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THE "BAD FAITH" DOCTRINE AS APPLIED TO FIRST PARTY AND THIRD PARTY CLAIMS

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INTRODUCTION

In the context of insurance contracts, *uberrima fides*, or "utmost good faith," is a principle that governs both the insured and the insurer, and applies to first party losses as well as to third party claims. Courts can impose significant penalties on an insurer which is found to have breached the duty of good faith. These penalties can include punitive damages, which are levied in exceptional cases of malicious, oppressive, and high-handed misconduct.[1] Punitive damages are not intended to reward the bad faith victim, but rather to punish the wrongdoer for its misconduct and to deter the wrongdoer (and other potential wrongdoers) from engaging in conduct that represents a marked departure from ordinary standards of human behaviour.[2] Essentially, punitive damages straddle the frontier between civil law (compensation) and criminal law (punishment).[3] For insurers, therefore, it is a matter of economic practicality to ensure that they treat their insureds with honesty and fairness and consider their insureds' interests on the same footing as their own.

The Canadian courts have rendered two decisions which define the parameters of the duty of utmost good faith by determining when an insurer's conduct amounts to "bad faith." In the first party context, *Whiten v. Pilot Insurance Co.*, is the leading case decided by the Supreme Court of Canada in February, 2002. In the third party setting, the seminal decision is *Shea* v. *Manitoba Public Insurance Corp.*, rendered by the British Columbia Supreme Court in 1991.[4]

A. FIRST PARTY PROPERTY LOSSES

It is rare for Canadian courts to make a finding of bad faith against an insurer in the context of a first party property loss. Generally, an insurer is entitled to exercise all reasonable efforts when investigating, adjusting, valuing, and resolving property claims.

In *Whiten,* the insurer, Pilot Insurance Company ("Pilot"), rejected the insured Ms. Whiten's claim arising from the total destruction of her family home by fire, justifying its position by asserting a groundless arson defence. Ms. Whiten had been in considerable financial difficulties before the fire, and when Pilot arbitrarily cut off payments for alternative (and very modest) accommodation shortly after the fire her situation became desperate. Even though several independent experts had concluded

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[1] *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130, at para. 196.
[2] [2002] S.C.J. No. 19 (QL), at para. 36 [hereafter "*Whiten*"].
[3] *Ibid*., at para. 36.
[4] [1991] B.C.J. No. 711 (S.C.) (QL) [hereafter "*Shea*"].(*Shea* was appealed to the Court of Appeal on an issue not relevant to this paper but is found at [1993] B.C.J. No. 2377 (C.A.)(QL).)

early in Pilot's investigation that the house fire was not caused by arson, Pilot nevertheless continued to deny Ms. Whiten's claim, and pressured her into litigation. During the course of trial, it became apparent that Pilot had intentionally ignored expert evidence on fire causation in an effort to convince the insured to accept an unfair settlement worth less than she was entitled to under her policy.

Whiten was heard by a judge and jury. The jury took a very dim view of Pilot's "starve them into submission" tactics, especially since the evidence overwhelmingly contradicted the insurer's position, and awarded $1 million in punitive damages in addition to the full value of the fire loss. Pilot's appeal of the punitive damages award was ultimately heard by the Supreme Court of Canada, which upheld the jury's decision. *Whiten* is a landmark case in that it has set a substantial benchmark for punitive damages against insurers in the bad faith setting.

Most recently, the majority decision in Whiten was affirmed in *Fidler v. Sun Life Co. of Canada*, 2006 SCC 30, specifically by McLachlin C.J.C., who stated:

> *By their nature, contract breaches will sometimes give rise to censure. But to attract punitive damages, the impugned conduct must depart markedly from ordinary standards of decency -- the exceptional case that can be described as malicious, oppressive or high-handed and that offends the court's sense of decency: Hill v. Church of Scientology of Toronto, [1995] 2 S.C.R. 1130 (S.C.C.), at para. 196; Whiten, at para. 36.*
>
> *The misconduct must be of a nature as to take it beyond the usual opprobrium that surrounds breaking a contract. As stated in Whiten, at para. 36, "punitive damages straddle the frontier between civil law (compensation) and criminal law (punishment)". Criminal law and quasi-criminal regulatory schemes are recognized as the primary vehicles for punishment. It is important that punitive damages be resorted to only in exceptional cases, and with restraint.*
>
> *In Whiten, this Court set out the principles that govern the award of punitive damages and affirmed that in breach of contract cases, in addition to the requirement that the conduct constitute a marked departure from ordinary standards of decency, it must be independently actionable. Where the breach in question is a denial of insurance benefits, a breach by the insurer of the contractual duty to act in good faith will meet this requirement. The threshold issue that arises, therefore, is whether the appellant breached not only its contractual obligation to pay the long-term disability benefit, but also the independent contractual obligation to deal with the respondent's claim in good faith. On this threshold issue, the legal standard to which Sun Life and other*

insurers are held is correctly described by O'Connor J.A. in 702535 Ontario Inc. v. Non-Marine Underwriters, Lloyd's London, England (2000), 184 D.L.R. (4th) 687 (Ont. C.A.), at para. 29:

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.

Some specific examples of what is considered to be "bad faith" on the part of an insurer are outlined by Mr. Justice Laskin in his dissenting judgment for the Ontario Court of Appeal in his summary of Pilot's "malicious," "vindictive," and "high-handed" approach to the insured's claim: [5]

In summary, the evidence overwhelmingly shows that Pilot handled the Whitens' claim unfairly and in bad faith; that it deliberately ignored any opinion, even of its own adjuster and its own experts, that would oblige it to comply with its contractual obligation to pay the claim; and, that it abused its financial position and contrived an arson defence to avoid payment of the claim or, at least, to force a significant compromise. This evidence includes:

- *Pilot deliberately ignored the opinion and recommendations of Derek Francis, an experienced adjuster it retained to investigate the fire loss.*
- *After receiving Francis' strong recommendation to pay the claim, Pilot replaced him.*
- *Pilot never provided Francis' reports to the experts that it later retained.*

[5] *Whiten* v. *Pilot Insurance Co.*, [1999] O.J. No. 237 (C.A.), at para 29.

- *Pilot asked the Insurance Crime Prevention Bureau to investigate, but when the Bureau concluded that Pilot had no defence to the claim, Pilot ignored the Bureau's conclusions.*

- *Pilot deliberately ignored the opinion of its engineering expert Hugh Carter, who gave three reports that the fire was accidental; and then Pilot refused to meet with Carter when he expressed concern that his opinion was being misunderstood.*

- *Pilot admitted that the jury could reasonably infer that Carter's later opinion reclassifying the fire as "suspicious, possibly incendiary," was influenced by Pilot's counsel.*

- *Pilot pressured its experts to provide opinions supporting an arson defence. Indeed, Pilot deliberately withheld relevant information from its experts and, instead, provided them with misleading information to obtain opinions favourable to its arson theory.*

- *Pilot even admitted that the jury could reasonably conclude that the two later expert opinions supporting an arson defence were influenced by Pilot's counsel.*

- *Pilot accepted as justified the trial judge's comments that Pilot's counsel acted improperly in suggesting opinions to experts whose livelihood was earned by providing services exclusively to the insurance industry.*

- *Pilot used the bad faith claim against the Whitens to refer to evidence of previous fires – evidence it now concedes was irrelevant and inadmissible – in order to convince the Whitens' counsel that a trial was risky.*

- *At every stage Pilot considered that it could safely deny the claim because the Whitens would not refuse an offer in the future. No representative of Pilot testified why the claim was denied and therefore the jury could reasonably infer that their testimony would not have shown that Pilot had a valid reason for denying the claim.*

- *When the Whitens had lost everything in the fire and when they were unemployed and on welfare, Pilot terminated the rent payments on their rented cottage and did so without telling them.*

This summary sets out examples of conduct that insurers should avoid lest they face the risk of punitive damages awards. Conduct that falls short of the reprehensible, bad faith conduct displayed by Pilot in *Whiten* may or may not be considered to be a breach of the duty of utmost good faith, depending on the extent to which the insurer puts its interests ahead of the insured's, and engages in unfair behaviour. A review of the caselaw surrounding *Whiten* provides a useful set of examples which illustrate what does, and does not constitute "bad faith."

In a decision that predates *Whiten*, the British Columbia Supreme Court considered two insureds' claim for punitive damages against their insurers (who were underwriters under a subscription fire insurance policy) for alleged bad faith in connection with the processing, negotiation, and settlement of the second of two fire loss claims. In *Suchy* v. *Zurich Insurance Co.* [6] the two insureds were the owner and tenant/operators of a hotel which was substantially damaged by two fires over the course of two years. After the first fire, the tenant assigned the insurance proceeds to its landlord as security for rent. After the second fire, the tenant advanced claims under the policy for business interruption loss, damage to tenant's improvements, and for contents and equipment loss.

The adjuster appointed by the insurer investigated both fires. During the course of contentious valuation negotiations, the insureds retained an independent adjuster to represent them in the claims process. Two years after the first fire, the claims had still not been settled. Eventually, since the tenant had been unable to obtain adequate liability insurance and had been unable to pay the rent, the landlord appointed a receiver, terminated the lease, and evicted the tenant/operator from the hotel. The insurance claim was settled by way of an appraisal arbitration under the *Insurance Act*. [7]

The trial judge rejected the insureds' position completely, and refused to accept that the insurers "had demonstrated a lack of fair play or arbitrariness … in dealing with the [insureds'] fire claim."[8]

The Court noted that investigations and negotiations can often be protracted and complicated for legitimate reasons due to innocent commercial factors rather than as a

[6] [1999] B.C.J. No. 304 (S.C.) (QL) [hereinafter "*Suchy*"].
[7] R.S.B.C. 1996, c. 226.
[8] *Suchy*, at para 230.

result of a bad faith strategy employed by the insurer. The Court found that the insurer was entitled to explore an arson defence as those causation investigations did not prevent the repairs to the hotel from being performed, and the adjuster continued to address construction difficulties as they arose. The insurers provided instructions and made appropriate interim payments to both the accountants and the adjuster in respect of an approved proof of loss in a reasonably timely way, although perhaps not to the total satisfaction of the insureds.

The Court found that the payment delays were not prejudicial to the insureds and were not systematically engaged to wear the insureds down. A dispute amongst the insurers and the adjuster over the release of an accountant's valuation report was taken to be a "*bona fide concern over releasing confidential reserve information*,"[9] rather than an attempt to delay paying the insureds' claim. Although the adjuster indicated in a report concerning the insureds' contents claim that he had been "fairly harsh in his depreciation,"[10] the Court did not consider that one reference to be terribly significant, particularly since it was not part of a pattern or an ongoing course of conduct. Further, the trial judge accepted the fact that the contents claim was vehemently contested by both parties, considering it to be a legitimate part of the adjusting process. The insurers did not refuse to engage in settlement negotiations, but rather, they participated in settlement meetings and discussions when asked to.

Lastly, the trial judge concluded that the insurers' failure to advance funds in the course of the claim did not amount to bad faith since that failure was not motivated by arbitrariness or bad faith, and, moreover, had an advance been made it would not have prevented the tenant from defaulting on its lease obligations as a result of its inability to purchase adequate liability insurance. The Court concluded that the insureds had been treated fairly and dealt with promptly and that the length of time required to resolve the claim was not a product of "bad faith."

Since *Whiten*, Canadian courts have considered a number of first party property claims. In September of 2002, the majority (two of three justices) of the Ontario Court of Appeal decided in *Ferme Gérald Laplante & Fils Ltee.* v. *Grenville Patron Mutal Fire Insurance Co.* [11] that the insurer had not breached its duty of utmost good faith in its handling of the insured's fire loss claim to its dairy farm, and overruled the jury's punitive damages award of $750,000.

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[9] *Ibid*., at para 224.
[10] *Ibid*., at para 225.
[11] [2002] O.J. No. 3588 (Ont. C.A.) (QL) [hereafter "*Grenville*"].

In *Grenville*, the insured, a dairy farmer, lost his barn, its contents, and some livestock as well as damages to other buildings and silos due to a ten-day fire. Within three months of the fire, almost $1 million had been paid to the insured for non-contentious items. Thereafter, both parties had retained counsel to handle the remaining complex valuation aspects of the claim, which were unresolved until a trial by judge and jury a little over four years later.

Approximately five months before trial (three years and ten months post loss), the insurer offered to pay the amounts it believed were owing under the policy, albeit lower amounts than what the insured had calculated. The jury favoured the insured's higher valuations for his losses, and accepted that the insured had not been paid the full value of his loss under the policy. Accordingly, the jury awarded compensatory damages, interest, and costs as well as substantial punitive damages.

As *Whiten* made clear, an insured who has suffered a significant loss will typically be in a vulnerable financial position and thus very dependent upon the insurer to provide relief against the monetary pressure caused by the underlying loss. As such, an insurer is obliged under the doctrine of *uberrimae fides* "*to act promptly and fairly at every step of the claims process*." [12] Against that background, the Court of Appeal majority reviewed the contentious evidence relating to disputes over the parties' experts' valuation of the insured's losses and accepted the jury's conclusions that the insurer had not paid the full amounts owing to the insured under the policy. Thus, the majority did not disturb the jury's award of compensatory damages.

However, the majority determined that even though the insurer's valuations of the disputed losses were lower than those of the insured's, they were reasonable in light of alternative but supportable interpretations of the applicable terms of the insurance policy. Moreover, the majority noted that the insurer was not bound by the valuation opinion of the expert it retained, and was entitled to investigate the disputed losses further. Although the insurer took a long time (close to three years) to retain a second expert to value the insured's loss of earnings, that delay was not sufficient to attract punitive damages.

Also, even though the majority commented on the very long delay by the insurer in making payment of the amounts it reasonably believed were owing under the policy, the majority specifically found that there was little evidence apart from conjecture to support the insured's theory that the insurer had abused its position of power and

[12] *Ibid*., at para 76.

purposely set out to force the insured into an unreasonable settlement.[13] Specifically, the majority stated that:

> *It is important to note, however, that the duty to pay promptly, as a component of the duty of good faith, must be considered in that context; it is not an absolute obligation giving rise to an automatic claim for consequential damages in the event of any failure to make a timely payment in accordance with the policy.*[14]

Furthermore, both parties were sophisticated, determined, represented by counsel, and the claim itself was commercially complex. In addition, the insured in *Grenville* was not in a vulnerable economic position as a result of the fire since his net equity position in the business one year afterwards was the same as before the loss, his long-term debts were paid off, and his net earnings increased in the year after the fire, at which time some of his employees even received raises.

Moreover, in summarizing that the insurer had not acted in bad faith in the overall course of the claims process, the majority noted that the insurer had:[15]

a) *never denied coverage under the policy;*
b) *commenced its investigation of the claim and assessment of the loss immediately;*
c) *assigned experienced and senior representatives at the outset of the claim;*
d) *treated the insured amicably;*
e) *spent a reasonable amount of time trying to settle the disputed issues; and*
f) *promptly paid loss items that were not disputed.*

The dissenting justice in *Grenville* determined that punitive damages were appropriate on the basis that the insurer's initial nine-month delay in making a loss of income payment and its almost four-year delay in concluding and paying out the balance of the insured's claims was reprehensible, as was its eventual refusal to abide by its earlier position – an advantageous one to the insured—as to one of the crucial factors in determining how the insured's loss of earnings would be calculated. However, the dissenting justice reduced the amount of punitive damages awarded from $750,000 to $200,000 as a more suitable and rational sum to deter the insurer from introducing such excessive and deliberate delay in withholding payment from an insured in future claims.

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[13] *Ibid.*, at para 101.
[14] *Ibid.*, at para 78.
[15] *Ibid.*, at para 91.

In November of 2002, the Ontario Superior Court of Justice decided in *Vlastakis (c.o.b. All Season Upholstery & Storage) v. National Frontier Insurance Co.*[16] that the insurer had not acted in bad faith. The insured ran an upholstery and storage business. The building containing his inventory of fabrics, furniture, and other items was extensively damaged in a fire. As in *Grenville*, there was a dispute as to the value of the insured's damaged inventory, including old and high quality fabrics, customers' furniture to be reupholstered, and property other than fabrics, as well as other stored items.

The two contentious issues were whether the policy provided for replacement value as opposed to actual cash value, and the appropriate depreciation to be applied to the present value of the goods. The parties were unable to settle the claim because the insured mistakenly believed he had replacement cost coverage.

The Court commented approvingly on much of the insurer's behaviour during the course of handling the insured's claim. Specifically, the insurer's two experts who itemized the property other than fabrics and who valued the lost and damaged fabric inventory were impartial. Indeed, the fabric expert arrived at values higher than the insured had claimed, without any supporting documentation, on his Proof of Loss. The insurer offered to settle the insured's fabric inventory claim for an amount consistent with its experts' assessment, but the insured refused. Although the insurer declined to produce one of its expert's reports, it offered to have its expert meet with the insured to review his findings, which the insured did not agree to do. The insurer paid an advance even though the insured was not in financial jeopardy, which satisfied the trial judge that the insurer did not abuse its position of power and purposefully set out to force the insured into an unreasonable settlement. Furthermore, both parties retained counsel and continued to negotiate until trial.

In contrast to all of these cases, *Khazzaka (c.o.b. E.S.M. Auto Body)* v. *Commercial Union Assurance Co. of Canada*[17] is an August 2002 decision in which the Ontario Court of Appeal upheld the jury's finding that there had been a breach of the duty of utmost good faith and its resulting award of $200,000 in punitive damages against the insurer. As in *Whiten*, the insurer denied the insured's claim on the sole basis of an unfounded arson defence. In this case, the insured was welding in his auto repair shop when he noticed a flame in an area of the car he was working on. He went to another part of the shop to get a fire extinguisher and upon returning to the car there was an explosion and extensive fire that caused him burn injuries and destroyed the shop.

[16] [2002] O.J. No. 4684 (Ont. Sup. Ct.) (QL).
[17] [2002] O.J. No. 3110 (Ont. C.A.) (QL)[hereafter "*Khazzaka*"].

The Court of Appeal acknowledged that the insurer was entitled to conduct its own independent investigation as to the cause of the fire after learning from the police and fire departments that they did not believe that it was arson. However, the insurer's conduct became unfair when the insurer continued to deny the claim, right to the date of trial, when it had no credible basis for alleging arson. It was unfair and inappropriate for the insurer, who was determined to prove arson, to also try to get the fire fighters and police to change their opinions about the origin of the fire and provide it with evidence to support its pre-determined conclusion that the fire was incendiary. The insurer went so far as to retain a so-called expert who concocted evidence to support its theory, which fabrication the Court characterized as "*clearly unfair.*"[18]

The Court of Appeal accepted the trial judge's condemnation of the insurer's pre-trial lack of co-operation with impartial experts, and the insurer's apparent lying during trial to support an otherwise crumbling defence of arson. The repeated and relentless unfairness demonstrated by the insurer in *Khazzaka* against the insured, who was an indebted small businessman dependent upon his destroyed shop for his income, amounted to conduct that merited punishment in light of the insurer's duty of the utmost good faith.

Some general principles can be distilled from the foregoing cases to apply to adjusting policies: [19]

- Investigation must be adequate and fair;
- There must be a proper and fair evaluation of the claim;
- There must be a fair interpretation of the policy;
- The claim should be handled in a timely fashion;
- Appropriate payments should be made in a timely fashion;
- Callous or abusive practices must be avoided;
- Insureds must be given accurate and fair information regarding the handling of their claim, including decisions to deny payment; and
- Conduct of the insurer after the commencement of litigation must continue in good faith.

[18] *Ibid*., at para 14.

[19] J. Soloman, "Defending Punitive Damage Claims", Practical Strategies for Advocates VIII: "Back to Basics" (The Advocates Society (Ontario): February 19 – 20, 1999) at para. 11. [hereafter "Practical Strategies"].

More particularly, the following are helpful guidelines for insurers to follow when meeting the duty of the utmost good faith: [20]

- Approach a claim with the expectation that the claim is legitimate and will be paid in full;
- Determine as expediently as possible what payment, if any, the insured is legally entitled to receive under the policy and provide the insured with this payment in a timely fashion;
- Do not respond to the claim on a strategic level with the intent of encouraging the insured to accept a settlement for less than the full value of the loss;
- Until evidence is discovered that raises questions about the validity of the claim, focus investigations on attempting to verify the claim rather than building a case against the claim; and
- Take steps, such as making voluntary or partial payments, to alleviate rather than aggravate any hardship suffered by the insured.

On a day-to-day level, there are specific practices that will help insurers avoid the spectre of dealing in "bad faith" with an insured: [21]

- Accurately and completely document all conversations with the insured and his representative(s);
- Be professional and avoid loose conversation which may be interpreted out of context;
- Respond as promptly as possible to enquiries or correspondence;
- Correspond regularly with the insured or his representative(s), clearly documenting for them steps which have been taken, decisions which have been made regarding the acceptance or denial of the claim, and the reasons for same;
- If there is a delay in responding to a claim or inquiry, correspond with the insured or his representative(s), advising of the nature and expected length of delay;
- When relying on surveillance or investigation, review the unedited video rather than simply relying upon the investigator's written report or isolated segments of the video;

[20] B. Billingsley, "Selected Good Faith Issues in Canadian Insurance Law", Defence Briefs (Canadian Defence Lawyers Edmonton Seminar: June 6, 2002) at page 17.
[21] Practical Strategies, at para 12.

- Obtain as much objective evidence that is available and give it all fair consideration; and
- When denying a claim, the reasons for the denial should be clearly set out in written correspondence and where necessary or appropriate, the policy and/or statutory provisions should be quoted.

B. THIRD PARTY CLAIMS

In the third party setting, instances of a breach of the duty of utmost good faith by an insurer are also rare. The behaviour that is characterized by the Canadian courts in third party claims as "bad faith" typically arises in litigated cases in which the insurer, or defence counsel (agent of the insurer), permits the insured to be unnecessarily exposed to personal financial risk at trial, either by allowing a case to go to trial that is over limits, or by trying to settle only the covered portions of the loss and leaving the insured exposed for the uninsured portions of the claim.

There has been no definitive analysis of the basis for bad faith claims against liability insurers by either the Supreme Court of Canada or the provincial appellate courts. The issue of bad faith associated with an insurer's failure to settle a claim for policy limits was first addressed in Canada in *Pelky v. Hudson Bay Insurance Co*.[22] In that case, counsel appointed by the insurer to defend the an action on behalf of the insured negligently failed to relay to either party the plaintiff's offer to settle the claim for the policy limits.. The action proceeded to trial, with the result that an excess judgment was awarded against the insured. The insured then sought an order that the insurer pay the excess. It was conceded by the insurer that it was vicariously liable for the negligence of the lawyer appointed to assume conduct of the defence. Since the insurer acknowledged that it would have accepted the settlement offer had it been received, the Court chose not to reach any conclusion on the obligation of the insurer to settle claims within policy limits. Instead, the Court simply held the insurer vicariously liable for the ngeligence of the lawyer.[23]

Subsequently, in *Dillon v. Guardian Insurance Co.*,[24] an insurer refused an offer to settle a liability action within policy limits. At trial, the plaintiff was awarded a judgment in excess of the policy limits against the insured. Counsel appointed by the insurer to

[22] (1981), 35 O.R. (2d) 97 (H.C.).
[23] This summary of *Pelkey v. Hudson Bay* is found at p. 64 of G. Hilliker, "Insurance Bad Faith", LexisNexis Butterworths, 2004.
[24] (1983), 2 C.C.L.I. 227 (Ont. H.C.J.).

defend the claim expressed the view that damages would likely be assessed at close to policy limits. The insured then sued his insurer and the lawyer acting for him and the insurer for the excess. The trial judge noted that he was unaware of any Canadian jurisprudence with respect to the standard to be applied to the conduct of the insurer, but in holding the insurer liable for the excess amount, the court found that it was not necessary to decide whether the standard to be applied to the conduct of the insurer was one of absolute liability or liability for failing to act reasonably, since the insurer was liable by either standard. In refusing to settle, the insurer did not use reasonable care for the protection of its insured and was for that reason guilty of bad faith.

As indicated above, the leading decision in British Columbia and what is likely the most reasoned decision in Canada on bad faith in the third party context is *Shea.* Accordingly, that case deserves a detailed analysis. In that case, a two-month-old infant was seriously injured in a single-vehicle accident in a car driven by his father and owned by a family friend. It became apparent early on in the course of litigation that the infant would never recover from his brain injuries, and would need full-time care for the rest of his life.

The car owner was insured against motor vehicle liability risks by the Manitoba public insurer, Manitoba Public Insurance Corporation ("Manitoba"), with policy limits of $300,000. The father/driver was insured by the British Columbia public insurer, Insurance Corporation of British Columbia ("ICBC").

The infant, by way of the Public Trustee, sued his mother, his father, and the car owner in tort for negligence. In two other actions, the infant also sued each of Manitoba and ICBC for accident benefits and court order interest. Manitoba conducted the defence of both the tort action, and the lawsuit for accident benefits and interest. Settlement negotiations were unsuccessful. From a fairly early stage of the litigation, the insurer and defence counsel understood that the infant's claim would well exceed the policy limits. Throughout the negotiations, Manitoba insisted on a consent judgment equal to the policy limit. This did not result in settlement primarily because the parties could not resolve questions of which insurer was liable for accident benefits and interest, and whether such benefits were to be deducted from the infant's anticipated judgment for damages or from the insured's policy limits.

The trial of the tort action was heard first. The infant was awarded damages in excess of $800,000, plus interest of over $100,000. The question of ongoing accident benefits was left to be decided in the two actions against the respective insurers. The owner and driver were both impecunious, and unable to pay the more than $600,000 owing on the judgment in excess of policy limits.

After judgment was rendered in the tort action, the owner and driver claimed against Manitoba, alleging that the infant's action against them should have been settled for policy limits plus accident benefits and interest. The owner and driver eventually assigned their cause of action against Manitoba to the infant, who, in turn, brought another action against Manitoba to enforce their claim against the insurer.

The Court carefully examined the course of the settlement negotiations in the tort action. In arriving at its finding of bad faith, the trial judge noted that the crux of the problematic behaviour was that Manitoba promoted its interests in the litigation ahead of its insured's. By insisting on settlement equal to the policy limit, Manitoba ignored the insured's interest in having an order encompassing interest and accident benefits in addition to the policy limit. Further, although defence counsel and Manitoba communicated with each other on the issue, Manitoba failed to notify the insured of the long-standing conflict of interest between them on the question of whether Manitoba was liable for accident benefits and interest in addition to the policy limits of $300,000. The Court outlined the situation between Manitoba and the insured in this way: [25]

> *… In addition to its role as a liability insurer, Manitoba also faced claims for court order interest and as an accident benefit insurer. In one sense, it had only one interest, namely its own interest, in defeating or minimizing a potential liability to pay accident benefits, and defeating the claim for payment of court order interest in addition to policy limits. Those are interests which it could properly assert, or defend, on its own behalf.*
>
> *But in doing so, it took a position which was directly opposite to the interests of its insureds. To the extent that they faced potential liability for a claim in excess of the liability coverage, they had a direct and legitimate interest in minimizing the extent of that excess exposure… So it would have been very much in the insureds' interests to attempt to maximize the amount of accidental benefits payable by Manitoba and to see that those benefits were payable in addition to the third party liability coverage, since all accident benefits paid or payable were potentially deductible from the amount of any judgment against them.*
>
> *… [T]he insured also had an interest in arguing that court order interest was payable in addition to the policy limits. [But] it was plainly in Manitoba's interests to contend that its liability was limited to [policy limits] inclusive of pre-judgment interest. It was clearly in the insureds' interests to contend that pre-judgment was payable by Manitoba because such an obligation on Manitoba*

[25] *Shea*, at para. 168.

would correspondingly reduce the insureds' potential liability for any judgment in excess of the third party liability limits.

The Court specifically noted that where the insurer and its agent (defence counsel) are fully aware before trial that judgment in the third party liability claim will certainly exceed the policy limits, such that there is no reasonable prospect of settling a tort claim for less than the limits of coverage, an insurer can have "no legitimate interest" in trying to do so.[26] The trial judge also summarized the unique commercial relationship between an insured and its insurer, and the insurer's special duties to its insured resulting from the duty of utmost good faith, including the following: [27]

…

3. *The exclusive discretionary power to settle liability claims given by statute to the insurer in this case, places the insured at the mercy of the insurer;*
4. *The insureds' position of vulnerability imposes on the insurer the duties:*
   a) *of good faith and fair dealing;*
   b) *to give at least as much consideration to the insureds' interests as it does to its own interest; and*
   c) *to disclose with reasonable promptitude to the insured all material information touching upon the insureds' position in the litigation, and in the settlement negotiations.*
5. *… [To] not act contrary to the interests of the insured, or, at least, fully advise the insured of its intention to do so;*
6. *… [Where conflicts of interest between the insured and the insurer arise] to advise the insured that conflicting interests exist, and of the nature and extent of the conflict.*
7. *… [W]here conflicting interests arise, to instruct counsel to treat the interests of the insured equally with its own; and where one counsel cannot adequately represent both conflicting interests, an obligation to instruct separate counsel to act solely for the insureds, at the insurer's own cost;*
8. *… [T]o defend on the issue of damages, and to attempt to minimize by all lawful means the amount of any judgment awarded against the insured; and*
9. *Defence preparations and settlement negotiations must take place in a timely way, and, where last minute negotiations are required, advance planning must be made to ensure that the insured's interests are given equal protection with those of the insurer.*

[26] *Shea*, at para. 167.
[27] *Shea*, at paras. 209-221.

Specifically, the Court found that Manitoba should have told the owner and driver about the conflict of interest between them, the exact issues upon which independent legal advice should be sought, and that Manitoba would pay for the independent legal advice.[28] The Court also determined that the parties could have achieved settlement with Manitoba paying the policy limits, and protecting the owner and driver from execution for the excess, but without prejudicing the interests of ICBC or Manitoba on the remaining issues regarding liability for accident benefits and interest. As a result of its failure to settle the tort action in these circumstances, Manitoba was found liable for the full amount of the judgment.

Of note since the *Shea* case is the decision of the Ontario General Division in *Drummond v. Fortune*.[29] Although that court was not called upon to consider *Shea*, or make a specific finding of bad faith, the court chastised, and awarded special costs against an insurer that should have been able to appreciate early on in litigation that its policy limits would be exhausted by an eventual award of damages, but failed to promptly offer that amount in settlement. The insurer's failure to pay out its policy limit at an early stage was described as "delay without conscience" and the court stated "I do not subscribe to the view that there is no duty upon an insurer to attempt to settle a claim. In fact, the reverse is true particularly where the responsibility to divest itself of the complete coverage is obvious."[30]

It is important to note that none of the above is to say that a failure to settle a case for the amount of the policy limit necessarily amounts to bad faith where a court subsequently orders damages in excess of that limit. Courts have recognized and made it clear, however, that while an exposure in excess of policy limits sets up a potential conflict between insurer and insured, that potential conflict does not in and of itself give rise to a finding of bad faith or a requirement that the insurer retain independent counsel for its insured. An insurer may have a legitimate interest in trying to effect a saving on the policy limit if, on the facts of the claim, there is a *reasonable prospect* of settling for less than the limits. It takes something more than that the mere possibility of conflict to establish bad faith.[31] As such, bad faith will be established only where an insurer, who is in exclusive control of settlement negotiations, consistently ignores the legitimate interests of its insureds, and treats its own interests as paramount.[32] It

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[28] *Shea*, at paras. 244-250
[29] *Drummond v. Fortune*, [1994] O.J. 2805 (Q.L.), *aff'd* 1988 CarswellOnt 587 (C.A.)
[30] *Drummond*, at paras. 16-18
[31] *McLean v. ICBC*, 2007 BCSC 91, at paras. 58-59. See also *Fredrikson v. ICBC* (1990), 44 B.C.L.R. (2d) 303 (S.C.).
[32] *Shea*, at para. 257; *McLean*, at para. 60.

appears, then, that the notion of absolute liability for failure to settle a claim at policy limits has been rejected as a test for bad faith in Canada.

Recently, Dolden Wallace Folick was able to assist an insurer in avoiding a possible bad faith claim, and that instance provides one final example of the insurer's overriding duty to put the interests of its insured on an equal footing with its own. In that case, a tradesperson who was providing extensive services on the insured's home, was deemed to have become an "employee" of that insured by virtue of lengthy periods of time spent working at the insured's home and by operation of British Columbia workers' compensation legislation. The insured was unaware that the tradesperson had become a deemed "employee" and therefore unaware of his obligation to pay for and obtain workers' compensation registration for the tradesperson. The tradesperson was injured while working at the insured's home, and brought a tort claim against the insured.

As is the case with many other jurisdictions in Canada, the British Columbia *Workers' Compensation Act* bars tort claims by workers injured on the job in favour of its own compensation scheme. This tort claim bar would have provided the insured with a complete defence to the tradesperson's claim against him in negligence. However, because the insured had unwittingly failed to obtain workers compensation coverage for the tradesperson, the insurer would expose its insured to penalties and a possible claim for any monies paid out to the tradesperson under the workers' compensation scheme, if it raised and actively pursued that defence. This, of course, created a significant potential conflict of interest for the insurer. The insurer was able to protect the interests of the insured, by appointing independent counsel for the insured at the insurer's own cost, and avert any allegation of bad faith associated with the conflict by ensuring that it did not put its interests ahead of those of the insured

GUIDELINES AND CONSIDERATIONS

A review of the general obligations of an insurer to its insured provides some basic guidelines for dealing with an insured in good faith. In *ICBC v. Hosseini, supra*,[33] Thackray, J.A. described these obligations as follows:

> *Once an insurer is put on notice of a claim, it should take certain actions vis-à-vis the insured. As a general matter, it should:*
>
> *1. Promptly respond to the notice of claim;*

[33] at paras. 70-71.

2. Notify the insured of its preliminary coverage position if the policy contains a duty to defend;

3. Promptly pay an undisputed claim;

4. Properly notify the insured if it decides to deny coverage; and

5. Promptly rescind the policy if there are grounds for doing so.

While generally applicable to first party claims, these obligations are also significant for the purposes of third party liability claims as Thackray, J.A. went on to note that "(t)he duty of an insurer to act both promptly and fairly when investigating, assessing, and attempting to resolve claims made by its insureds applies equally to the investigating, assessing and resolving of claims made against its insureds."

More specifically, a number of guidelines may be distilled from the *Shea* decision and other cases that have applied it to assist insurers in meeting the duty of good faith in the context of third party liability claims. These include:

- Constantly recognize that an insurer is obliged to give at least as much consideration to the insured's interests as it does to its own interests;
- Promptly disclose to the insured all material information relating to the insured's position in the litigation and settlement negotiations;
- Be aware of potential conflicts of interest with insureds, and where such conflicts arise, advise the insured of the existence of the conflict, as well as its nature and extent;
- In the case of such conflicts, specifically instruct defence counsel to treat the interests of the insured equally with its own. Where this cannot be achieved, instruct separate counsel to provide advice to the insured at the insurer's own cost;
- Ensure that defence counsel preparations and settlement negotiations take place in a timely way;
- Where last minute negotiations are required (as they often are), do not lose sight of the fact that the insured's interests must be given equal protection with those of the insurer; and
- Evaluate claims objectively and without regard to policy limits and treat any settlement offer as though the insurer alone would be responsible for payment of any judgment in its entirety.

CONCLUSION

The Canadian Courts are reluctant to find that an insurer has breached the duty of utmost good faith in both the first and third party settings. The applicable standard for first party cases was established in *Whiten*, which, as noted above, requires a pattern of intentional, malicious, and unfair conduct towards the insured throughout the course of the claim.

In the third party context, the standard as set out in *Shea* is more relaxed, but still requires an insurer to needlessly expose an insured to personal financial risk by going to trial instead of settling a case within policy limits when there is an opportunity to do so, and in the absence of a reasonable prospect of settling for less. Where an insurer provides services which give rise to clear conflicts of interest with its insured, it has a positive duty to establish clear mechanisms by which it can discharge its duties to its insured, and at the same time protect its own interests.[34]

The cost of bad faith claims is significant to insurers, both from an economic and reputational standpoint. In first party claims, punitive damage awards can be substantial, and in third party claims the insurer can be liable for an entire judgment including amounts in excess of policy limits. Even if insurers can "weather" a large damages or judgment payout from time to time, the negative consequences of having their conduct and policies scrutinized and publicly condemned can be long-lasting and difficult to overcome. Insurers can look to the principles and guidelines in this paper to avoid the harsh realities of acting in bad faith.

[34] *Shea*, at para. 246.