The Court in *Sidhu* held that the lack of "promptness of the investigation and communications" with the insurers was key to the finding of bad faith.[23] Although there were highly suspicious circumstances on behalf of the insureds, the Court nevertheless concluded the insurer was liable in bad faith. The Court held that the insurer was entitled to take all necessary steps to assess the merits of the claim in a balanced and reasonable manner, but that the "enormous" delay in denying the claim was unexplained and was clearly unfair to the insureds, thereby in breach of good faith.[24] The Court also explained that although the delay did not appear to have targeted the insurers, the accusations outlined in the January, 2007 letter had an offensive tone and that the insurers were unsophisticated and vulnerable victims of the delay.[25]

In deciding on an award for punitive damages, the Court explained that "[h]ouse insurance contracts are purchased by the public to achieve a level of assurance and peace of mind that they will be treated promptly and fairly if their home is damaged by fire. Punitive damages are not compensatory damages and the focus of this claim must be on the blameworthy conduct of the insurer."[26]

The Court ultimately awarded $50,000 in punitive damages to the insured. In doing so, the Court referred to the level of conduct of the insurer, which rose to blameworthiness but which did not require a "large penalty to reflect the denunciation required".[27] The award was less than half of the total loss.

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[22] *Ibid* at para 178.
[23] *Ibid* at para 180.
[24] *Ibid.*
[25] *Ibid* at para 191.
[26] *Ibid* at para 190.
[27] *Ibid* at para 192.

Shortly after ***Sidhu***, the British Columbia Supreme Court in ***McDonald v. The Insurance Corporation of British Columbia*** awarded $75,000 in punitive damages against an insurer for bad faith.[28]

In this case, the insured was involved in a motor vehicle accident under suspicious circumstances. On the night of the accident, the insured had consumed alcohol before leaving home in Abbotsford with a friend to get sushi in downtown Vancouver after midnight. The insured had borrowed her mother's vehicle and planned on picking up another friend in Surrey on the way to Vancouver. The insured and her friend got lost for close to two hours before they arrived in Surrey at 3:00am. After picking up the third friend they headed to Vancouver, where they were randomly stopped by the police nowhere near downtown. The police officer ran standard checks of the vehicle, the insured, and the passengers and allowed them to move on. After the police stop, the group decided to abandon their search for sushi and head back to Abbotsford. On the return trip home, the insured mistakenly took a wrong exit ramp onto the highway near Abbotsford, driving into oncoming traffic and colliding head-on with another vehicle.

Once the police officers arrived at the scene of the accident, they noticed a faint smell of alcohol on the insured. The officers attempted to administer a breath sample to the insured, however the insured was uncooperative and provided multiple failed readings of the breath sample instrument. Thus, the insured was arrested at the scene of the accident for refusing to provide a breath sample and for impaired driving. The insured was also charged under the *Motor Vehicle Act* for driving without reasonable consideration.

The driver of the other vehicle commenced an action against the insured. The insurer, ICBC, did not appoint counsel for the insured nor did ICBC file a statutory third party notice adding itself as a party to the action. Rather, the insurer's claims handler performed a cursory investigation into coverage and largely relied on the criminal proceedings to provide evidence that the

[28] *McDonald v. The Insurance Corporation of British Columbia,* 2012 BCSC 283.

insured was in breach of her contract of insurance for being impaired by alcohol at the time of the accident.

In the midst of the alcohol related criminal proceedings, the insured pleaded guilty to the offence of driving without reasonable consideration and the criminal charges against her were subsequently stayed. In the action commenced by the third party driver, the insurer defended the leasing company of the vehicle the insured was driving and, without her knowledge, settled the third party claims against her for $182,085.36. Thereafter, ICBC sought reimbursement from the insured of the settlement amount on the basis that she was intoxicated which deemed her to be in breach of the insurance contract.

The insured then commenced an action against the insurer seeking punitive damages for bad faith conduct. The insured alleged that the conduct of the insurer was unreasonable, misguided and aimed at advancing the insurer's interests to her detriment. The insured also claimed that the insurer acted in bad faith in failing to discharge its duty to defend her in the third party action.

The British Columbia Supreme Court explained “bad faith” as follows:

> Bad faith is a term of convenience and does not carry a precise legal definition. Like many other judicial constructs, such as fairness and reasonableness, the notion of what will constitute bad faith is highly dependent on the factual context within which it is said to have arisen. It is therefore axiomatic that a bad faith claim must be evaluated in light of the surrounding circumstances on a case-by-case basis: a closed category of defining attributes is neither possible nor desirable.[29]

[29] *Ibid* at para 188.

The Court held that the insurer breached its duty of good faith through its multiple failings in the investigation, assessment, and its misconduct in relation to the third party action. The Court explained that the alcohol-related criminal charges triggered a legitimate question about her coverage. However, the insurer displayed an "unfortunate readiness to assert a policy breach on the flimsiest grounds."[30]

The insurer relied on the police officer's initial comments to ground its decision. The report stated the opinion that the insured would have been at or close to the legal limit, however the insured's driving evidence was sufficient to show that she was impaired. The fact that the insured was driving in the wrong direction at 5:00am gave the officers the impression that she was impaired.

The insurer did not take into account the Vancouver police officer's report, which did not contain the view or opinion that the insured was impaired or intoxicated at the time of the accident, nor did it express any view on her capacity to drive or control a vehicle. The Court explained that this should have alerted the insurer to the need for additional investigation and clarification, which never occurred. The insurer did not hear from the insured regarding the circumstances and the insurer's file did not record a reason for abandoning that avenue of inquiry. The Court found that the insurer placed undue emphasis on the officer's inconclusive views which aligned with the insurer's interests.

The Court described how the duty of good faith "does not impose a standard of absolute liability" and that an insurer "is not expected to investigate a claim with the skill and forensic proficiency of a detective", but rather requires that an insurer bring "reasonable diligence, fairness, an appropriate level of skill, thoroughness and objectivity to the investigation, and the assessment of the collected information with respect to the coverage decision."[31]

[30] *Ibid* at para 227.
[31] *Ibid* at para 248.

The Court held that it was not each of the insurer's individual omissions or inadequacies in handling the insured's claim that violated the duty of good faith and fair dealing, but rather it was their cumulative effect that caused the breach.

The Court also expanded on the duty of good faith in the conduct of the insured's defence as follows:

> The duty entails that the insurer inform the insured about settlement matters that could adversely affect the insured's interests, and that it do so with reasonable promptitude. The rationale underscoring that obligation is an obvious one: insureds can only take steps to protect their personal interests and minimize their financial risk if they are informed of material information in a fulsome and timely way. Notifying an insured, who the insurer regards as being in a precarious coverage position, of the settlement only after it has been concluded is the equivalent of no notice at all, and certainly does not amount to the disclosure with reasonable promptitude.[32]

In awarding damages, the Court explained that this was an exceptional case. The Court concluded that the overall handling and evaluation of the claim was overwhelmingly inadequate. In order for the insurer to be held accountable for its bad faith conduct, the Court awarded $75,000 in punitive damages to the insured, condemning the insurer for its "harsh, high-handed and oppressive" conduct.[33] The Court commented that this was an award that the insurers "could well afford" and that it was "appropriately proportionate and rationally accomplishes the objectives of punitive damages."[34]

The decisions of ***Sidhu*** and ***McDonald*** opened insurers' eyes to the possibility of a finding of bad faith even when the conduct was nowhere near the level of "malicious, oppressive and

[32] *Ibid* at para 255.
[33] *Ibid* at para 264.
[34] *Ibid* at para 266.

high-handed" conduct that was required by our Supreme Court of Canada in ***Whiten***. In the writer's view, these decisions broaden the scope of behavior that may attract a finding of bad faith – poor handling can be found to be bad faith. Poor handling includes an insurer taking too long to investigate a claim, even when there were initial grounds justifying further investigation. In addition, not conducting a reasonable or proper investigation, for example by drawing inappropriate fact conclusions, could also be considered poor handling and resulting in a finding of bad faith. Finally, insurers have an obligation to keep the insured informed when coverage issues arise, and must not do anything that could prejudice the insured. An insurer's obligation of good faith requires an insurer to have consideration for, and to prioritize, the insured's interests as if they were the insurer's own interest.

Insurers will do well to ensure appropriate training for its claims adjusters and examiners and to have internal policies and protocols to ensure claims are appropriately, adequately and promptly investigated, along with measures to keep the insured informed. Coverage positions must be taken reasonably and communicated in a timely manner.

C. THE BRANCO DECISION – BAD FAITH IN THE CONTEXT OF DISABILITY INSURANCE

While there has been a decline in the quantum awarded for punitive damages since ***Whiten***, punitive damages awarded in the context of disability claims continue to be assessed on a relatively higher scale.

Notably, the 2013 Saskatchewan Court of Queen's Bench decision of ***Branco v. American Home Assurance Co.*** significantly departed from previous awards of punitive damages for bad faith conduct.[35] This case garnered the attention of the insurance industry with the largest award of punitive damage against an insurer in Canadian history, amounting to $4,500,000, plus $450,000 in aggravated damages, against American Home Assurance (AIG) and Zurich Life Insurance Co. Ltd.

[35] *Branco v. American Home Assurance Co.,* 2013 SKQB 98.

In ***Branco,*** the insured worked as a welder for a Canadian company in Kyrgyzstan and injured himself twice at work by dropping a steel plate on his foot. AIG was to provide benefits for work-related injuries and Zurich was to provide benefits for non-work related disability. The insured advised the insurers of his work-related injury and AIG appointed a doctor abroad. After an unsuccessful surgery and sincere attempts at physiotherapy, the doctor ultimately concluded and advised AIG that the insured was permanently disabled

Despite the doctor's conclusion, AIG's adjuster suspended his income benefits when she was unable to get information from the doctor whom AIG appointed. Several months later, AIG requested further examinations of the insured by specialist physicians in Saskatchewan. The insured agreed to make the trip to Canada, at which time he saw various specialists as arranged by AIG. The insured's disability was confirmed by the specialists, yet AIG continued to refuse to make any payments.

Zurich was also aware of the extent of the insured's disability, yet did not provide him with benefits until nine years after the accident, six years after the claim was filed and nearly two years after Zurich requested a medical examination of the insured, which once again confirmed that he was permanently disabled.

The Court held that the insured was entitled to aggravated damages and damages for mental distress caused by the insurer's failure to honor its duty of good faith and fair dealing. Drawing from the Supreme Court of Canada's decision in ***Fidler v. Sun Life Assurance***, the Court reaffirmed the principle that damages for mental distress may be recoverable when the "insurance contract was intended to secure a psychological benefit that brought the prospect of mental distress upon breach within the reasonable contemplation of the parties at the time the contract was made."[36]

[36] *Fidler v. Sun Life Assurance,* 2006 SKQB 30 at paras 136-137.

The evidence adduced at trial demonstrated that the consequences of the insurer's delay had a major negative impact upon the insured's life and continued to affect his quality of life. The Court described both insurers' conduct as "cruel and malicious" and established a "pattern of abuse of an individual suffering from financial and emotional vulnerability".[37]

In awarding punitive damages, the Court specifically commented on the award in ***Whiten***, explaining that it was not sufficient to deter insurers from acting in bad faith. Justice Acton went on to state:

> The court is cognizant of the fact that a punitive damages award of $3 million may not be particularly significant to the financial bottom line of a successful worldwide insurance company. It is hoped that this award will gain the attention of the insurance industry. The industry must recognize the destruction and devastation that their actions cause in failing to honour their contractual policy commitments to the individuals insured.

In 2015, ***Branco*** was appealed to the Saskatchewan Court of Appeal where it ultimately upheld the finding of bad faith against both insurers, but significantly reduced the damages.[38] The damage awards against AIG and Zurich were reduced to $675,000 in punitive damages and $45,000 in aggravated damages for mental distress, an overall reduction of greater than $3.8 million.

In reducing the damages, the Court of Appeal specifically acknowledged that AIG had attempted to secure the insured's cooperation numerous times throughout the claims process and that the sum of $175,000 was more proportionate to AIG's blameworthiness, the vulnerability of the insured and the need for deterrence. As for Zurich, the Court of Appeal found the trial judge's award to be so high as to be irrational and out of line with precedent, but still awarded a larger quantum of $500,000 in punitive damages in order to denounce its

[37] *Supra* note 15 at para 214.
[38] *Branco v. American Home Assurance Co.,* 2015 SKCA 71.

conduct in deliberately withholding the insured's entitled benefits for nine years while acknowledging that he was permanently disabled.

The Court of Appeal's decision in ***Branco*** reiterated the very significant and long standing principle that the duty to act in good faith is fundamental to dealings between insurers and insureds, and a failure to meet that duty will result in punitive damage awards, although not to the monetary degree as first awarded in the ***Branco*** case in the lower court.

Insureds also have a duty of good faith to insurers, which includes a duty to provide accurate material information to the insurer in a timely manner. Failure to do so could be bad faith on the part of the insured. In ***Branco***, the insurers hired a doctor in Portugal to examine the insured, who lived in Krzygystan. There was some difficulty and delay in the insured providing information needed by the insurer in the ***Branco*** case, but that delay did not amount to bad faith on the part of the insured, and certainly did not justify the positions of coverage taken by the insurers in that case.

D. THE 2018 GODWIN DECISION – DAMAGES FOR MENTAL DISTRESS

More recently, in 2018, the British Columbia Supreme Court in ***Godwin v. Desjardins Financial Security Investments Inc.*** awarded punitive damages of $30,000 along with damages for mental distress against an insurer due to its bad faith in handling the insured's disability claim.[39]

The insured was under a group disability insurance policy made available to members of the Canadian Bar Association. The insured became completely disabled from her employment as a paralegal due to psychiatric illness and remained disabled up to the date of trial. The insurance policy provided for two classes of long-term disability benefits for non-lawyers: one for coverage of employee disability in the first 24 months in respect of their own occupation, and one after 24 months in respect of any gainful occupation.

[39] *Godwin v. Desjardins Financial Security Investments Inc.,* 2018 BCSC 99, refused leave to appeal: 2018 BCCA 278.

The insured's claim for "own occupation" benefits was initially denied on the basis of a medical report authored by a psychiatrist who opined that the insured was not "totally disabled" according to the definition under the policy. The insured appealed the denial, which was ultimately rejected for the same reason as the initial denial. The insured responded to the rejection of her appeal by obtaining another medical report which clearly responded to all of the concerns that the insurer has expressed in its denial. After several months, the insured's claim was approved with benefits payable retroactively. There was no written evidence of why or how the insurer determined that the benefits were ultimately payable.

Following an independent medical examination, the insured's claim for "any occupation" benefits was denied. The insured was dissatisfied with the examination and expressed her concerns to the insurer. The insurer did not provide the insured with a coherent rationale for why her claim was denied. The Court explained that the denial and its rationale "appears to reflect not a studied review of the evidence, but instead a grab-bag of whatever considerations Mrs. Da Silva could identify to justify a denial of coverage."[40]

Again, the insured appealed the denial of the "any occupation" benefits and provided a further opinion from a psychiatrist. The appeal was ultimately rejected.

After the series of denials and appeals, the insured commenced an action, claiming damages for mental distress and punitive damages for bad faith conduct in handling her claim and in the conduct of litigation. Just days before the scheduled commencement of the trial, the insurer advised the insured that it was electing to reinstate her disability benefits. The trial proceeded, however, on the issues of damages for mental distress and punitive damages for bad faith conduct.

The Court held that the insurer breached its duty of good faith because the insurer's claims examiner repeatedly failed to assess the evidence available, applied tests for disability beyond

[40] *Ibid* at para 91.

those set out in the Policy, and made findings which were not adequately supported by the evidence. The Court explained that the overall impression created was of a claims examiner looking for reasons to avoid the insurer's coverage obligations.[41] The Court also held that here was a lack of good faith throughout, but not entirely to the extent that it should all be seen as having been arbitrary, callous, high-handed or malicious. However, the claims examiner's failure to act in good faith ultimately caused a delay in the payment of the insured's coverage benefits by 34 to 40 months.

Additionally, the Court held that the claims examiner's denial of coverage was severely flawed and arbitrary in nature. Specifically, the insurer's failure to investigate the existence of an audio recording for the insured's independent assessment with the insurer-appointed psychiatrist was a breach of duty of good faith.

Thus, the Court awarded $30,000 in punitive damages and $30,000 in damages for mental distress. In awarding damages, the Court conducted a review of awards for damages for mental distress in the context of disability policies and noted that such damages have traditionally been modest, generally amounting well under $100,000.

E. NO PUNITIVE DAMAGES AWARDED

Two of the most recent cases in Canadian courts for claims of bad faith against an insurer were unsuccessful, with no punitive damages awarded. In the 2018 decision of ***688857 Ontario Ltd. v. Aviva Insurance Company of Canada,*** the Ontario Supreme Court held that the insurer's delay of nine months in denying the claim did not amount to bad faith as it was due to the insured's difficulties calculating the loss, errors in the calculation, difficulty understanding the insured's calculation, and the insured's extended periods out-of-country.[42] Further, the investigation was not overwhelmingly inadequate and there was no evidence of improper

[41] *Ibid* at para 29.
[42] *688857 Ontario Ltd. v. Aviva Insurance Company of Canada,* 2018 ONSC 5891 at 150.

considerations taken into account when deciding to deny coverage.[43] The Court emphasized that denial of a claim that ultimately succeeds is not in itself bad faith.[44]

In 2019, the Alberta Provincial Court in ***Rahall v. Intact Insurance Co.*** denied the insured's application to amend its Statement of Claim to allege bad faith against the insurers.[45] Before turning to bad faith, the Court found that there was no coverage under the policy for which the insured was claiming. The Court then refused the insured's application to amend the claim to plead bad faith, relying on previous case authorities such as ***Saskatchewan Government Insurance v. Wilson***, where the Court of Appeal noted:

> …the foregoing passage is authority for the proposition that a breach of the duty of good faith, even though an independent cause of action, does not arise in the absence of an underlying breach of the express terms of the contract of insurance.[46]

Thus, the Court held that a bad faith claim could not succeed where the insurer has not breached its obligations pursuant to the policy.[47]

F. CONCLUDING COMMENTS ON CANADIAN LAW ON BAD FAITH SINCE WHITEN

Awards for punitive damages in bad faith claims have decreased in both quantum and frequency over the seventeen years since the ***Whiten*** award for $1,000,000. Perhaps this can be explained by the modern litigious trend toward settlement before trial, rendering litigation less likely to proceed to the point where the court has the opportunity to assess bad faith conduct of an insurer and accordingly giving the court fewer chances to grant large awards for punitive damages. Ultimately settlement before trial, if possible, is good risk management,

[43] *Ibid* at para 147.
[44] *Ibid* at para 132.
[45] *Rahall v. Intact Insurance Co.*, 2019 ABPC 11.
[46] *Saskatchewan Government Insurance v Wilson*, 2012 SKCA 106 at para 10.
[47] *Supra* note 45 at para 96.

given the unknowns of litigation and the inherent risks of trial. An optimist would surmise that insurers are generally better at handling claims since ***Whiten***, which was a loud wake up call to insurers, and the potential for bad faith is a reality which is ever present in the consciousness of insurance companies and their claims handlers.

Courts have begun to reflect upon the purpose behind awarding punitive damages and how the level of these awards equate to impacting the actions of insurers, namely deterring bad faith conduct. While not in an insurance context, the Quebec Court of Appeal recently commented on the quantum of awards for punitive damages. In ***Vidéotron v. Girard***, the Court of Appeal reduced the trial judge's award of punitive damages against a telecommunications company for overcharging consumers with fees, and making false or misleading representations in violation of the *Consumer Protection Act*.[48] Despite a particularly high standard of review, the Court of Appeal amended the quantum of punitive damages from $1,000,000 to $200,000, based on the decision that the trial judge's damage award amount was excessive and disproportionate to the circumstances of the case.[49] The company's behavior was a consideration in the Court of Appeal's decision to reduce the quantum of punitive damages. The Court of Appeal acknowledged that punitive damages do not serve a compensatory purpose, thus the Court will generally award the lowest amount necessary to achieve the intended deterring effect, and will consider all facts available in its calculation of these damages.

As a persuasive authority from a Canadian appellate court, it is quite conceivable that the courts in other Canadian provinces would take into consideration this principle from ***Vidéotron*** when faced with bad faith claims and claims for punitive damages against insurers. If it does, each claim for punitive damages will depend on the conduct alleged and the amount of deterrence needed.

[48] *Vidéotron v Girard*, 2018 QCCA 767.
[49] *Ibid* at para 227.

VI. US LAW

In discussing the development of bad faith claims in Canada, it is useful to examine the development of these claims in neighbouring jurisdictions which may have an effect on the perception of bad faith claims in the insurance industry and serve as an indicator of how this area of law may evolve in Canada .

In comparison to Canada, bad faith claims are more heavily litigated in the United States and the awards for punitive damages are much larger, and the tests for what conduct constitutes bad faith are easier to satisfy.

This is most clearly illustrated by **the *State Farm Mutual Automobile Insurance Company v. Campbell*** decision where $145 million in punitive damages was awarded at the trial court level against an insurer for bad faith handling of an excess liability claim under a third party policy.[50] In this case, State Farm refused to cover the excess liability of the policyholders, the Campbells, after they negligently caused a motor vehicle accident, killing one driver and permanently disabling another. State Farm also refused to post bond so the Campbells could appeal the judgment, forcing the Campbells to obtain their own counsel.

The award of $145 million in punitive damages was subsequently reduced by the Supreme Court of the United States (the "SCUS").[51] In its decision, the SCUS held that although the insurer's conduct was in bad faith, the punitive damages were disproportionate to its wrongdoing. The SCUS explained that this award was overreaching and did not adequately consider the Due-Process clause of the United States Constitution, which prohibits the imposition of grossly excessive or arbitrary punishments on a tortfeasor. The Court held that it was impermissible for the Utah courts to punish and deter conduct through punitive damages that did not relate to the harm caused by the Campbells.[52] That is, the Court ruled that "a

[50] *Campbell v. State Farm Mutual Automotive Insurance Co.*, 2001 WL 1246676 (Utah 2001).
[51] *State Farm Mutual Automobile Insurance Company v. Campbell et al.*, U.S., 2003 WL 1791206.
[52] *Ibid* at para 6.

defendant's dissimilar acts, independent from the acts upon which liability was premised, may not serve as the basis for punitive damages."[53] Still, even with this reduction, the final award is twenty times that of the highest award for punitive damages granted in Canada.

Although the reasoning of the SCUS in ***State Farm*** applies across the United States, how bad faith is interpreted in each state varies as insurance law is governed at the state level.[54] The majority of states have acknowledged insurers have an implied duty of good faith and fair dealing to policyholders in both first party and third party coverage. As there is unequal bargaining power between an insurer and an insured, many state courts ruled that bad faith in the insurance context can give rise to an action in tort and in breach of contract.[55]

States apply different tests in order to determine whether an insured acted in bad faith, with liability thresholds ranging from mere negligence to intentional wrongdoing.[56] Certain states, including Ohio, apply a strict test for determining bad faith conduct. This test requires more than mere negligence or poor judgment on the part of the insurer. In Ohio, bad faith "imports a dishonest purpose, moral obliquity, conscious wrongdoing, breach of a known duty through some ulterior motive or ill will partaking of the nature of fraud. It also embraces actual intent to mislead or deceive another."[57] The majority of states, however, apply the less stringent negligence standard, which only requires that the insurer failed to exercise ordinary care and prudence in defending or settling a claim. For instance, in Idaho, the application of this standard means "an inference of bad faith can almost always be suggested by the merest of showing that the insurer's conclusions… are or may be incorrect or that the insurer's investigation was not complete in all details."[58]

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[53] *Ibid*.
[54] *Insurance Bad Faith* at 6.
[55] Adam Smith & Caroline Crichton, "Bad Faith Under a Commercial General Liability Policy" (American Bar Association: 2017), online: <https://www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2012/march_2012/bad_faith_under_commercial_general_liability_policy/>.
[56] *Insurance Bad Faith* at 6.
[57] *Centennial Ins. Co. v. Liberty Mut. Ins. Co.,* 404 N.E.2d 759, 762 (Ohio 1980).
[58] *State Farm Fire & Cas Co. v. Trumble*, 663 F. Supp. 317, 321 (D. Idaho 1987).

The United States has also adopted two separate approaches when the duty to settle and coverage are at issue, with each approach informing how a court will interpret the concept of bad faith. In some states, such as California, an insurer takes coverage into consideration at its own risk. If an insurer fails to settle within policy limits before trial where it had the opportunity to do so, and at trial it is held that the claim was within its coverage, the insurance company is liable for the whole claimed amount.[59] Other states also permit the insurer to take coverage issues into account when determining whether to settle a claim within its policy limits. However, an insurer's position in these states with regards to coverage must have a reasonable basis. If it does, the insurer would be liable up to the policy limit but not in excess. If its position of the insurer is unreasonable, the insurance company could be liable for the entire amount.[60]

Despite the differences across the United States when it comes to the courts' interpretation of bad faith, the general characterization of bad faith conduct in the United States is similar to Canada. The courts in both countries take a liberal approach to its interpretation in the insurance context, viewing good faith to be fundamentally defined by fairness and reasonableness. Nevertheless, Canadian legal policy can glean limited insight from its southern border on account of the higher volume of bad faith claims and excessive punitive damage awards. Canadian courts are already in the process of diverging from past decisions, in favour of a reduction of damages that more accurately represents the purpose of deterring such conduct.

VII. UK LAW

In comparison to Canada and the United States, an insurer's obligations to an insured are not as developed in the UK. Bad faith in the UK is mainly governed by statute, and the duty of good faith is divided into a pre-contractual and post-contractual duty.[61] The *1906 Marine Insurers Act*

[59] Travelers Insurance Company Limited, "Recent Trends in Bad Faith" (2002), online < https://d2mqw5602n62j3.cloudfront.net/prod/3b7c9528d66e429bb881076a8bc58166/TravelersRecenttrendsinBadFaith002002.pdf>.
[60] *Ibid.*
[61] H. Thanasegaran, *Good Faith in Insurance and Takaful Contracts in Malaysia* (Springer Science and Business Media: Singapore, 2016) at ch. 2.

("MIA") established the pre-contractual duty—which mandates an insurer must act in good faith when forming a contract with an insured—and allows for the avoidance of a contract if this duty is not fulfilled.[62] The roots of the post-contractual duty are not as clear. While it may be argued to have originated in the MIA as well, some have argued it is based on an implied term of the insurance contract.[63] The remedies for post-contractual breaches of the duty of good faith were more uncertain when compared to the pre-contractual remedy of avoidance.[64] However, the UK removed the remedy of 'avoidance' of contract in the MIA by implementing the *2015 Insurance Act* ("IA"), without introducing a new remedy. Thus, UK insurers' obligations are still being developed without clear remedies for breaches of the pre-contractual or post-contractual duty.[65]

The UK adopts a uniform approach to the concept of utmost good faith in insurance contracts. The 1776 case of ***Carter v. Boehm*** created the governing principle of utmost good faith that applied to all contracts. Subsequent judgments, however, limited its applicability to certain agreements, including all insurance undertakings, which was codified in the MIA.[66] In insurance contracts, the principle of utmost good faith was insurer-friendly, as it was used primarily to ensure that insureds provided adequate disclosure and to prevent misrepresentation at the pre-contractual stage. If an insured breached its duty of utmost good faith in an insurance contract, the insurer could simply avoid the contract.[67] In the decision of ***Banque Financière***, where the insurer was obliged to disclose relevant facts, the Court did not award damages or establish an alternative cause of action, stating that the MIA did not mandate that authority.[68] The current IA regulating commercial insurance contracts has abolished this skewed advantage to insurers.

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[62] *Ibid* at 2.
[63] Katharina Seethaler & Bonifasius Satriyo, "Insurer's duty of good faith and remedies in the case of a breach" (Leiden Law Blog: 2018), online: < https://leidenlawblog.nl/articles/insurers-duty-of-good-faith-and-remedies-in-the-case-of-a-breach>.
[64] *Manifest Shipping & Co Ltd v Uni-Polaris Insurance Co Ltd*: [1997] 1 Lloyd's Rep 360, 370.
[65] *Supra* note 61 at 15.
[66] *Insurance Bad Faith* at 6.
[67] *Supra* note 63.
[68] *Banque Financiere De La Cite v. Parc (Battersea) Ltd and Others*, [1998] UKHL 7; [1998] 1 All ER 737.

The IA now provides for more nuanced remedies for insurers when a policyholder breaches the principle of utmost good faith at the pre-contractual stage. Although the principle has maintained its integrity, it is less clear as to how it will be interpreted in insurance contracts in the UK. It has been argued that the IA has provided for the reciprocity of the principle between insurers and insureds to be greater, obligating insurers to owe some pre- and post-contractual duties to insured parties, such as providing adequate disclosure of material circumstances and factoring in the insured's interests with claims involving third parties.[69]

The UK courts have not taken the opportunity to introduce any new remedies for bad faith after the abolishment of the avoidance remedy. Unlike in Canada and the United States, the UK courts have not yet awarded damages for bad faith conduct despite rationale available to support such an award. For instance, the UK courts could recognize that the pre-contractual duty of good faith has its roots in the common law in ***Carter v. Boehm,*** which would permit damages to be awarded for a breach of the duty.[70] The abolishment of avoidance from the MIA also provides a gap in the law which a new tort could fill. Yet, since the implementation of the IA, the UK courts have not acted on either of these possibilities, and have not indicated whether damages will ever be awarded in the insurance context for bad faith. With respect to the post-contractual duty, the courts have not had a chance to adopt changes as there has been no case law with respect to a breach of this duty.[71] When given the opportunity, the courts may choose to award damages for such a breach.

VIII. CONCLUSION

As established in ***Whiten***, the standard for breaching the duty of good faith in first party cases involves prior intentional and malicious conduct towards the insured throughout the claim. In more recent years mere poor handling by an insurer could result in a finding of bad faith against an insurer. By contrast, bad faith in the third party setting, as established in ***Shea***, involves the

[69] *Supra* note 63.
[70] *Supra* note 66.
[71] *Ibid.*

insured being exposed to avoidable personal financial risk by going to trial, rather than settling within policy limits when given the option. In instances whereby insurers provide services that clearly involve conflicts of interest with the insured, the onus is on the insurer to fairly discharge its services to the insured while simultaneously managing its own interests.

Bad faith claims can harm insurers via the dual prongs of financial and social capital, which act not just through the direct vehicle of the court but also indirectly through the damage to reputations of insurers on account of public perception. It is true that from an economic standpoint, punitive damage awards in first party claims can be quite sizable and in third party claims, insurers can be liable for entire judgments, even quite possibly in excess of policy limits. Insurers may very well tolerate the intermittent payouts for bad faith as awarded by the court, but the secondary consequences of subjecting their conduct and policies to public scrutiny can be just as severe and can pose issues that are not easy to resolve.

Although the scope of conduct the court determines to be in bad faith has remained relatively stable since ***Whiten***, it is prudent for insurers to remain apprised of pending court decisions regarding bad faith and resultant punitive damages. As punitive damages have recently been subjected to scrutiny by the Canadian courts, the importance that these damages maintain its intended purpose has been highlighted, and hopefully will result in courts keeping with the practice of granting awards with the principle of deterrence in mind.

The fear of bad faith claims may increase desire of insurers to settle claims before trial. However, since the scope of conduct the court determines to be in bad faith has remained stable since the ***Whiten*** decision, as long as insurers avoid inadequate investigation and undue delay in denying coverage they should reliably avoid bad faith claims and confidently opine on coverage.