AUGUST 2005

Blaney McMurtry
BARRISTERS & SOLICITORS LLP

Insurance Observer

IN BRIEF

W. Colin Empke

Total-Loss Deductible Class Actions Dismissed

On June 15, 2005, a five-judge panel of the Ontario Court of Appeal took the very unusual step of holding that one of its own previous decisions had been wrongly decided. In this appeal, the court was asked to reconsider its 2001 decision in McNaughton. In this case, the Ontario Court of Appeal held that insurers were obliged to waive the deductible when they took possession of the salvage in vehicles totally destroyed in an accident. That decision resulted in class actions being brought against automobile insurers in Ontario, seeking the recovery of deductibles in total-loss cases.

In the decision released on June 15, 2005, entitled *David Polowin Real Estate Ltd. v. Dominion of Canada General Insurance Co.*, the insurers challenged the McNaughton decision and asked the Court of Appeal to overrule it. The panel agreed to do so.

In deciding to overturn McNaughton, the Court of Appeal was assisted by fresh evidence related to the legislative history of Insurance Act provisions addressing the salvage of vehicles in total-loss cases. Based on this new review of the law, the Court of Appeal agreed that insurers should be permitted to retain the salvage value of a vehicle after payment of the actual cash value to the insured, less the deductible. As a result of this decision, the class action lawsuits commenced after the McNaughton decision are likely to be dismissed, subject to any appeal to the Supreme Court that may be attempted.

Restrictions Placed on Insurers When Added as Third Parties

In most Canadian provinces, there are legislative provisions governing contracts of automobile insurance that permit an insurer to take an off-coverage position yet still participate in the underlying litigation, by adding itself as a statutory third party. This statutory right means that insurers are permitted to participate in the litigation in a meaningful way. This ensures that an insurer that may face a large indemnity exposure can be protected by challenging the liability and damages issues (which might otherwise be the subject of a default judgment against the insured), should the ultimate decision on coverage require it to provide such indemnity.

The right to be added as a third party does not, however, entitle the insurer to use its pleading to advocate in favour of its own coverage position. In a recent decision of the New Brunswick Court of Appeal, an insurer was chastised for attempting to enter a pleading that was adverse in interest to its insured. The insurer had denied coverage by reason of misrepresentations and refused to appoint defence counsel for the insured. The insurer was added as a third party and proposed to take a position in its pleadings adverse in interest to that of its insured's coverage position.

The Court of Appeal noted that the only issues to be resolved in the underlying action were those between plaintiff and defendant. The insurance coverage issues were not at issue. The right to be added as a third party is limited to acting to the same extent as if the insurer were actually defending its insured. That right requires the insurer to act in the best interests of the defence of the insured. Accordingly, the Court of Appeal held that if the insurer is added

as a third party, it is not permitted to advance a position that is contrary to the interests of the insured, even if there is a coverage dispute between them.

It is notable that this right to participate in the underlying litigation is unique to situations involving automobile coverage. In the liability insurance context, a denial of coverage has very serious ramifications on the insurer's ability to receive information about the case and to participate in its progress.

See *Parlee v. Pembridge Insurance Co., 2005 NBCA 49*.

Contractual Obligations to Obtain Insurance

On July 11, 2005, the Ontario Court of Appeal took the opportunity to discuss the nature of agreements to provide indemnity and obtain insurance commonly found in construction contracts. The general contractor, BWK, was responsible for the construction of a municipal building and was obliged to maintain an all-risks property insurance policy on its own behalf and for the Town. Contrary to that obligation, BWK did not obtain the necessary insurance.

Active Fire subcontracted with BWK to install a fire protection system. Pursuant to the subcontract, Active Fire was required to indemnify BWK for any losses. Active Fire was also required to purchase insurance and it did so.

Unfortunately, the fire protection system leaked during installation and caused flood damage to the building, totalling approximately $51,000. BWK paid that sum to the Town, as compensation and in accordance with the general construction contract. BWK then sought to recover that sum from Active Fire. Active Fire admitted it was negligent in installing the system, but denied it had any obligation to compensate BWK.

The Court of Appeal noted that if BWK had obtained the insurance it was contractually obliged to purchase, that insurance would have responded to the loss and BWK would not have been forced to make the payment to the Town out of its own pocket.

Reference was made to a 1997 decision (*Madison Developments Ltd. v. Plan Electric Co.*), in which the Court of Appeal had held that when a contractor covenants to obtain property insurance for a building project, the contractor is thereafter barred from suing a subcontractor for property damage covered by that policy. The effect of that decision also bars a contractor's insurer from commencing a subrogated action against a subcontractor. (A similar bar exists in landlord and tenant situations.)

Active Fire's policy was stated to be in excess to any other valid and collectible property insurance. BWK argued that there was no other such insurance and, accordingly, Active Fire and its insurer should respond to the loss. The Court of Appeal rejected this submission, as it would reward BWK for its breach of contract. Had BWK obtained the insurance it was contractually required to purchase, it would have no cause of action against Active Fire. In reaching this conclusion, the Court also noted that Active Fire's insurer was aware of the construction project and that BWK was expected to secure insurance. Active Fire's insurer, therefore, drafted its policy and set its premiums in reliance on that fact. The failure by BWK to honour its contractual commitments should not entitle it to seek damages related to that failure.

This is the most recent articulation of the relationship between covenants to insure and the impact on the insurer's subrogation rights. If such subrogation is being contemplated, it is important to obtain and review each and every contract associated with the construction project.

See *Active Fire Protection 2000 Ltd. v. B.W.K. Construction Company Limited* (July 11, 2005, Ont. C.A.). ■

RECENT DEVELOPMENTS IN COST ALLOCATION

Dominic Clarke and W. Colin Empke

It is common ground that, in Canada, the insurer's duty to defend is dictated by the terms of the policy and the scope of the allegations in the statement of claim. One corollary of that principle is that an insurer has no obligation to defend allegations for which there is no possibility of indemnity. This basic insuring principle is clearly articulated in the *Nichols v. American Home* case and the many Supreme Court of Canada decisions subsequent to it. This basic principle, in theory, leads to the necessary conclusion that in cases where some allegations fall outside of coverage and some fall within, the insurer should be permitted to restrict its contribution to defence costs to those covered items only. This view has been accepted, in theory, but remains elusive in practice. Some recent decisions in Canada have addressed this issue and have demonstrated that issues of allocation will remain a case-by-case analysis.

Between Covered and Non-Covered Allegations

With respect to the allocation of defence costs between covered and uncovered claims, New Brunswick jurisprudence has recently suggested that a carefully drafted pleading will deprive a liability insurer of the benefit of allocation. In *Morrison v. Co-operators General Insurance Co.*, the New Brunswick Court of Appeal was asked to consider the issue of allocation in a case involving allegations of assault, which were clearly not covered by the policy. The underlying lawsuit had its origins in a "road rage" assault that followed a motor vehicle accident. The plaintiffs alleged that the injuries were a result of the negligent operation of the motor vehicle and that there was the possibility that some of the injuries may have been the result of the subsequent assault. The allegations were made in the alternative. The claim did not distinguish between those injuries alleged to be caused by the assault, and those that might have been caused by the motor vehicle accident. In such circumstances, the Court of Appeal did not consider it feasible to apportion the costs between the covered and non-covered allegations.

Shortly after Morrison was decided, the New Brunswick Court of Queen's Bench cited it for authority that where a plaintiff's allegations are "seamlessly pleaded," it is impossible to separate the defence costs between covered and non-covered allegations. (See *Conservation Council of New Brunswick Inc. v. Encon.*) While the court did not elaborate on what it meant by "seamlessly pleaded," it is clear that if the plaintiff, either deliberately or inadvertently, pleads a case without sufficient particulars, the allocation attempt can be defeated.

Recently, the Ontario Superior Court, in *Sommerfield v. Lombard Insurance Group*, accepted an insurer's submission that defence costs ought to be apportioned in a manner so that the insurer would not have to pay for claims clearly falling outside the scope of coverage. The underlying action involved allegations of sexual abuse brought against four former teachers of Upper Canada College. The action was framed in the intentional tort of sexual battery, as well as for professional negligence in failing to report the abuse. The liability insurer refused to defend the teachers on the basis that the conduct alleged was excluded from coverage. The teachers sought a declaration that the insurer had a duty to defend. Their application was granted in part.

Although the allegations of professional negligence were closely related to the intentional tort of sexual battery, the court held that the former allegations were not entirely derivative of the sexual battery. The "true substance" and "derivative pleadings" principles set out by the Supreme Court of Canada in the Scalera decision were therefore not applicable and did not result in all allegations being excluded from coverage. The court held that the allegations of professional negligence fell within the scope of coverage. However, the court held that the insurer would only be responsible for the defence costs attributable to the covered allegations of professional negligence and not for the costs of defending the battery claims.

The court was also prepared to approve an allocation formula immediately, over the objections of the teachers. The teachers had submitted that allocation should occur only at the completion of the underlying litigation. The court in Sommerfield rejected this submission and noted that "[t]o require the insurer to pay for the entire defence in these unique circumstances would be unfair." Because the causes of action were distinct and liability would be based upon separate findings of fact, the court felt it was possible to distinguish the legal services required to defend the separate claims. Apportionment was feasible and permitted in the circumstances. The court recognized that the bulk of the defence efforts would be directed at the sexual battery claims. Accordingly, the court ordered the insurer to pay 20 per cent of the defence costs, as representing a fair allocation. Note, however, that had the allegations not been capable of being distinguished, the allocation would likely not have occurred at this stage of the proceedings. If no allocation formula was possible, the court would likely have ordered the insurer to defend, subject to reimbursement at the end of the day. Since such reimbursement is often impossible to recover, the significance of an advance ruling on the allocation formula is important.

Between Insurers

In the well-known case of *Alie v. Bertrand & Frère*, the Ontario Court of Appeal addressed the issue of allocating costs between insurers in situations where they are on risk over successive policy periods and as between the excess and primary carriers. That decision has been the subject of recent judicial comment in the context of allocation decisions.

For example, in *Ayr Farmers Mutual Insurance Co. v. CGU Group Canada*, the underlying action was a class proceeding related to the inadequate drainage system in a new subdivision. The defendants were the owners of a new home in that subdivision and it was their property from which the water flowed. The defendants were

insured pursuant to a homeowner's liability policy issued first by Ayr Farmers and subsequently by CGU. The allegations against the defendants asserted continuous damage occurring over a period of time spanning both policy periods, although the bulk of the time was insured by Ayr Farmers. Ayr Farmers brought an application seeking that CGU contribute 50 per cent of the defence costs, although it only insured the property for 15 per cent of the time. Accepting that the principles of equitable subrogation required CGU to contribute to the defence costs, the court ordered the allocation as requested. It was the court's view that the equal division of the defence costs was fair in the circumstances, although it left open the possibility of a reconsideration of the allocation at the conclusion of the underlying litigation. Further refinement to the concept of equitable subrogation has been provided by the Ontario Superior Court of Justice in Boreal Insurance Inc. v. Lafarge Canada Inc., a case arising out of the same circumstances of Alie, but involving a second and later class action and the apportionment of defence costs for it.

The primary insurer requested an order requiring the excess insurer to take over the responsibility of paying for the defence of the insureds, effective from the moment they exhausted their limits of liability by being ordered to pay the judgments in the Alie case. The excess insurer argued that the duty to defend obligation of the primary insurer continued indefinitely, because the duty to defend was an obligation that was separate and distinct from the duty to indemnify. It was the excess insurer's view that exhaustion of limits should not terminate the duty to defend. They took this view because the Ontario Court of Appeal, in Alie, had found a duty-to-defend obligation on the part of excess carriers, even though they had no duty to indemnify.

The court recognized that the principles of equitable subrogation are not intended to be used in this manner. It accepted that there was no equitable reason to compel the primary insurer to contribute to the cost of defence once its payable limits of indemnity were exhausted. The court noted:

> I am also of the view that there is no equitable reason to compel a primary insurer whose policy limits have been exhausted to contribute to defence costs. As already noted, the facts before me are different from the situation where a primary insurer whose limits are not exhausted, conducts a defence of its claim that can be perceived as inuring to the benefit of the excess insurer. That situation may indeed call for an equitable contribution for defence costs from the excess insurer, as the excess insurer may be advantaged by a successful defence.

The court concluded that "Where there is no possible indemnity because the limits have been exhausted, the duty to defend passes to the next insurer in the layered scheme."

In a decision released May 5, 2005, the Ontario Court of Appeal in *ING Insurance Co. of Canada v. Federated Insurance Co. of Canada*, revisited the issue of when an excess insurer is required to contribute to defence costs incurred by a primary insurer in defending an action against a common insured.

The underlying actions involved a very serious motor vehicle accident and were all commenced in 1998. The operator of the vehicle was insured by a garage liability policy and an

umbrella policy, each with limits of $1 million and issued by Federated. The owner of the vehicle was insured by ING pursuant to a standard auto policy with limits of $2 million. The insurers agreed that the ING policy was first-loss insurance and the Federated policies were excess only.

ING defended the underlying action. The first notice that Federated ever received that a tort action had been commenced against its insured was when ING informed it of the action in March 2001. Very late in the proceedings, Federated was made aware that the claims might exceed the primary layer of coverage. Federated ultimately agreed to contribute to the settlement, but reserved its rights concerning ING's request that it pay half of the defence costs incurred in the whole action.

ING commenced an application for the determination of the defence costs allocation issue. The judge hearing the application ordered Federated to pay 31 per cent of the defence costs, which represented its share of the final settlement. Federated appealed this decision and the Ontario Court of Appeal accepted that the application judge had erred in principle in making this allocation.

The Court of Appeal reviewed the principles of equitable subrogation that state that, if equity or fairness demand, an excess insurer can be obliged to contribute to the costs of the defence. However, such obligation can exist only if the excess insurance policy contemplates a duty to defend.

Allocation of defence costs to an excess insurer is not an automatic right of the primary insurer. The circumstances must establish that it is fair and equitable for the contribution to be ordered. In this particular case, the Court of Appeal noted that ING had not placed Federated on notice that the claim might exceed the primary limits until nearly the eve of trial. Further, it was apparent that ING and Federated were in an adversarial relationship from the moment the notice was given.

The Court of Appeal observed that:

> This is not one of those cases where the excess insurer, knowing of the claim, sat back and was able to benefit from the work of the primary insurer. In such circumstances, it would not be fair to require Federated to pay any portion of ING's defence costs.

In the result, Federated was not required to make any contribution. ■

SOUTH OF THE BORDER

W. Colin Empke

American jurisprudence in insurance coverage matters can be very influential in Canadian courtrooms. From time to time, we will briefly review U.S. cases of interest.

Insured Versus Insured Exclusion Applied in Directors and Officers Policy

On June 14, 2005, the 11th Circuit Court of Appeal confirmed the application of an "insured v. insured" exclusion in a Directors and Officers (D&O) policy issued by Genesis Indemnity Insurance Co. A former director had commenced a class action against his former company, Sphinx International Inc., alleging missed earnings projections. Sphinx sought coverage under its D&O policy.

Genesis denied coverage on the basis that the class plaintiff was a former director or officer of the company and that claims by such persons were excluded. The company argued that the class plaintiff had been fired from his job as director by reason of his misrepresentation about his background. The company argued that he had not been "duly elected" as a director because the persons electing him had not been given the full facts on which to base their decision.

The court rejected this argument. It held that the phrase "duly elected" did not require "perfect procedure and substance" in the election process. The class plaintiff was a former director of the company, at least for a time, and his status as such triggered the "insured v. insured" exclusion and barred coverage for the class action lawsuit.

See *Sphinx International Inc. v. National Union Fire Ins. Co.*, 2005 WL 1389234 (11th Cir.).

Telephone Banking Does Not Qualify as "On-Premises" Activity

Private Bank and Trust Co. had "on premises" fraud coverage provided by a financial bond issued by Progressive Insurance Co. This afforded the bank coverage for loss of property resulting from "theft, false pretenses, common-law or statutory larceny committed by a person present in an office or on the premises of the insured."

A fraud artist opened an account, in person, at the bank and made a false deposit. Two days later, he withdrew the money by way of telephone banking. After being arrested, the fraudster was unable to make restitution and the bank sought recovery from its insurer. The insurer denied the claim and the 7th Circuit Court of Appeal agreed with that decision.

The court rejected the bank's argument that the fraud was a single scheme, incorporating both the opening of the account (which occurred on the premises) and the withdrawal of funds (occurring over the telephone). The court instead noted that the bank's loss occurred only when the telephone transfer was initiated. The court stated that the coverage agreement requires that the person causing the loss be physically present in the bank when the loss occurs. The court held that the telephone transfer did not constitute an "on premises" transaction.

See *Private Bank & Trust Co. v. Progressive Ins. Co.*, 409 F.3d 814 (7th Cir. 2005).

The Word "Household" Is Ambiguous

"G" was tragically injured when he dived off a boat owned by the woman he was living with in Florida. The boat was insured by Continental, which policy included liability coverage. G sued his intimate partner for liability related to her ownership of the boat. The insurer sought to limit his recovery by operation of a clause in the policy limiting recovery to $25,000 for any claim commenced by a "family member." If that clause was not operative, G could recover up to the full policy limits of $100,000.

The policy defined "family member" as "any member of the named insured's household." The term "household" was not defined. Continental commenced these declaratory proceedings against G and its named insured (G's partner), seeking a determination of the limit of recovery.

The insurer argued that "household" must be interpreted to mean all people living together in one dwelling, regardless of whether or not the individuals are related by blood, marriage or adoption. The insured and G argued that "household" must be limited to people sharing a dwelling who are so related. Florida law has not yet conclusively determined which definition is correct – there are conflicting decisions on the point.

Faced with the competing interpretations, the court concluded that the term "household," as used in the policy, was subject to two reasonable interpretations and was therefore ambiguous. Ambiguity must be resolved in favour of broader coverage. G was therefore entitled to recover pursuant to the higher limit of liability.

See *Continental Insurance Co. v. Roberts*, 2005 WL 1313692 (11th Cir.).

"Wear and Tear" Must Arise from Ordinary Operations

Meridian purchased a newly built airplane. Five months later, while starting the aircraft prior to flight, the engine caught fire and was damaged, requiring replacement at a cost of $250,000. Meridian was insured under an all-risk property policy issued by Associated Aviation Underwriters Inc., which insured physical damages caused by a covered loss. The policy contained an exclusion for damages resulting from wear and tear.

The insurer argued that the engine fire must be considered damage resulting from wear and tear. The court disagreed, noting that the ordinary and normal use of the aircraft should not result in an engine fire. The court held that, in the absence of a policy definition of "wear and tear," the term must be construed based on its everyday meaning. Further, in an all-risk policy, there is a substantial burden on the insurer to make sure that its exclusionary language is very precise. In the court's opinion, "wear and tear" refers to events that arise from the normal everyday operation of an object. It does not refer to unusual or fortuitous events.

Accordingly, the "wear and tear" exclusion was held not to exclude all damage arising from the operation of the aircraft, but only to exclude damage resulting from the normal or ordinary usage of the aircraft. The findings of fact in this case indicated the engine fire was not caused by such ordinary usage, the engine being nearly new.

See *Meridian Leasing Inc. v. Associated Aviation Underwriters Inc.*, 409 F.3d 342 (6th Cir. 2005). ■

EXPECT THE BEST

Blaney McMurtry
BARRISTERS & SOLICITORS LLP

2 Queen St. East, Suite 1500
Toronto, Canada M5C 3G5
416.593.1221 TEL
416.593.5437 FAX
www.blaney.com

RMC Risk Management Counsel of Canada

Blaney McMurtry is a member of the *Risk Management Counsel of Canada*, a Canada-wide association of independent law firms with expertise in meeting the needs of the risk management industry by providing a range of services for the insurance industry, risk retention groups and self-insureds.

To learn more about *Risk Management Counsel of Canada* and how its members can assist you, contact Tim Alexander (416.593.3900) or Larry Reimer (416.593.3997).

Insurance Observer is a publication of the Insurance Law Group of Blaney McMurtry LLP. The information contained in this newsletter is intended to provide information and comment, in a general fashion, about recent cases and related practice points of interest. The information and views expressed are not intended to provide legal advice. For specific legal advice, please contact us.
Editor: Giovanna Asaro (416.593.3902)
Assistant Editor: Caroline Mostyn (416.593.3960)

We welcome your comments. Address changes, mailing instructions or requests for additional copies should be directed to Chris Jones at 416.593.7221 ext. 3030 or by email to cjones@blaney.com. Legal questions should be addressed to the specified author.