COURT OF APPEAL FOR ONTARIO

CITATION: Loblaw Companies Limited v. Royal & Sun Alliance Insurance Company of Canada, 2024 ONCA 145
DATE: 20240227
DOCKET: C70335, C70336, C70337, C70342, C70347, C70350, C70358, C70366 & C70378

Pepall, Trotter and Nordheimer JJ.A.

BETWEEN

Loblaw Companies Limited, Shoppers Drug Mart Inc. and Sanis Health Inc.

Applicants (Respondents)

and

Royal & Sun Alliance Insurance Company of Canada*, AIG Insurance Company of Canada*, Aviva Insurance Company of Canada*, Liberty Mutual Insurance Company*, Zurich Insurance Company Ltd.*, Chubb Insurance Company of Canada*, Certain Underwriters at Lloyd's as represented by their coverholder Markel Canada Limited*, Allianz Global Risks US Insurance Company, Certain Underwriters at Lloyd's as represented by their coverholder Elliot Special Risks, Certain Underwriters at Lloyd's as represented by their coverholder Catlin Canada Inc., XL Insurance Company SE, Temple Insurance Company, Sentry Insurance Company, National Union Fire Insurance Company of Pittsburgh, Pa., Teva Canada Limited and QBE Syndicate 1886 at Lloyd's of London*

Respondents (Appellants*)

Mark M. O'Donnell and Cameron L. Foster, for the appellant Royal & Sun Alliance Insurance Company of Canada

Nina Bombier, Sean Lewis and Mari Galloway, for the appellant AIG Insurance Company Canada

Alan L. W. D'Silva and Glenn Zacher, for the appellant Aviva Insurance Company of Canada

James P. Thomson, for the appellant Liberty Mutual Insurance Company

Jamie Macdonald, for the appellant Zurich Insurance Company Ltd.

John Nicholl, Heather Gray and Julia Vizzaccaro, for the appellant Chubb Insurance Company of Canada

Marcus B. Snowden and Akash D. Brijpaul, for the appellant Certain Underwriters at Lloyd's as represented by their coverholder Markel Canada Limited

Dominic T. Clarke and Anthony H. Gatensby, for the appellant QBE Syndicate 1886 at Lloyd's of London

Lawrence G. Theall, Jeffrey A. Brown and Dylan J. Cox, for the respondents Loblaw Companies Limited, Shoppers Drug Mart Inc. and Sanis Health Inc.

Heard: April 25-26, 2023

On appeal from the judgment of Justice Marie-Andrée Vermette of the Superior Court of Justice, dated January 19, 2022.

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Pepall J.A.:

A. INTRODUCTION

[1] The allocation of defence costs amongst serial insurers who owe their insured a duty to defend raises complex issues in the context of consecutive coverage periods and multiple class action claims that span lengthy time frames.

[2] The respondent, Loblaw Companies Limited ("Loblaw"), is a Canadian grocery retailer that operates pharmacies across Canada. The respondent, Shoppers Drug Mart Inc. ("SDM"), is primarily a Canadian franchisor for retail pharmacies. SDM was acquired by Loblaw in 2014. The respondent, Sanis Health Inc. ("Sanis"), manufactures generic drugs including two drugs classified as opioids. Sanis has been a wholly-owned subsidiary of SDM since 2009. The three respondents are variously facing five class actions that relate to the manufacture, distribution, and sale of opioid drugs in Canada beginning in 1996 (the "Class Actions").

[3] The appellants, Royal & Sun Alliance Insurance Company of Canada ("RSA"), AIG Insurance Company of Canada ("AIG"), Aviva Insurance Company of Canada ("Aviva"), Liberty Mutual Insurance Company ("Liberty"), and Zurich Insurance Company Ltd. ("Zurich") (collectively, "the Primary Insurers"), issued primary Commercial/Comprehensive General Liability ("CGL") policies to the respondents during the class periods. Each of the Primary Insurers also issued excess liability policies to one or more of the respondents from time to time.

[4] The appellants, Chubb Insurance Company of Canada ("Chubb"), Certain Underwriters at Lloyd's as represented by their coverholder Markel Canada Limited ("Markel"), and QBE Syndicate 1886 at Lloyd's of London ("QBE"), are excess insurers of the respondents (collectively, the "Excess Insurers").[1]

[5] The respondents brought applications seeking declarations that each of the Primary Insurers had a duty to defend the Class Actions under their insurance policies. The respondents also sought a declaration that each respondent was entitled to select any single policy under which there was a duty to defend and require the selected insurer to defend all the claims against it. The respondents proposed to select either RSA or AIG to defend Loblaw, and Aviva to defend SDM and Sanis. Alternatively, the respondents sought an order allocating the respective share of defence costs that each insurer should pay.

[6] Although none of the insurers brought separate applications requesting an equitable allocation of defence costs amongst insurers, all parties agreed that the application judge could determine this issue without the need for such an application. Based on the respondents' application, absent agreement or a court order, the insurers selected by them would initially have to bear the cost of the defence.

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[1] The respondents are also insured under policies issued to Teva Canada Limited by QBE and potentially by other insurers. It was agreed that the issues related to those insurers would be dealt with by the application judge at a subsequent date.

[7] Certain of the Primary Insurers' policies contain varying self-insured retentions ("SIRs") or deductibles that must be satisfied before the insurer will assume responsibility for defence costs. Some insurers, such as Aviva, have agreed that the applicable SIRs have been exhausted, while others assert that their SIRs or deductibles have not.

[8] One of the main issues in contention relates to the application judge's conclusion that each of the respondents was entitled to select a single insurance policy under which there was a duty to defend and to require the selected insurer to bear the costs of the defence including those that related to claims outside that insurer's coverage period. In addition, even though the respondents had sought coverage for defence costs under all policies, the application judge further concluded that the respondents themselves were only required to exhaust all the SIRs and deductibles in the single policies they had selected because the defence costs paid by the selected insurers could serve to exhaust the SIRs in the other policies.

[9] The appellants argued that each of the Primary Insurers should contribute to defence costs based on a *pro rata* "time-on-risk" calculation upon which they had agreed. This calculation reflected the insurers' respective coverage periods as a percentage of the over 20-year time frame described in the Class Actions. No gap in coverage for defence costs would arise from the proposal but the respondents would be required to exhaust all of the SIRs and deductibles

described in the applicable primary policies before an insurer would have to contribute its proportionate share of defence costs. The respondents would have to pay the *pro rata* share of an insurer whose SIR or deductible remains unpaid.

[10] The appellants bring multiple appeals challenging those portions of the judgment authorizing each respondent to choose a single policy and requiring that insurer to defend all claims rather than imposing a *pro rata* time-on-risk allocation, and permitting the SIRs to be exhausted by the payments by the selected insurers rather than by the respondents.

[11] Another area of contention relates to a Defence Reporting Agreement ("DRA") proposed by the respondents. They had applied for a declaration that only those insurers who entered into the DRA be entitled to associate in the defence of the Class Action claims and receive privileged defence information. Among other things, the DRA required an insurer who wished to associate in the defence of the claims and receive defence side reporting to erect ethical screens to prevent the misuse of privileged information disclosed during the defence of the Class Actions.

[12] Some insurers argued that a DRA was unnecessary because they were entitled to use privileged defence information to inform their coverage positions and, furthermore, their existing internal conflict screens provided sufficient protection.

[13] The application judge disagreed, finding that there were admitted party conflicts and additionally, that the insurers' coverage positions created a reasonable apprehension of a conflict of interest. Furthermore, their internal procedures were insufficient. The DRA represented a reasonable balance between the rights of the insureds and the insurers.

[14] Several of the appellants appeal from the provisions of the judgment relating to the DRA.

[15] Lastly, the application judge concluded that Loblaw was entitled to relief from forfeiture to recover defence costs it had incurred prior to providing notice of the Class Action claims to AIG and RSA under their primary policies and in contravention of the voluntary payment provision in those policies. These costs are commonly referred to as "pre-tender defence costs". AIG and RSA appeal from that part of the judgment.

[16] For the reasons that follow, I would allow the appeals in part. First, the respondents were not each entitled to select only one policy under which there was a duty to defend and to require the selected Primary Insurer to defend the Class Action claims. Having given notice of the claims and having asked each of the Primary Insurers to defend the Class Actions, the proper disposition was a *pro rata* allocation of defence costs among the Primary Insurers based on their time-on-risk, subject to the exhaustion of applicable SIRs/deductibles.

[17] Second, each Primary Insurer's SIR/deductible must be exhausted before a duty to defend arises and until then, the respondents must contribute that insurer's *pro rata* share of the defence costs. The issue of attribution of the SIR obligations falls away in the face of acceptance of the *pro rata* time-on-risk formula as does the issue of whether the language of the individual applicable policies permits the respondents to use funds received from third parties, including other insurers, to exhaust the Primary Insurers' SIRs/deductibles.

[18] Third, I would allow the appeal on the issue of relief from forfeiture. The Loblaw respondent should not be relieved from forfeiture for pre-tender defence costs.

[19] Lastly, I would dismiss the appeals relating to the application judge's order on the DRA with the exception of the appeal of QBE and Chubb insofar as it relates to execution of the DRA.

B. FACTS

(1) The Class Proceedings

[20] The Class Actions claim billions of dollars in damages from all or some of the respondents. The class periods span over 20 years, beginning in 1996 when Purdue Pharma began selling the opioid "OxyContin".

(a) British Columbia Government Action

[21] On August 29, 2018, the Government of British Columbia ("B.C.") commenced a class action against 49 opioid manufacturers and distributors including the respondents (the "B.C. Government Action"). The Government of B.C. seeks damages arising from their allegedly negligent manufacturing, marketing, distribution and sale of opioid drugs or opioid products. It also pleads breach of the federal *Competition Act*, R.S.C. 1985, c. C-34, fraudulent misrepresentation and deceit, unjust enrichment, and fraudulent concealment. The action is brought on behalf of all federal, provincial, and territorial governments and agencies that paid healthcare, pharmaceutical, and treatment costs related to opioids during the class period, from 1996 to the present. Sanis is one of the named manufacturers and SDM is a named distributor. The action against Loblaw was discontinued on July 6, 2021.

[22] The Statement of Claim describes the history of opioid manufacturing and prescribing in Canada, beginning with Purdue Pharma's release of OxyContin in 1996. This is followed by allegations of how Purdue Pharma and other manufacturers including Sanis subsequently developed and promoted a narrative that pain was undertreated, and that, among other things, opioids were less addictive than other pain medications. The pleading describes campaigns in the late 1990s and early 2000s during which the manufacturers either knowingly or

recklessly targeted family doctors, medical students, and teaching and research publications with false and misleading materials that pushed this narrative.

[23] The distributors, including SDM, are alleged to have delivered the manufacturers' opioids to pharmacies and hospitals in Canada in quantities that they knew or should have known exceeded any legitimate market.

[24] The pleading alleges that the combined actions of the manufacturers and distributors have caused widespread opioid-related addiction and death across Canada over the course of more than two decades.

(b) British Columbia Users' Action

[25] On December 18, 2019, an anonymous representative plaintiff commenced a class action against Loblaw, SDM, Sanis, and 38 other defendants for damages relating to their allegedly negligent manufacturing, marketing, distribution, and sale of opioid drugs or opioid products (the "B.C. Users' Action"). The claim also pleads breaches of the *Competition Act* and the B.C. *Business Practices and Consumer Protection Act*, S.B.C. 2004, c. 2, fraudulent misrepresentation and deceit, unjust enrichment, and fraudulent concealment. The action is brought principally on behalf of all Canadians or, alternatively, all British Columbians who consumed any one or more of the opioids manufactured, marketed, distributed, or sold by the defendants from 1996 to the present.

[26] The claims in this action are largely similar to those in the B.C. Government Action.

(c) Ontario Users' Action

[27] On May 15, 2019, Darryl Gebien commenced a class action in Ontario against Sanis and 37 other defendants for damages arising from their allegedly negligent research, development, manufacture, testing, regulatory licensing, distribution, sale, and marketing of opioids. The class also pleads breach of the *Competition Act*, fraudulent misrepresentation and deceit, unjust enrichment, and fraudulent concealment. The action is brought principally on behalf of all persons in Canada who were prescribed opioids and who subsequently developed an addiction to opioids.

[28] The pleading focuses on the manufacturers. Loblaw and SDM are not parties to the action. The allegations it contains are very similar to the allegations in the other Class Actions.

(d) Quebec Users' Action

[29] On May 23, 2019, an anonymous representative plaintiff commenced a class action in Quebec against Sanis and 26 others for damages arising from their allegedly negligent research, development, manufacturing, testing, regulatory licensing, distribution, sale, marketing, and after-market surveillance of opioids in Quebec. Various other causes of action are pleaded including breaches of the

federal *Competition Act*, the *Civil Code of Québec*, S.Q. 1991, c. 64, and the Quebec *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12. The action is brought principally on behalf of all persons in Quebec who have been prescribed and have consumed any opioids manufactured, marketed, distributed, and/or sold by the defendants from 1996 to the present, and who suffer or have suffered from opioid use disorder.

[30] Loblaw and SDM are not parties to the action and the claims against Sanis are similar to those in the other Class Actions.

(e) Alberta Municipalities' Action

[31] On June 3, 2020, the City of Grande Prairie commenced a class action in Alberta against Loblaw, SDM, Sanis, and 42 other defendants for damages arising from their allegedly negligent manufacturing, marketing, distribution, and sale of opioid drugs and opioid products. Other pleaded causes of action include conspiracy, public nuisance, fraud, and unjust enrichment. The action is brought on behalf of all Canadian municipalities and local governments who collect taxes and/or provide services to their communities.

[32] The allegations in the statement of claim are similar to the allegations in the other Class Actions, although more detailed.

(2) Status of the Litigation

[33] The respondents gave notice of the claims to the appellants, asked each of the Primary Insurers to defend the litigation, and retained the law firm of Osler, Hoskin & Harcourt LLP to defend them in the Class Actions. The appellants have not contested the respondents' selection of counsel. By February 2021, the respondents had paid counsel more than $2.6 million and at the time of the hearing before the application judge, Aviva and Liberty had contributed to the defence costs.

[34] All the Primary Insurers and some Excess Insurers have reserved their rights to deny coverage based on "intentional act" exclusions in their policies.

(3) The Insurance Policies

[35] The five Primary Insurers issued primary CGL policies that covered one or more of the respondents for the following time periods:

- Liberty insured SDM for the period April 1, 1995 to February 4, 2000;
- Aviva insured SDM and Sanis for the period February 4, 2000 to July 1, 2014;
- AIG insured Loblaw for the period July 1, 1995 to May 1, 1997;
- RSA insured Loblaw for the period May 1, 1997 to January 1, 1998; and
- Zurich insured Loblaw for the period January 1, 1998 to January 1, 2019, and SDM and Sanis for the period July 1, 2014 (i.e., after they were acquired by Loblaw) to January 1, 2019.

[36] As can be seen, these policies were consecutive in nature rather than concurrent, the shortest coverage period being 8 months in the case of RSA and the longest being over 14 years in the case of Aviva.

[37] The primary policies generally provide coverage for the respondents' legal liability to pay damages arising from "bodily injury" sustained as a result of an "occurrence" happening "during the policy period", or words to that effect.[2] For example:

- **Aviva** shall "pay on behalf of the 'Insured' all sums resulting from the liability imposed by law upon … the 'Insured' … including damages for care and loss of services resulting from … 'Bodily Injury', as a result of an 'Occurrence' within the 'Coverage Territory' during the policy period." [Emphasis Added.]
- **AIG** shall "pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of … Bodily Injury" and "[t]his policy applies to accidents or occurrences happening anywhere during the policy period." [Emphasis Added.]
- **RSA** shall "pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of … Bodily Injury" provided that the damages "aris[e] from an occurrence covered by this policy which occurs during the policy period". [Emphasis Added.]

[38] The primary policies define "bodily injury" and "occurrence" in substantially similar terms. "Bodily injury" includes sickness, disease, disability, shock, mental

[2] Liberty's primary policies were not provided to this court. For the other policies, I have excerpted representative samples upon which the parties relied.

suffering, mental injury, and death. An “occurrence” is an “accident”, including a continuous or repeated one.

[39] **Zurich**’s Integrated Policy is slightly different, but the substance is the same. The policy provides that Zurich will pay on behalf of the Insured the “ultimate net loss” – defined as the sum of damages, defence expenses, and other covered fees – in excess of the SIR, for a “loss event” (i.e., occurrence) causing bodily injury “which occurs during the Policy Term” (emphasis added). The application judge found that in the absence of underlying insurance, this policy applied as primary coverage after the SIR was exhausted, a finding that is not challenged on appeal.

[40] The language in these policies clearly shows that the parties bargained for time-limited coverage. The Declarations that formed part of each policy expressly specified that each policy had a term and that any covered “occurrence” had to occur within that term.

[41] Except for the two policies issued by Zurich for the 1998-2001 and 2001-2003 periods, each primary policy contains an express duty to defend any claim for bodily injury against the insured. Examples of provisions concerning the duty to defend are as follows:[3]

> **Liberty:** “With respect to such insurance as is afforded by this policy, [Liberty] shall: (a) If claim is made or suit brought within Canada or the United States of America,

[3] Where there are minor changes in policy wording over time, the changes do not affect the substance of the provisions prescribing the duty to defend.

their territories or possessions, defend any such claim or suit against the Insured."

Aviva: "As respects such Insurance as is afforded by this policy: (1) [Aviva] has the right and duty to defend in the name of and on behalf of the 'Insured', allegations, claims, demands or suits, which may at any time be instituted against the 'Insured' even if such allegations, claims, demands or suits may be groundless[,] false or fraudulent; or to make settlement of such claims as may be deemed expedient by [Aviva], or if [Aviva] is prevented by law or otherwise from defending the 'Insured' as aforesaid, [Aviva] will reimburse the 'Insured' for defence costs and expenses incurred with the consent of [Aviva]; but [Aviva] shall not be obligated to pay any claim or judgment or to defend suit after applicable limit of [Aviva's] liability has been exhausted by payment of judgments or settlements."

AIG: "With respect to such insurance as is afforded by this policy, [AIG] shall: (A) Defend any suit against the Insured alleging such injury, sickness, disease or destruction and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; but [AIG] may make such investigation, negotiation and settlement of any claim or suit as it deems expedient."

RSA: "With respect to such Insurance as is afforded by this policy, [RSA] shall: (A) Defend any suit against the Insured alleging Bodily Injury, Personal Injury or Property Damage and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; but [RSA] may make such investigation, negotiation and settlement of any claim or suit as it deems expedient."

Zurich for the policy period 2004-2006: "As respects such Insurance as is afforded by this policy, Zurich also agrees: a) to defend in the name of or on behalf of the Insured, allegations, claims, demands, suits or other proceedings which may at any time be instituted against the Insured for any accident or 'Occurrence', even if such allegations, claims, demands or suits may be wholly

> groundless, false, or fraudulent; or to make settlement of such claims as may be deemed expedient by Zurich." (Emphasis added.)

[42] Zurich's policies for 1998-2001 and 2001-2003 do not include an express duty to defend. However, the application judge held that these policies require Zurich to pay for the "ultimate net loss" in excess of the SIR, which includes defence expenses incurred by the insured. This determination is not under appeal.

[43] Under each of the aforementioned policies, the quantum of defence costs is not subject to the policies' limits of liability.[4]

[44] The respondents relied on each primary policy to defend the Class Actions. The application judge held that, subject to the exhaustion of applicable SIRs and deductibles, the Class Actions triggered duties to defend under the primary policies of each Primary Insurer. No one has challenged that finding.

C. ISSUES

[45] The issues on appeal fall into four main categories:

(i) payment of defence costs;

(ii) the treatment of the SIRs and deductibles;

(iii) relief from forfeiture for pre-tender defence costs; and

(iv) the DRA and ancillary related matters.

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[4] With the exception of the 1998–2001 and 2001–2003 Zurich policies.

(1) Payment of Defence Costs

(a) The Application Judge's Reasons

[46] In brief, the application judge concluded that the Primary Insurers were required to pay all reasonable costs associated with the defence of the Class Actions. Rather than adopting a *pro rata* allocation in proportion to each insurer's time-on-risk, each respondent was entitled to select any single policy under which there was a duty to defend that respondent and require the appellant insurer to defend. The selected insurer was required to defend all claims, including claims that fell outside its coverage periods, but entitled to seek a reallocation of the defence costs at the end of the proceedings to the extent that they dealt solely with uncovered claims, or exceeded the reasonable costs associated with the defence of the covered claims. Once an insurer assumed its obligation to defend or to pay defence costs, that insurer could then seek equitable contribution from the other insurers with a concurrent obligation to defend or pay. The Primary Insurers for each respondent had agreed to a time-on-risk equitable allocation of defence costs and this was appropriate.[5] The Primary Insurers could seek a different calculation of defence costs at a later stage, based on the evidence at trial or findings on interlocutory motions.

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[5] In contrast, the time-on-risk equitable allocation proposal advanced by the Primary Insurers operated from the inception of the obligation to pay defence costs.

[47] In reaching this determination, the trial judge purported to rely on *Hanis v. Teevan*, 2008 ONCA 678, 92 O.R. (3d) 594, leave to appeal refused, [2008] S.C.C.A. No. 504; *Family Insurance Corp. v. Lombard Canada Ltd.*, 2002 SCC 48, [2002] 2 S.C.R. 695; and *Markham (City) v. AIG Insurance Company of Canada*, 2020 ONCA 239, 445 D.L.R. (4th) 405, leave to appeal refused, [2020] S.C.C.A. No. 170.

[48] She determined that the claims set out in the pleadings could not be reasonably, practically, and realistically separated or allocated between covered and uncovered claims for each insurer at this stage of the proceeding. Accordingly, the selected insurers were obliged to pay for defence costs for the entire time period covered by the Class Actions.

(b) The Positions of the Parties

[49] The following is a brief outline of the parties' positions on the payment of defence costs.

(i) The Appellants

1. Aviva

[50] The appellant Aviva submits that the application judge erred in finding that the respondents had the right to select a single Primary Insurer to provide a defence over the entire Class Action period when the insurer's policies only covered a portion of that period. The proposed class periods extend over 20 years,

potentially commencing over four years before and ending several years after Aviva was on risk for SDM and Sanis. The application judge's order requires Aviva to defend Sanis and SDM for this entire period, which includes a period during which Aviva was not on risk, and simultaneously relieves other insurers from their defence obligations.

[51] Aviva submits that this order contravenes, rather than enforces, the express language of the policies. Aviva's insurance policies each reflected a time-limited bargain. Aviva agreed to indemnify the respondents for damages resulting from an occurrence "during the policy period". Aviva only agreed to defend claims that fell within "such insurance as [was] afforded by [the] policy". The scope of the duty to defend was thus expressly linked to the duty to indemnify, which, given its time-limited nature, was not triggered for a substantial portion of the class period.

[52] Aviva further submits that the Class Actions' claims are temporally separable. The Statements of Claim allege several claims over the course of decades. These claims would have evolved over time such that defending claims within one period would not necessarily further the defence of claims within another.

[53] Moreover, Aviva, Zurich and Liberty proposed an allocation covering all of SDM and Sanis' defence costs for the entire period in proportion to each insurer's time-on-risk. (A similar proposal was made by Loblaw's insurers.) The application

judge erred in allowing each respondent to choose a single policy and requiring the selected insurer to defend all claims rather than imposing this *pro rata* time-on-risk allocation. For SDM, the agreed-upon allocation was Liberty at 20%, Aviva at 60%, and Zurich at 20%. For Sanis, the agreed-upon allocation was Aviva at 50% and Zurich at 50%. For Loblaw, the agreed-upon allocation was RSA at 3%, AIG at 6%, and Zurich at 91%. These allocations would be subject to adjustment, for example upon settlement or completion of the Class Action proceedings.

[54] Finally, Aviva argues that the application judge misconstrued the caselaw upon which she relied in holding that the Class Action claims were inseparable, including *Hanis*, *Family Insurance Corp.*, and *Markham*. Those cases involved insurers who concurrently insured the same risk during the same time period, rather than insurers with successive duties to indemnify or defend claims stretching over multiple policy years. The application judge disregarded principles articulated by this court in *Tedford v. TD Insurance Meloche Monnex*, 2012 ONCA 429, 112 O.R. (3d) 144 and *Goodyear Canada Inc. v. American International Companies*, 2013 ONCA 395, 115 O.R. (3d) 728.

2. RSA and AIG

[55] RSA and AIG take issue with the application judge's analysis and conclusion for many of the same reasons advanced by Aviva. As mentioned, RSA provided insurance for only eight months out of the over 20-year class period described in

the claims (approximately 3% of the total time-on-risk). RSA emphasizes that the application judge erroneously applied an “all sums” approach that this court expressly rejected in *Goodyear*.[6] Among other things, RSA also submits that the application judge’s decision improperly allows the respondents to target one insurance carrier over others. This could lead to the absurd result of making an insurer who provided only one day of coverage liable for all upfront defence costs.

[56] Like the other Primary Insurers, AIG points to its short time-on-risk, as it only provided insurance for the first 16 months of the over 20-year class period (approximately 6%). The respondents could not have reasonably expected that AIG would defend their interests for this entire period when they only bargained for such a short period of coverage.

[57] Like Aviva, AIG also submits that the application judge failed to analyze the temporal aspect of the alleged occurrences in the Class Action. The allegations evolved over time such that the defence of claims inside AIG’s narrow coverage window would require separate evidence and argument from the defence of claims outside of the window. It was incumbent on the application judge to analyze this temporal separation so as to ensure that AIG was not responsible for defending claims that clearly fell outside its policy.

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[6] This concept will be discussed later in these reasons.

3. Other Insurers

[58] Zurich adopted the positions advanced by the other Primary Insurers on this issue, while Liberty similarly supported a time-on-risk approach. Indeed, Liberty submits that it is unclear that SDM was selling opioids during the five years Liberty was on risk.

(ii) The Respondents

[59] The respondents submit that the application judge properly explained how the contractual analysis mandated by *Hanis* led her to conclude that each insurer had an unqualified duty to defend the entire action. Relying in part on *Lombard General Insurance Company of Canada v. 328354 B.C. Ltd.*, 2012 BCSC 431, 32 B.C.L.R. (5th) 364, at paras. 57-58; and *St. Paul Fire & Marine Insurance Co. v. Durabla Canada Ltd.* (1996), 29 O.R. (3d) 737 (C.A.), at pp. 1, 3-5, she rejected the argument that *Hanis* does not apply to cases with claims extending over multiple policy periods (“long-tail” injury claims) like those detailed in the Class Actions. She found that there was no way that the defence of the claims set out in the pleadings could be reasonably, practically, and realistically separated or allocated between covered and uncovered claims. Allegations of intentional acts, which some insurers may seek to exclude, are inextricably interwoven with the negligence claims. The appellants are asking this court to abandon the contractual analysis in favour of the “fairness” theory rejected in *Hanis*.

[60] If the insurers cannot show a principled and practical basis on which the court could readily distinguish the costs of defending covered, mixed, and uncovered claims, and if the insurers and insureds do not agree on an allocation, then the selected insurer must pay for the entire defence, subject to a right to reallocate at the end of the underlying litigation. Through equitable contribution, the Primary Insurers chosen to defend the claims will all have their respective obligations reduced, and they have agreed on what would be the most equitable means for doing so.

[61] The respondents argue that the “risk insured” includes the duty to defend the claims in the underlying actions. Thus, in cases involving multiple insurers who provide different scopes of indemnity but who each owe a duty to defend, the insured may select any of the insurers to defend.

[62] The respondents argue that the duty to defend is broader than the duty to indemnify and that different allocation principles apply. When applied to defence costs, the *pro rata* time-on-risk approach assumes that the costs of defending a claim should be allocated to the same policy period(s) as that in which the damages occurred. However, the insurer is obliged to fund the defence of all covered claims, even if they are groundless. This obligation does not depend on what amounts, if any, the insurer is later required to pay as damages or for what years those damages are paid. The *pro rata* time-on-risk approach incorrectly assumes no overlap in defence effort across policy years and ignores the cost of

defending mixed claims. The insurers erroneously rely on cases applying a duty to indemnify analysis, such as *Goodyear*, or that do not apply the contractual interpretation analysis required by *Hanis*.

(c) Standard of Review

[63] The interpretations of the standard-form CGL insurance policies in this case are reviewable for correctness: *Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co.*, 2016 SCC 37, [2016] 2 S.C.R. 23, at para. 4. However, on a duty to defend application, issues involving the factual matrix specific to the parties in the proceeding may attract a deferential standard of review: *AIG Insurance Company of Canada v. Lloyd's Underwriters*, 2022 ONCA 699, 474 D.L.R. (4th) 502, at paras. 34-38.

[64] That said, the overarching question of the proper legal approach to allocating defence costs in the context of long-tail claims is an extricable question of law subject to a correctness standard: *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at para. 31; *Sattva Capital Corp. v. Creston Moly Corp.*, 2014 SCC 53, [2014] 2 S.C.R. 633, at para. 53.

(d) Analysis of Payment of Defence Costs

[65] The challenge presented by these appeals is what to do with the cost of defending claims that involve allegations of continuous or progressive injury that span many years (long-tail claims) where there are insurance policies with different

insurers, different provisions governing deductibles and SIRs, and consecutive rather than concurrent coverage periods and therefore different risks. The American Professor Leo P. Martinez aptly described this as "among the thorniest problems in insurance law": "The Allocation of Costs in Multi-Insurer Cases Spanning Multiple Years: The Deceptively Simple Problem of Defence Costs" in *New Appleman on Insurance: Current Critical Issues in Insurance Law* (New York: LexisNexis, 2012), at p. 53.

[66] At the outset, it is important to note what this case is not about. First, there is no denial of a duty to defend. None of the appellants contest their responsibility to defend the Class Actions. Indeed, the application judge found that, subject to the exhaustion of SIRs/deductibles, the duty to defend was triggered under each primary CGL policy. Second, the Primary Insurers had agreed beforehand on a *pro rata* time-on-risk allocation amongst themselves.[7] There was no need for this to be the subject of a separate contested application. As mentioned, even the respondents themselves sought in the alternative an order allocating the respective share of defence costs that should be paid by each insurer. Notably, they do not contest the proposed formula reached by the Primary Insurers. Third, this is not a case of any gap in coverage.

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[7] I note that the proposal advanced by the Primary Insurers includes coverage for intentional acts which they state are uncovered claims. This is obviously of benefit to the respondents. RSA observes that there are 32 uncovered claims in the Class Actions. Indeed, RSA states that the substance of the Class Actions are not negligence based but coverage for defence costs is being provided nonetheless.

[67] As mentioned, the application judge concluded that each respondent was entitled to select one policy and require the selected insurer to defend for the entire multi-decade period over which the Class Actions spanned. So by way of example, RSA, whose policy only covered 8 months or approximately 3% of the class period was obliged to provide a defence for Loblaw for the entire period.

[68] In my view, the application judge's decision in this regard was in error for numerous reasons.

(i) The policies provide for a time-limited bargain

[69] First, the judgment fails to give effect to the express language of the parties' bargain. The proposed *pro rata* time-on-risk allocation accords with the contractual time-limited duty to defend which the respondents and the Primary Insurers agreed to.

[70] The relationship between an insurer and its insured is contractual in nature. An inquiry into the nature and scope of the duties an insurer owes to its insured starts with the insurance policy that governs them: *Hanis*, at para. 22; *Family Insurance Corp.*, at para. 19; and *Markham*, at para. 44. When interpreting contracts of insurance, the court should give effect to clear language, reading the contract as a whole and applying general rules of contractual construction to resolve any ambiguities: *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada*, 2010 SCC 33, [2010] 2 S.C.R. 245, at paras. 21-24.

[71] Here, the application judge ignored the language found in the policies of each of the Primary Insurers that qualified the duty to defend and linked it to the insurance provided by the policy. The indemnity coverage provided by the Primary Insurers is for the policy period that is in each case described in the declarations that form part of the policies. The policies are all limited to coverage “during the policy period” and the duty to defend in each case is qualified by the words “with respect to such insurance as is afforded by the policy” (or equivalent language). This language clearly links the duty to defend to the coverage for which the parties bargained.

[72] As the Alberta Court of Appeal stated in *International Radiography and Inspection Services (1976) Ltd. v. General Accident Assurance Company of Canada* (1996), 47 Alta. L.R. (3d) 137 (C.A.), at para. 8:

> The obligation to defend arises only “[a]s respects insurance afforded by this policy”. The duty to defend therefore arises only in circumstances where the claims against the insured would, if proved, require the insurer to provide indemnity under the policy. As McLachlin, J. said in *Nichols v. American Home Assurance Co.* (1990), 68 D.L.R. (4th) 321 (S.C.C.), at p. 326, "the duty to defend imposed by the defence clause is unambiguously restricted to claims for damages which fall within the scope of the policy".

[73] Unlike in *Hanis*, where there was only one policy period and no contractual language qualifying the duty to defend in respect of mixed claims, here there is language prescribing the temporal scope of that duty. Claims falling outside that

temporal scope would not require a Primary Insurer to provide indemnity under its policy and the insurer's duty to defend could therefore not be triggered.

[74] The Primary Insurers were not insuring the same risk. Rather, they each agreed to cover risks within certain time parameters. Each insurer covered a successive period of time that captured a different risk profile. No insurer agreed to cover risks falling outside their prescribed time period.

[75] Consistent with the bargain made, the respondents managed their insurance coverage on the basis of successive coverage. They selected different insurers and policies for different time periods, paying the attendant premiums for the years for which they contracted and always ensuring there was no insurance gap.

(ii) The Primary Insurers are not "concurrent" insurers

[76] Second, the application judge erred in extending *Family Insurance* and *Markham* to the present case. Both cases dealt with allocation issues as between "coordinate" or concurrent insurers.

[77] Writing for the Supreme Court in *Family Insurance*, Bastarache J. noted, at para. 14, that where an insured holds more than one policy of insurance that covers the same risk, the insured is entitled to select the policy under which to claim indemnity, subject to any conditions to the contrary. The selected insurer is then entitled to contribution from all other insurers who have covered the same risk. At para. 14, Bastarache J. stated that "[t]his doctrine of equitable contribution

among insurers is founded on the general principle that parties under a coordinate liability to make good a loss must share that burden *pro rata*." *Markham* was to the same effect and also involved concurrent obligations by the two insurers providing coverage. The insurers in those cases had insured the same risk and accordingly both had a contractual duty to defend the same claim. Allowing the insured to choose whichever insurer it wanted to defend the claim was entirely consistent with the parties' bargains.

[78] Here, the application judge erred in concluding that the insurers were concurrent insurers. The Primary Insurers insured discreet risks in successive time periods. They did not agree to indemnify for risks falling outside those time periods and therefore have no duty to defend claims arising entirely from them. To require the Primary Insurers to defend claims outside of their policy periods is inconsistent with the parties' bargains.

[79] Accordingly, in the absence of concurrent obligations, the application judge further erred in concluding that the selected insurer could then seek equitable contribution from the other insurers.

(iii) *Hanis* is not applicable to situations involving multiple policy periods

[80] Third, it was an error to apply the principles from *Hanis*, which focussed on mixed claims giving rise to multiple theories of liability, to a situation involving multiple policy periods. *Hanis* involved a dispute between the insured and the

insurer concerning “mixed claims”. There were multiple causes of action, some of which were covered by the insurance policy (e.g., malicious prosecution) and others to which coverage did not extend (e.g., wrongful dismissal). The issue was how the defence costs should be apportioned between the insurer and the insured at the conclusion of the trial. The trial judge had found that only 5% of the defence costs related exclusively to the defence of uncovered claims. He ordered that the insurer pay the remaining 95% of the costs of the mixed claims: *Hanis v. University of Western Ontario* (2005), 32 C.C.L.I. (4th) 255 (S.C.), at para. 198.

[81] On appeal, this court affirmed this allocation. In analyzing who should bear the defence costs as between the insured and the insurer, Doherty J.A. favoured a contractual analysis over consideration of equitable principles. He concluded, at para. 22, that the nature and scope of an insurer’s duty to pay defence costs should start with the language of the policy. Based on his interpretation, the insurer was required to pay “all reasonable costs relating to” the defence of the covered claims even if those costs furthered the defence of uncovered claims: at para. 23. He stated that the costs did not increase because they also assisted the insured in the defence of an uncovered claim: at para. 23.

[82] The term of the policy and successive obligations were not in issue; only one policy period was engaged.

[83] *Tedford*, decided several years after *Hanis*, also dealt with mixed claims in a single policy period. Like *Hanis*, *Tedford* dealt with the issue of allocation of defence costs as between the insured and the insurer. There the insurer submitted that it should not be responsible for 100% of the defence costs, arguing that only about $25,000 of $185,000 claimed in damages related to bodily injury covered by the insurance policy. This court held, at para. 19, that the application judge had erred in requiring the insurer to defend the entire action without making provision for apportionment of defence costs. Hoy J.A. distinguished *Hanis* on the basis that apportionment of costs in that case was determined following a trial whereas in *Tedford*, the insured sought to have the insurer assume the conduct of the defence at an earlier stage in the proceedings. Furthermore, in *Tedford*, the covered claims represented a small portion of the total damages claimed. Hoy J.A. noted that *Hanis* established that an insurer is responsible for all reasonable costs associated with the defence of a covered claim. She stated at para. 24: “It would be unfair to the insurer to fix it with defence costs that are disproportionate to the extent of its potential liability for the covered claim.”

[84] The insured was to bear the costs of the defence to the extent they exceeded the reasonable costs associated with the defence of the covered claims and in determining reasonable costs, it was appropriate to consider the quantum of the covered claims. If the parties could not agree on allocation, they could apply to court after the matter was concluded or at such time as the parties may agree.

[85] As emphasized in *Tedford*, *Hanis* establishes that an insurer is responsible for all reasonable costs associated with the defence of covered claims. Such costs may fortuitously further the defence of uncovered claims but an insurer should not be saddled with costs that are "disproportionate to the extent of its potential liability for the covered claims": *Tedford*, at para. 24. Indeed, in *Hanis*, in holding the insurer responsible for 95% of the defence costs, the "insurer's exposure for liability for defence costs [had not been] increased": at para. 23. The insurer would have paid these costs to defend the covered claims even if they furthered the defence of uncovered claims.

[86] Conversely, in this case, the application judge's disposition places a disproportionate and unreasonable burden on the selected insurers. The application judge ordered that each respondent could select a single policy to provide the defence for all the Class Action claims against it. The heavy burden associated with funding the legal costs of the Class Actions cannot seriously be challenged. For instance, as counsel for RSA argues, defence legal counsel would receive voluminous quantities of productions for the class in five actions and, in the first instance, the selected insurer would be responsible for payment of the costs associated with the review of those productions. The application judge permitted the selected insurer to seek apportionment of the defence costs at the end of the proceeding and also to seek contribution from the insurers whom she said had a concurrent obligation to defend. Seeking apportionment at the end of

the proceeding requires the selected insurer to fund both lengthy and costly proceedings. Although I reject the notion that the remedy of equitable contribution is permissible in the absence of concurrent obligations, the application judge's reliance on equitable contribution placed the burden of collecting contributions from other insurers on risk on the selected insurer: D. Carol Morgan, "Time on Risk" in Sébastien A. Kamayah, Marcus B. Snowden & Mark G. Lichty, *Annotated Commercial General Liability Policy* (Toronto: Thomson Reuters, 2021) (loose-leaf updated 2023, release 2), s. IF:3. Both options expose the selected Primary Insurer to costs that are disproportionate to the extent of its potential liability. AIG, for example, and as mentioned, was only on risk for approximately 6% of the class period, having agreed to defend claims only up to May 1, 1997. Requiring AIG to defend <u>all</u> the claims against Loblaw, including those occurring between May 1, 1997 and present, is quite clearly disproportionate to AIG's potential degree of liability. It is not reasonable, unlike *Hanis*, to initially require the selected insurers to pay all the costs of the defence.

(iv) The application judge did not meaningfully analyze the pleadings

[87] The application judge's finding that the defence of the claims in the various Class Actions could not be separated between covered and uncovered claims is not determinative. As Aviva and AIG argued, the application judge did not

meaningfully consider the temporal aspect of the alleged occurrences in the Class Action pleadings.

[88] To determine if a duty to defend has been triggered, the insurance policy and the claims in the pleadings are to be examined to ascertain whether there is a possibility of the claims falling within the insurance coverage: *Progressive Homes*, at paras. 6, 19-20. Where it is clear that a claim does not fall within the original grant of coverage or is excluded, there is no duty to defend: *Nichols v. American Home Assurance Co.*, [1990] 1 S.C.R. 801, at p. 810. So, for example, fraud was excluded from the policy in *Nichols* and as such, there could be no indemnity for claims of damages for fraud. Hence, there was no duty to defend.

[89] In the B.C. Users' Action, the representative plaintiff alleges that he was first prescribed OxyContin in or around 2003. By that time, AIG, RSA, and Liberty's coverage periods had expired. Requiring them to defend this claim, as the respondents have opted to do, improperly increases the scope of responsibility contemplated under these insurers' policies which were time-limited in nature.

[90] In a similar vein, the B.C. Government Claim alleges that:

- In 1996, the first year of the class period, Purdue Pharma had only just released OxyContin, seeking to have it prescribed for chronic conditions and claiming that "there is very little risk of addiction";
- In 1998, medical professionals began raising concerns about the prevalence of controlled-release opioids like OxyContin on the black market, indicating that they were more addictive than Purdue Pharma had claimed;

- Throughout the late 1990s and early 2000s, the manufacturer defendants developed a campaign to educate doctors on the use of opioids to treat chronic conditions;

- In 2007, companies selling opioids had given more than $500,000 in funding to the University of Toronto and course materials there began to contain information that was aligned with the manufacturing defendants' interests; and

- In 2016, Purdue Pharma gave Canadian doctors more than $2 million as part of its marketing efforts.

[91] It is clear from these allegations that the defendants' allegedly tortious conduct was qualitatively different across time periods. In 1996, OxyContin had only just hit the market. Clear signs as to the drug's addictiveness were not yet present. The defendants' marketing campaigns did not ramp up until the late 1990s and early 2000s, reaching new highs in the 2010s. Recall that AIG, one of the two selected insurers for Loblaw, insured Loblaw from July 1, 1995 to May 1, 1997 and the other, RSA, insured Loblaw from May 1, 1997 to January 1, 1998.[8]

[92] In addition, although it is the case that the allegations in the pleadings cannot be neatly divided into distinct and precise time periods at this stage, the claims are divided into those against manufacturers and those against distributors and do provide certain timelines. Loblaw is pleaded to be a distributor. AIG reasonably argues that a claim against a distributor could only follow conduct by the

[8] Even though this action was discontinued against Loblaw in 2021, defence costs would have been incurred given that the proceeding was commenced in 2018 and notice was given to AIG and RSA on July 25, 2019.

manufacturer. Similarly, as mentioned, the proposed class periods commence over four years before and end several years after Aviva was on risk for SDM and Sanis.

[93] The Class Action claims will have to be outside the time parameters of at least some of the policies targeted. There is no single policy that could possibly be called upon to indemnify the respondents in full for the claims given the evolving nature of the claims and the time-limited nature of the coverage provided. The consecutive nature of the insurance policies renders a time-on-risk allocation a simple exercise at a preliminary stage in these proceedings. The time periods in the policies are readily identifiable. A time-on-risk allocation fits with the temporal nature of the allegations asserted against the respondents.

[94] I would also note that in the present appeals the Primary Insurers collectively propose to pay all of the defence costs for the entire period. Unlike *Hanis,* none of the claims will be “uncovered”.

(v) An “all sums” approach was erroneously applied

[95] Fifth, although denying that she was doing so, in permitting each insured to select one policy each for their defence, the application judge adopted an “all sums” approach to defence costs. Based on learned commentary, there is limited support for this approach.

[96] The “all sums” concept is described by Heather Sanderson in her article entitled “A Canadian Perspective on Insuring the ‘Next Asbestos’” in Hon. Todd Archibald, ed., *Annual Review of Civil Litigation 2017* (Toronto: Thomson Reuters, 2017), at pp. 165-67. The author commences by noting that there are two theories of allocation used in the United States[9]: the *pro rata* theory of allocation and the “all sums” theory of allocation. The former has two alternatives: *pro rata* by time-on-risk and *pro rata* by limits (I will not address this second alternative of *pro rata* by limits as it is not relevant to this appeal and does not appear to have been applied in Canada). Sanderson explains the *pro rata* by time-on-risk allocation at pp. 165-66:

> Under “the *pro-rata* approach” defence costs are pro-rated. Defence costs are spread among the insurers whose policies apply to the injury or damage in issue, as well as the insured (for uninsured periods), in one of two ways, either a “time-on-the-risk” allocation or allocation by limits.
>
> …
>
> Time on the risk refers to the period of time in which that particular insurer offered coverage in proportion to the time during which the injury or damage occurred. Each insurer is liable for a proportion of the insured’s loss, with the amount determined by the number of years the insurer was on the risk, relative to the total number of years of triggered coverage.
>
> …

[9] Other commentators also recognize other methods of allocation: see for example Martinez, at pp. 69-75.

> Proponents of a *pro-rata* by time on the risk rule urge that such a rule is supported by CGL policy language. CGL policies agree to pay only for an insured's losses which occur within the policy's coverage.

[97] She then addresses the "all sums" theory of allocation, noting that it derives its name from policies which state: "[The insurer] will pay on behalf of the insured all sums which the insured shall be legally obligated to pay as damages because of … bodily injury or … property damage to which this policy applies caused by an occurrence." She explains at pp. 166-67:

> Under this theory it is argued that the policy language mandates that each insurer is liable for the whole of the defence costs incurred and it is up to that insurer to seek contribution and indemnity from any other insurer whose policy is triggered by the injury or damage in issue. This theory also states that the policy language dictates that the insured does not contribute to any of the costs incurred.
>
> Under this theory, the insured picks the period where it has maximum coverage (i.e., a primary policy with high limits and a low deductible plus an excess policy) and forces that insurer to pay all the defence costs and all of the indemnity, subject to limits. That insurer is then forced to seek contribution and indemnity from any other insurer whose policy applies to the insured's liability for injury or damage.
>
> The "all sums allocation" theory is disingenuous as the policy must be read as a whole. The policy is very clear that it only applies to injury or damage occurring during the policy period.

[98] Carol Morgan describes the two approaches in a similar fashion: Morgan: IF-3. pp. 78-82.

[99] In Craig Brown *et al., Insurance Law in Canada* (Toronto: Thomson Reuters, 2023) (loose-leaf updated 2023, release 3), s. 18:16, the authors suggest that a *pro rata* time-on-risk approach may be justified in situations where multiple policy periods are triggered in cases of long-term bodily injury. They describe three situations in which courts might consider allocating defence costs among primary insurers. The first occurs where there are multiple theories of liability, usually where one incident gives rise to one injury with differing theories of liability or causes of action. The authors explain that cases such as *Daher v. Economical Insurance Company* (1996), 31 O.R. (3d) 472 (C.A.), and *Hanis* declined to allocate defence costs where there were multiple theories of liability. So too did *Carneiro v. Durham (Regional Municipality)*, 2019 ONCA 909, 55 C.C.L.I. (5th) 1. The second situation described by the authors in which courts may consider the allocation of defence costs involves different classes of insurance where an insured may be covered under more than one type of insurance policy. *Derksen v. 539938 Ontario Limited*, 2001 SCC 72, [2001] 3 S.C.R. 398, is an example where both a CGL insurer and an automobile insurer were required to defend a negligence action.

[100] The third situation is where, as in these appeals, multiple policy periods are engaged. The authors describe this situation as follows:

> Multiple policy periods come into effect in cases of long-term bodily injury (*i.e.*, asbestosis) or long-term property damage (*i.e.*, gradual deterioration of building materials).

> The argument for allocation is that the insurer should only be responsible for a *pro rata* share of the damage. For example, if the insurer was only on risk for two of the ten years in which the property damage took place, the argument is that the insurer should only be responsible for 20% of the defence costs.

[101] Brown *et al.* conclude their discussion of this issue at pp. 18-36 with:

> In summary, courts are very reluctant to allocate defence costs in advance of trial or settlement where there are multiple theories of liability [situation number one]. This is because it is usually impossible or very difficult to separate the cost of defending the uncovered allegations from the costs of defending the covered allegations. Courts are more likely to allocate where there are multiple policy periods because it is easier to establish a formula based on the number of years the insurer was on risk, or where the insured is covered under different classes of insurance policies [situations three and two].

[102] Notwithstanding this commentary, the respondents in these appeals, like the application judge, rely on two cases in which courts adopted what could be described as an all sums approach.

[103] First, the application judge in this case relied on the B.C. motion judge's decision in *Lombard*, which extended the principles from *Hanis* to a continuous property damage claim involving a single insurer over multiple policy periods, including periods where the insured was uninsured. Unlike this case, *Lombard* is not a situation where a number of serial insurers have requested equitable allocation, but rather a situation involving contribution between the insurer and an insured who was uninsured for an extensive period of time. Accepting that the

insurer's time-on-risk proposal in *Lombard* would have placed over 83% of the defence costs on the insured, the motion judge concluded, at para. 39, that there was "no settled principle in Canadian decisions regarding continuous damage claims that favoured an apportionment based on time on risk."

[104] Sanderson, at p. 173, describes the *Lombard* decision as an "outlier" and suggests that despite the pronouncement to the contrary by the court, there is a significant body of caselaw that supports the application of the *pro rata* time-on-risk method of distributing costs in cases of continuing injury or damage. Morgan also suggests at IF-3, pp. 87-92, that the judicially-favoured method of allocation amongst multiple successive insurers has been some form of time-on-risk formula. Indeed, there are numerous examples of cases where courts permitted *pro rata* allocations in the face of clear time parameters in the insurance policies: see e.g., *Surrey (District) v. General Accident Assurance Co. of Canada* (1996), 19 B.C.L.R. (3d) 186 (C.A.); *Royal & SunAlliance Insurance Co. of Canada v. Fibreglas Canada Inc.* (1999), 12 C.C.L.I. (3d) 282 (Ont. Gen. Div.), appeal abandoned in part and quashed in part, [2000] I.L.R. I-3848 (Ont. C.A.); *International Comfort Products Corporation (Canada) v. Royal Insurance Company of Canada*, [2000] I.L.R. I-3828 (Ont. S.C.); and *Hay Bay Genetics Inc. v. MacGregor Concrete Products (Beachburg) Ltd.*, (2003), 29 C.L.R. (3d) 60 (Ont. S.C.).

[105] Second, the application judge also relied on *Durabla* in adopting what amounted to an all sums approach. *Durabla* involved an insured who had

manufactured asbestos products in 1973, was uninsured after 1985 and faced over 50 lawsuits for exposure to asbestos over an extensive time period. The insurers sought a *pro rata* allocation as among themselves and the insured based on time-on-risk. This would mean that the insured would bear much of the cost of the defence. Although there was some fairness to the insurers' proposal, the court refused the request on the following basis, at pp. 4-5:

> Having regard to the fact that the insured did not have insurance coverage throughout the entire period covered by the claims asserted against it, we can see an element of fairness in the appellants' submission that the respondent should be obliged to make some contribution to the costs of its defence. But it is clear that, unlike as in some of the American authorities to which we were referred, a simple declaration of the fairness of proration will not suffice. Rather, the court would have to devise some mathematical formula as a basis for such proration. We do not find ourselves in a position to articulate an equitable formula for such proration at this stage of the proceedings. The impediments to a formulation that would fairly reflect the competing interests of the insurer and the insured at this stage of the proceedings are the imprecision of the allegations asserted by the claimants in the underlying actions and the absence of any firm factual foundation for whatever proration formula might be selected. In these circumstances, we have concluded that the appellants should bear the sole cost of discharging their duty to defend, subject to such entitlement as they have in law to recover all or an appropriate portion of their costs of defence from the insured following the ultimate disposition of the underlying actions.

[106] I am not persuaded that *Durabla* applies in the circumstances of the present appeals. First, the allocation sought in *Durabla* was between the insurers and the

insured who was uninsured for specific periods of time. No equitable allocation was agreed to or sought by one insurer against other insurers as is the situation in the present appeals. Second, if *Durabla* is to be interpreted as accepting the application of an all sums approach, this court has since rejected the application of this approach in *Goodyear*.

[107] In *Goodyear*, the insured, Goodyear Canada Inc., manufactured asbestos-filled products which it sold in the United States. It was sued for injury arising from asbestos-related diseases that occurred between 1969 and 2010. Goodyear had insurance from 1969 until 1985 but thereafter was unable to secure coverage. The coverage grant in the policies included: the “all sums” language previously described and present in many of the policies in issue on these appeals; per claim deductibles that Goodyear had to pay for both defence costs and indemnity before the policies were required to respond; the absence of any dollar cap on defence costs; and time-limited coverage, again similar to the policies in issue on these appeals. The timing of the exposure to asbestos could not be established with precision.

[108] The parties brought a pre-trial motion to determine certain allocation issues. Goodyear argued that based on the “*Stonewall Principle*” that arose from the American decision in *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*, 73 F. (3d) 1178 (2nd Cir. 1995), the insurers on risk from 1969 to 1985 should share the burden that arose from the gap in coverage after 1985. It argued

that based on the coverage grant, those insurers could be held jointly and severally liable for “all sums” Goodyear was required to pay. As Cronk J.A. explained at paras. 17-18 and 21, Canadian courts have instead tended to prefer the *pro rata* approach to allocating liability:

> Under this “all-sums approach” to liability allocation, a single insurer could be required to pay the entire amount of an asbestos injury claim, notwithstanding that multiple policy periods are triggered by the applicable claim.
>
> …
>
> To avoid the unfairness inherent in the all-sums allocation method, courts in the United States and Canada have sometimes employed a “pro-rata approach” to the allocation of loss in continuous injury cases where multiple insurance policies are in play. The aim of the pro-rata allocation method is to ensure that the allocation of loss to a particular insurance policy is proportionate to the damages during the policy’s term.
>
> …
>
> [Canadian] courts that have considered the all-sums and pro-rata allocation approaches have tended to prefer to allocate the relevant losses over policy periods based on some type of pro-rata allocation method.

[109] *Goodyear* mainly addressed indemnification rather than defence costs and, for the purposes of the pre-trial motion to determine the applicability of the *Stonewall* Principle to the allocation of liability under the policies for post-1985 occurrences, the parties had agreed that the *pro rata* approach and the continuous

trigger theory[10] would apply. However, it is clear that Cronk J.A.'s analysis and conclusion that "all sums" did not apply in Ontario was applicable to both indemnification and defence costs. This is evident from the language that she used and the principles that she expressed. At para. 57, she wrote:

> As I have already explained, the [insurers'] indemnity and defence obligations were undertaken with reference to occurrences that "happen" during the "policy period". Premiums were set based on this assumption of risk. The application of the *Stonewall* Principle would oblige the respondents to compensate injured plaintiffs (and to pay associated defence costs) for bodily injuries sustained from 1986 to the present, a period long after the expiry of the Policies. The unfairness of this result to the respondent insurers is evident since they neither underwrote nor received any premium for such coverage. [Emphasis added.]

[110] In conclusion, there is substantial commentary and jurisprudence to ground a rejection of the approach adopted by the application judge.

(vi) Defence costs are not a peril in the nature of an insured risk

[111] Sixth, I reject the respondents' submission that the duty to defend the Class Actions is a "risk insured" by the appellants, such that the Primary Insurers have overlapping duties. As Denis Boivin notes in *Insurance Law*, 2nd ed. (Toronto: Irwin Law, 2015), at p. 28, the concept of "risk" involves two variables: the object

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[10] The continuous trigger theory refers to an approach to determining the timing of latent or continuous claims where damage is deemed to have occurred from the initial exposure to when it manifested itself: see *Alie v. Bertrand & Frère Construction Co.* (2002), 62 O.R. (3d) 345 (C.A.), at para. 98, leave to appeal refused, [2003] S.C.C.A. No. 48.

of the insurance and the insured peril. The insured object is the person or thing covered by the insurance while the insured peril is the unanticipated occurrence that causes the loss, or as he describes it, the danger that has materialized. Barbara Billingsley, in *General Principles of Canadian Insurance Law*, 3rd ed. (Toronto: LexisNexis Canada Inc., 2020), at p. 17, similarly characterizes "risk" as the cause of loss or peril.

[112] In my view, defence costs are not a danger or peril in the nature of an insured risk. The relevant peril for which the respondents sought insurance under most of the primary policies was their unintentional infliction of "bodily injury". That is the harm that is causing the respondents to incur losses. Defence costs are a consequence of that peril, not the peril itself.

(vii) The courts should limit conflicts of interest

[113] Lastly, I also agree with counsel for some of the Primary Insurers who submit that potential conflicts of interest are embedded in the scheme adopted by the application judge. The Supreme Court explained this concept in *Nichols*, at p. 812, underscoring the conflict that may arise if an insurer has to defend a claim that is outside its policy:

> Moreover, conflicts of interest may result. The insurer's interest in defending a claim is related to the possibility that it may ultimately be called upon to indemnify the insured under the policy. It is in the insurer's interest that if liability is found, it be on a basis other than one falling under the policy. Requiring the insurer to defend claims which cannot fall within the policy puts the insurer in the

> position of having to defend claims which it is in its interest should succeed.

[114] It makes no sense for an insurer with minimal exposure to be tasked with controlling the defence and the defence costs. The participation of all insurers at an early stage is conducive to the conduct of the best defence possible and also serves to promote settlement.

[115] In conclusion, I would allow the Primary Insurers' appeals as they relate to the right to select one policy in this case of consecutive coverage periods, class actions that span lengthy time frames, and no uncovered claims. The Primary Insurers' proposed *pro rata* allocation of defence costs was the correct disposition.

(2) Self-Insured Retentions and Deductibles

[116] This leads me to the related issue of the application judge's treatment of the SIRs and deductibles.

(a) The Application Judge's Reasons

[117] The application judge ordered that no insurer had a duty to contribute to defence costs until the applicable SIR in its policy had been exhausted. None of the appellants, aside from Aviva,[11] take issue with that component of the application judges' decision. However, the application judge went on to hold that a

[11]Aviva would like Liberty and Zurich to start contributing to defence costs even if their SIRs are not yet exhausted.

Primary Insurer's duty to defend and contribute defence costs would be triggered once its insured had exhausted the SIR/deductible under its single primary policy. She reasoned that the ongoing defence cost contributions of the insurer with the exhausted SIR could be applied toward the exhaustion of the other insurers' SIRs/deductibles. It did not matter who had extended the funds, only that defence costs had been incurred and funds had been extended.

[118] In addition, the application judge ordered that any equitable allocation of defence costs was to be adjusted for any period where a particular insurer was not obliged to contribute to defence costs because its applicable SIR/deductible had not been exhausted. Lastly, there was to be a trial of an issue on whether aggregate SIRs or deductibles under policies issued by RSA, AIG, and Liberty have been exhausted.[12]

(b) The Positions of the Parties

(i) The Appellants

1. Liberty

[119] Liberty has five consecutive policies that span the annual time frames of April 1, 1995 to February 4, 2000. Only the 1998 to 1999 policy includes an SIR; the others are subject to deductibles. So for the 1998 to 1999 period, SDM was

[12] Liberty abandoned its appeal of this issue.

self-insured for the first $1 million per occurrence or $2 million in aggregate including damages and defence costs. Presumably on the basis that there are five policies but only one with an SIR, Liberty submits that SDM should pay one-fifth of the defence expense until it has paid $2 million in aggregate. It argues that SDM should abide by its contractual obligation to voluntarily self insure as was the case in *Goodyear*, *Hay Bay Genetics,* and *General Electric Canada Co. v. Aviva Canada Inc.*, 2010 ONSC 6806, 10 C.C.L.I. (5th) 16.

2. Zurich

[120] Zurich provided an integrated programme of insurance for seven consecutive three-year periods starting in 1998 and ending in 2019. Loblaw was insured for this whole period and SDM and Sanis became insureds on July 1, 2014. For the first three policy periods from January 1, 1998 to January 1, 2007, there is an SIR of $1 million ($3 million in total) and for the four policy periods from January 1, 2007 to January 1, 2019, an SIR of $1 million in total. These figures are inclusive of damages and defence costs.

[121] Zurich submits that the application judge correctly found that there was no contractual basis to require contribution to defence costs by any insurer until the applicable SIR(s) were exhausted. However, she erred in applying an all sums approach to defence costs and by shifting the obligation to exhaust the SIRs from the respondents to the other insurers. Zurich argues that despite any allocation of

defence costs as between insurers, an insured is still contractually responsible to pay the SIRs. The respondents should not be able to exhaust the SIRs in the Zurich policies through payments made by the other insurers.

3. Aviva

[122] As mentioned, Aviva states that its SIRs have been exhausted. Aviva submits that the application judge erred in holding that the allocation among the Primary Insurers would have to be adjusted for periods of time in which the respondents' SIRs in their policies with Liberty or Zurich had not been exhausted.

[123] Like Zurich, it also states that the application judge erred in concluding that the respondents could apply defence costs paid by Aviva towards the exhaustion of the SIRs under Liberty and Zurich's policies. Her holding conferred an unjustified windfall onto the respondents.

4. AIG

[124] AIG submits that the application judge erred in finding that Loblaw was not required to fund its own defence costs during the periods it was self-insured and that insurers whose duties have been triggered must disproportionately fund the defence for these periods (until the retention is exhausted). An insured is self-insured until the SIR is satisfied.

5. RSA

[125] RSA's policy contains not an SIR but a deductible of $1 million per occurrence that encompasses legal expenses.[13] That said, it too complains that the application judge erred in finding that defence costs incurred by each of the respondents can contribute towards the exhaustion of SIRs and deductibles of their respective insurers even if they are reimbursed by another insurer.

(ii) The Respondents

[126] The respondents submit that where, as here, the costs of defending covered and uncovered claims are intertwined, the costs of an insured's defence are payable under each of the applicable policies. The payment of such costs therefore operates to exhaust any SIR/deductible to which the insured has agreed. The application judge did not grant the insureds a windfall. Only one SIR must be exhausted at the duty to defend stage, but things could change if the insureds seek to enforce the duty to indemnify.

[127] The respondents argue that an SIR does not constitute insurance. All insurance involves a transfer of risk between parties. An SIR/deductible involves no transfer of risk. Even if the insureds were considered "insurers", the unqualified

[13] The parties disagree on the applicable aggregate deductible.

contractual agreement between each Primary Insurer and its respective insured would take precedence over equitable allocation.

(c) Standard of Review

[128] The principle subject of debate is whether the respondents may exhaust the SIRs or deductibles by payments of defence costs made by the other insurers. This raises a question of law. As a result, a correctness standard applies.

(d) Analysis of Self-Insured Retentions and Deductibles

(i) Exhausting the SIRs

[129] To understand this ground of appeal, it is helpful to commence with an examination of the concept of deductibles and SIRs.

[130] *Black's Law Dictionary*, (11th ed., 2019), defines a "deductible" as "the portion of the loss to be borne by the insured before the insurer becomes liable for payment." Traditionally, a deductible was applied to indemnity and did not remove or postpone an insurer's duty to defend, although a policy could provide otherwise.[14]

[131] The authors Deborah M. Minkoff and Abby Sher, in "Self-Insured Retentions Versus Large or Matching Deductibles" in Jeffrey E. Thomas & Francis J. Mootz

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[14] As noted above, only RSA's policy has an up-front payment deductible. Even though deductibles are traditionally applied to indemnity, RSA seeks the exhaustion of its deductible before its duty to defend arises. The respondents did not dispute that the deductible required up-front payment and so I express no view on this issue.

(eds.), *New Appleman on Insurance Law Library Edition*, Vol 1. (LexisNexis, 2009) (loose-leaf updated 2022, release 34-5), ch. 1A. at pp. 3 and 9-10, explain the distinction between deductibles and SIRs, underscoring that an SIR must be satisfied before the insurer's defence obligation arises:

> For example, if a policy's limit of liability is $1 million subject to a $250,000 deductible, the insurer's indemnity exposure is the $750,000 difference between the policy limit and the deductible. However, the insurer's defence obligation arises at dollar one, even before the insured satisfies its $250,000 deductible obligation.
>
> …
>
> [An] SIR represents the amount of risk (defence and indemnity) that the insured retains before true coverage applies. Courts recognize that:
>
> > A "self insured retention" is "[t]he amount that is not covered by an insurance policy and that usu[ally] must be paid before the insurer will pay benefits…." The difference between a self-insured retention and a deductible is usually that, under policies containing a self-insured retention, the insured assumes the obligation of providing itself a defense until the retention is exhausted.
>
> The most significant characteristic of an SIR is that the insured must satisfy its SIR obligation before the insurer has any obligation to respond.
>
> Courts often analogize SIRs to primary insurance in discussing the insured's own obligation to defend claims until the SIR amount is satisfied. [Citations omitted.]

[132] As stated in Kamayah, Snowdon & Lichty, *Annotated Commercial General Liability Policy*, s. 43:11, SIR provisions are often drafted to give a sophisticated, commercial insured a degree of control typically absent in deductible clauses:

> SIR provisions serve a slightly different purpose [than deductibles] and contemplate a sophistication in the handling of claims usually absent in the context of a policy containing a deductible clause. SIR clauses are often drafted to give the commercial policy holder a degree of control over claims investigation, handling and defence. This "management device" is reflected by the language which provides the policyholder control or a voice in matters including investigation, adjusting and legal expenses. Deductible clauses are usually silent in this respect. As such, terms giving the carrier the right to control investigation, defence, etc. prevail.

[133] In the 1980s, economic factors such as the increased cost of certain lines of liability insurance led many large businesses to reconsider risk retention. Common arrangements included high deductibles and SIRs: Minkoff & Sher, ch. 1A., at p. 1. Generally speaking, the higher the deductible and the higher the SIR(s), the lower the premium the insured was required to pay: *David Polowin Real Estate Ltd. v. Dominion of Canada General Insurance Co.* (2005), 76 O.R. (3d) 161 (C.A.), at para. 49, leave to appeal refused, [2005] S.C.C.A. Nos. 388-95.

[134] The respondents were clearly experienced and sophisticated users of commercial insurance products and in many instances opted to negotiate policies with significant SIRs with attendant reductions in premium payments. This is the degree of exposure they chose to adopt, and they adopted it multiple times with

respect to several discreet time periods under policies with many different insurers. In short, they agreed to pay new and additional SIRs/deductibles for each period.

[135] Given that the respondents look to each policy for coverage for separate policy periods, it follows that the SIR obligation in each policy must be satisfied before that insurer has a duty to defend. The SIRs do not have to be collectively exhausted before the obligation of a single insurer with an exhausted SIR is triggered. As indicated in *Ontario v. St. Paul Fire and Marine Insurance Co.*, 2023 ONCA 173, 480 D.L.R. (4th) 30, at para. 54, the duty to bear the costs of the defence is only engaged when the SIR has been exhausted. Until then, the payment obligation remains with the insured.

(ii) Application Judge's Order on Exhausting SIRs Through Payment by Other Insurers is Inapplicable

[136] The significance of this issue flows from the application judge's determination that the respondents could each select one policy to defend and payments made by the selected insurer could be used to reduce the SIRs on other policies.

[137] An SIR depends on the legal obligations to pay, among other things, defence costs. The language of the policies in issue on SIR obligations differs. For example, Aviva's policy states that the SIR shall "be eroded by payments for covered damages and defence, legal, loss adjustment costs and supplementary payments." AIG's policy states that the "Company's liability under this policy shall

not attach until the Insured becomes legally obligated to pay the amount of the Retained Limit [SIR] as damages and/or Expenses resulting from an event to which this policy otherwise applies." As noted by the application judge, Liberty's policy provided that its SIR shall be eroded by payments for covered damages and defence, legal, and loss adjustment costs. Zurich's Integrated Policy defines the SIR as that portion of the ultimate net loss "for which the insured is liable for each and every 'loss event' before coverage is afforded by this policy." The ultimate net loss includes "Defence Expenses", which in turn are defined as "[l]egal costs and other expenses incurred by or on behalf of the 'insured' in connection with the defence of any actual or anticipated 'claim'". RSA's policy states that its deductible amount "shall be deducted for claims arising from any one occurrence including the costs of legal investigation and adjusting fees and other expenses incurred in connection therewith and which sum shall be payable by the Insured".

[138] Unquestionably an SIR must be paid before an insurer has an obligation to defend. However, as a *pro rata* time-on-risk formula is applicable, the issue of payment by another insurer disappears. This is because the *pro rata* time-on-risk formula applies to the exhaustion of the SIRs.

[139] To use an example, recall that the SIR under Aviva's policy with SDM has been exhausted. A trial of the issue was ordered to determine whether the SIR of Liberty had been exhausted and it is conceded that the SIR of Zurich, SDM's other insurer, has not been satisfied. Under the time-on-risk formula, Aviva, Liberty and

Zurich are to pay 60%, 20%, and 20% of the defence costs respectively. Given that Aviva's SIR has been exhausted, Aviva will pay 60% of SDM's defence costs. SDM's future payments of the remaining 40% of defence costs may be used to reduce SDM's SIR obligations to Liberty and Zurich[15] to the extent of 20% and 20% respectively.

(iii) Adjusting Equitable Allocation Among Insurers

[140] The application judge held that the percentages for the allocation among the insurers would have to be adjusted for periods where a particular insurer did not have an obligation to contribute to defence costs as a result of an SIR that had not been exhausted. I take this to mean that the selected insurer whose SIR has been exhausted is responsible to pay all of the defence costs until the SIRs of the remaining insurers for that particular insured have been exhausted. I do not agree.

[141] Each Primary Insurer agreed to cover a portion of the defence costs of the Class Actions. Within each policy period, the insured is responsible for defence costs up to the exhaustion of the SIR, but that does not affect the proportion of time for which other insurers are responsible. Until the judge on the trial of an issue determines whether the SIRs relating to the Liberty, AIG, and RSA policies have

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[15] If I had upheld the application judge's determination of allocation of defence costs, the issue of whether payment of defence costs by one insurer could serve to exhaust the SIR in another policy would turn on the language of the policy. Whether an insured is required to pay the SIR or a third party or another insurer may pay the SIR turns on the language of the policy. See Minkoff and Sher at pp. 1A-22 and 24. No submissions were made on this issue of interpretation.

been satisfied, or until a further court order, it is incumbent on the respective respondents to pay the percentages of legal fees allocated to those policies based on the time-on-risk formula. After that point, the insurers are responsible for the proportion of defence costs equivalent to their time-on-risk.

[142] So by way of example, Aviva acknowledges that its SIRs in its policies with SDM have been exhausted. Accordingly, it is obliged to pay SDM's defence costs. However, in light of the allocation amongst the Primary Insurers, Aviva's exposure is limited to 60% of SDM's defence costs. As the SIR may not yet have been exhausted under the one Liberty policy (one of SDM's other Primary Insurers), SDM is responsible for the remaining 40% until that determination has been made and until Zurich's SIRs have been exhausted. Any subsequent adjustment following the determination of the trial of the issue will be as between SDM and Liberty. Aviva's obligation will be unaffected.

[143] In conclusion, I would allow the second ground of appeal concerning SIRs/deductibles.

(3) Pre-Tender Defence Costs

[144] The third issue relates to the application judge's conclusion that Loblaw was entitled to relief from forfeiture of pre-tender defence costs from AIG and RSA. Pre-tender defence costs are defence costs incurred by an insured prior to providing notice of a claim to its insurer, in this case AIG and RSA. Consistent with its

position before the application judge, RSA did not advance any independent argument or submissions in its factum on this issue but included it as a ground of appeal and adopted the submissions made by counsel for AIG. Accordingly, RSA will be bound by the analysis and result relating to AIG.

(a) Facts Relating to Pre-tender Defence Costs

[145] As mentioned, AIG issued a primary CGL policy to Loblaw for the period July 1, 1995 to May 1, 1997, and RSA issued a primary CGL policy to Loblaw for the period May 1, 1997 to January 1, 1998. AIG's primary policy provided that Loblaw was to give notice of an accident, occurrence, claim, or suit to the insurers "as soon as practicable." RSA's policy required notice of an accident or occurrence "as soon as practicable" and notice of a claim or suit "immediately", but it has not suggested that this distinction is relevant or material in this case.

[146] AIG's policy contained a cooperation and voluntary payment provision, which stated:

> The insured shall cooperate with the Company and, upon the Company's request, shall attend hearings and trials and shall assist in effecting settlements, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of suits. The Insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be deemed necessary at the time of bodily injury, sickness or disease. [Emphasis added.]

[147] RSA's policy contained a substantially similar provision.

[148] AIG also issued excess umbrella liability policies to SDM for the years 1998 to 2000 and RSA issued excess liability policies to Loblaw for the years 1997 and 1998.

[149] The B.C. Government Action was commenced on August 29, 2018. (It was discontinued against Loblaw on July 6, 2021.)

[150] On being served with the B.C. Government Action, Loblaw searched its historical files to locate all relevant policies. It was initially unable to locate the CGL policies for the 1996-1998 time frame, namely the AIG and RSA primary policies. The respondents provided notice of the underlying claims to the other appellants under the policies it had located in September 2018. This included notice to AIG and RSA under the excess policies issued by them. Once the AIG and RSA primary policies were tracked down, Loblaw gave notice to AIG and RSA under the primary policies on July 25, 2019.

[151] Prior to providing notice to AIG and RSA under their primary policies, the respondents retained Osler, Hoskin & Harcourt LLP to defend the underlying claims. By the time they had given notice under those primary policies, they had incurred defence costs just short of $220,000 relating to the B.C. Government Action.

[152] After notice was provided, AIG responded to Loblaw’s request for coverage on March 9, 2020. It advised that it reserved all rights under the policy. AIG also

indicated that it did not intend to control the defence. As a preliminary matter, AIG advised that AIG's liability did not attach until Loblaw became legally obligated to pay the amount of the SIR as damages and/or expenses resulting from an event to which the policy otherwise applied. It sought additional information in connection with its ongoing investigation of Loblaw's claim for coverage. This included copies of pleadings filed by any party on an ongoing basis and an update on any settlement discussions.

[153] Loblaw sought payment of its pre-tender defence costs from AIG and RSA but they refused to pay. As part of its amended application below, Loblaw sought relief from forfeiture in respect of any alleged failure to comply with a policy condition or statutory condition in accordance with s. 129 of the *Insurance Act*, R.S.O. 1990, c. I.8, and s. 98 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 ("*CJA*").

[154] Before the application judge, AIG argued that Loblaw's failure to provide timely notice and the prohibition in the policy against Loblaw voluntarily incurring costs except at its own expense justified AIG's refusal to pay pre-tender costs.

(b) The Application Judge's Reasons

[155] The application judge found in favour of Loblaw on this issue. In doing so, she relied on this court's decision in *Monk v. Farmers' Mutual Insurance Company (Lindsay)*, 2019 ONCA 616, 92 C.C.L.I. (5th) 84, at para. 79, which summarized

the following principles regarding relief from forfeiture and insurance claims described in earlier cases including *Kozel v. Personal Insurance Co.*, 2014 ONCA 130, 119 O.R. (3d) 55:

(i) relief from forfeiture under s. 129 of the *Insurance Act*, is available where there has been "imperfect compliance with a statutory condition as to the proof of loss to be given by the insured or other matter or thing required to be done or omitted by the insured with respect to the loss", thereby restricting the availability of the section to instances of imperfect compliance with terms of a policy after a loss;

(ii) relief from forfeiture under s. 98 of the *CJA* is available to contracts regulated by the *Insurance Act*;

(iii) section 98 of the *CJA* generally operates where the breach of the policy occurred before the loss took place;

(iv) relief under s. 98 and s. 129 is unavailable where the breach relates to compliance with a condition precedent to coverage, but a court should find that an insured's breach "constitutes non-compliance with a condition precedent only in rare cases where the breach is substantial and prejudices the insurer". Otherwise, it is just imperfect compliance and relief from forfeiture is available; and,

(v) where relief from forfeiture is available, the insured must also show that (a) its conduct was reasonable, (b) the breach was not grave, and

(c) there is a disparity between the value of the property forfeited and the damage caused by the breach.

[156] The application judge found that relief from forfeiture was available, writing at para. 117 of her reasons:

> It is argued that Loblaw did not comply with the policy and lost the benefit of the insurer's obligation to defend for the period preceding July 25, 2019 as a result of the late notice of the claim. Assuming that Loblaw did not provide notice to AIG "as soon as practicable", as required, it is my view that this is not one of the rare cases where the insured's breach constitutes noncompliance with a condition precedent. This is because … there is no evidence of prejudice in this case. AIG has filed no evidence on this Application and has not argued that it has been prejudiced by the late notice. Accordingly, relief against forfeiture is available.

[157] The application judge did not address the voluntary payments provision relied upon by AIG.

[158] AIG relied on *Lloyd's Underwriters v. Blue Mountain Log Sales Ltd.*, 2016 BCCA 352, 87 B.C.L.R. (5th) 111, in support of its argument that Loblaw was not entitled to defence costs incurred prior to notice and that relief from forfeiture should not be granted. The application judge distinguished this decision on three grounds. First, unlike the insurer in *Blue Mountain*, AIG did not immediately provide a defence after receiving notice from Loblaw and it had not contributed to defence costs. Second, in Ontario, relief from forfeiture was available under both s. 129 of the *Insurance Act* and s. 98 of the *CJA*, and the B.C. Court of Appeal did not

address B.C.'s s. 98 equivalent which calls for a broad interpretation. Third, she considered herself bound by *Monk*, which was decided a few years after *Blue Mountain*. Furthermore, she was not referred to any Ontario decision that precluded the availability of relief from forfeiture in these circumstances.

[159] As relief from forfeiture was available, the application judge went on to address the other three requirements. She first determined that Loblaw's conduct was reasonable and understandable in the circumstances. There was no evidence that the delay in giving notice was intentional or that Loblaw knew about AIG's and RSA's policies and chose not to give notice earlier. It was understandable that there could be difficulties locating documents that are more than 20 years old in a large organization with employees who come and go. Loblaw did not conceal the lawsuit as it gave notice pursuant to the excess policies.

[160] Second, she concluded that the breach was not grave. There was no prejudice nor did AIG file evidence to that effect or argue that there was prejudice. The breach had no serious impact on AIG's rights. It had taken the position that it had no duty to defend as of yet given the applicable SIRs. Moreover, it had not contributed to defence costs. She found that there was no reason to believe that AIG would have behaved any differently had it received notice earlier.

[161] Lastly, in examining the third factor of the disparity between the value of the property forfeited and the damage caused by the breach, she reasoned that in the

absence of any prejudice or damage to AIG, the proportionality analysis favoured Loblaw. Accordingly, she granted relief from forfeiture and held that the pre-tender defence costs should either be reimbursed or contribute to the exhaustion of the SIRs.

(c) The Positions of the Parties

(i) The Appellants, AIG and RSA

[162] Before this court, AIG submits that the application judge erred in concluding that Loblaw was entitled to relief from forfeiture and to recovery of its pre-tender defence costs from AIG and RSA. It argues that the duty to defend a claim can only arise after notice has been given to the insurer. Once it received notice, AIG did not repudiate its contract with Loblaw by denying a duty to defend, but instead sought to apply it. As such, AIG had waived Loblaw's late notice so nothing had been forfeited.

[163] In addition, the policy expressly prohibited Loblaw from voluntarily making any payment, assuming any obligation, or incurring any expense, except at its own cost. AIG argues that relief from forfeiture is not available in respect of this contractual provision. Lastly, it submits that the application judge's decision was contrary to the prevailing jurisprudence, including *Blue Mountain*.

(ii) The Respondent, Loblaw

[164] In response, Loblaw observes that the matter in question is only relevant to the issue of equitable contribution among insurers as, if unsuccessful, Loblaw can tender its entire defence on another of its insurers to whom notice was given before any defence costs were incurred, such as Zurich.

[165] That said, it submits that the application judge correctly determined the issue of relief from forfeiture. There was imperfect compliance which caused a forfeiture of coverage in whole or in part, and it would be inequitable for the coverage to be forfeited.

[166] It argues that any failure either to give notice as soon as practicable or to comply with the voluntary payment provision of the policy amounted to imperfect compliance with a thing required to be done or omitted by the insured with respect to the loss under s. 129 of the *Insurance Act*. There was no evidence of prejudice to AIG. The breach was not substantial and the application judge found that it was reasonable and understandable that Loblaw took some time to identify the historical AIG policy. In the meantime, it had to defend itself.

[167] Loblaw acknowledges that the duty to defend and pay defence costs is not triggered until the insured gives notice but states that “any imperfect compliance by Loblaw has caused a partial forfeiture of coverage (i.e., the delayed triggering of the duty to defend).” Assuming that the SIR under AIG’s policy had not been exhausted before the underlying actions were issued, which is a matter to be

determined following a trial of an issue as ordered by the application judge, Loblaw states that the pre-tender costs could not be used to exhaust the SIR, thus delaying the triggering of the duty to defend. The delayed notice therefore amounted to a partial forfeiture of coverage. The Court of Appeal for B.C. overlooked this issue in *Blue Mountain* and therefore erroneously found that relief from forfeiture was unavailable. That case was put before this court in in *GFL Infrastructure Group v. Temple Insurance Company*, 2022 ONCA 390, 24 C.C.L.I. (6th) 171, but this court did not follow the decision.

[168] Loblaw submits further that the application judge did not err in finding that it would be unfair for coverage to be forfeited. The purpose of the voluntary payment clause in the insurance policy – to control the costs of the defence – is not served by allowing an insurer to deny pre-tender costs when it would not have defended the claim in any event. Any breach by Loblaw was technical in nature and relief from forfeiture was warranted.

(d) Standard of Review

[169] The parties agree that whether relief from forfeiture is available for pre-tender defence costs as a matter of law is subject to a correctness standard. Otherwise, the question of whether to grant such relief in the circumstances is generally a discretionary decision entitled to deference: *Monk*, at para. 78.

(e) Analysis of Pre-Tender Defence Costs

[170] Loblaw's admitted failures were twofold. First, it failed to provide notice of the B.C. Government Action to AIG and RSA in a timely manner as required under the primary policies of insurance. Second, it incurred defence costs contrary to the voluntary payments provision found in the policies.

[171] The purpose that animates the notice provision is to enable an insurer to conduct an investigation and mitigate damages: Gordon G. Hilliker, *Liability Insurance Law in Canada*, 7th ed. (Toronto: LexisNexis Canada, 2020), at p. 57; *Sovereign General Insurance Co. v. Walker*, 2011 ONCA 597, 107 O.R. (3d) 225, at para. 35.[16] An insurer also has the right to control the defence of an insured claim and this includes the right to appoint defence counsel: *Brockton (Municipality) v. Frank Cowan Co.* (2002), 57 O.R. (3d) 447 (C.A.), at para. 31. The right to control the defence and to appoint defence counsel flows from the insurer's obligation to indemnify: *Zurich of Canada v. Renaud & Jacob*, [1996] R.J.Q. 2160 (C.A.), at p. 2168; *Brockton*, at para. 31. In *Brockton*, the insurer was not obliged to pay for independent counsel hired by the insured without the insurer's consent.

[16] Although Hilliker is dealing with the statutory provisions on notice, the same principles apply.

[172] Given that the insurer controls the defence and appoints counsel, it follows that the insurer is also required to pay for all reasonable costs that have been incurred at the insurer's request: *Brockton*, at para. 54.

[173] Although independent from the notice provision, the voluntary payments provision complements the notice provision.

[174] Loblaw sought to impose an obligation on AIG and RSA to pay its defence costs incurred prior to notice and in contravention of the voluntary payments provision and it relied on relief from forfeiture to do so.

[175] Relief from forfeiture refers to the power of a court to protect a person against the loss of an interest or a right because of a failure to perform a covenant or condition in an agreement or contract: *Kozel*, at para. 28. It is an equitable and discretionary remedy. Relief from forfeiture is granted sparingly and the party seeking the relief bears the onus of proof: *Ontario (Attorney General) v. 8477 Darlington Crescent*, 2011 ONCA 363, 279 O.A.C. 268, at para. 87.

[176] As I have explained, in Ontario, relief from forfeiture is governed by s. 98 of the *CJA* and in the insurance context also by s. 129 of the *Insurance Act*.

[177] Section 98 of the *CJA* provides that a "court may grant relief against penalties and forfeitures, on such terms as to compensation or otherwise as are considered just."

[178] Section 129 of the *Insurance Act* provides:

> Where there has been imperfect compliance with a statutory condition as to the proof of loss to be given by the insured or other matter or thing required to be done or omitted by the insured with respect to the loss and a consequent forfeiture or avoidance of the insurance in whole or in part and the court considers it inequitable that the insurance should be forfeited or avoided on that ground, the court may relieve against the forfeiture or avoidance on such terms as it considers just. [Emphasis added.]

[179] In *Kozel*, LaForme J.A. reasoned, at para. 58, that s. 98 was available to relieve against relatively minor, good faith breaches of a policy that occurred before a loss took place rather than afterwards. Relief from forfeiture under s. 98 of the *CJA* was granted, for example, where there was a mistaken failure to renew a driver's licence prior to an accident contrary to the terms of the statutory automobile insurance policy.

[180] He noted that in contrast, s. 129 of the *Insurance Act* addresses proof of loss and non-compliance with the insurance policy after a loss has occurred. In *Monk*, at para. 79, Brown J.A. stated that s. 98 "generally" applies to pre-loss issues. For the purposes of this appeal, any distinction between s. 98 of the *CJA* and s. 129 of the *Insurance Act* is immaterial. This is because, as I will subsequently explain, on the facts of this case, there was no forfeiture.

[181] The purpose that animates relief from forfeiture in insurance cases was described by McLachlin J. (as she then was) in *Falk Bros. Industries Ltd. v. Elance Steel Fabricating Co.*, [1989] 2 S.C.R. 778, at p. 783:

> The purpose of allowing relief from forfeiture in insurance cases is to prevent hardship to beneficiaries where there has been a failure to comply with a condition for receipt of insurance proceeds, and where leniency in respect of strict compliance with the condition will not result in prejudice to the insurer.

[182] In that decision, the Supreme Court held that Saskatchewan's relief from forfeiture provision equivalent to s. 129 of Ontario's *Insurance Act* empowered a court to relieve against forfeiture where there has been imperfect compliance with: (i) a statutory condition as to proof of loss to be given by the insured; or (ii) another matter or thing required to be done or omitted by the insured with respect to the loss. Failure to give notice within the time prescribed generally amounted to imperfect compliance. McLachlin J. explained that a court had power to relieve for imperfect compliance as opposed to non-compliance and likened the distinction between the two to a breach of a term of a contract and breach of a condition precedent or condition.

[183] Furthermore, the Saskatchewan section applied to both statutory conditions and contractual provisions. As relief from forfeiture is required only where there has been a breach of contract, it must derogate from contractual arrangements if it is to have any effect. McLachlin J. stated that this broad interpretation was appropriate given that the section was remedial legislation.

[184] The question in this part of the appeal is whether relief from forfeiture is an argument that was available to Loblaw. As mentioned, relying on *Blue Mountain*,

AIG submits that relief from forfeiture may be available for the obligation to indemnify, but absent proper notification of the claim, AIG owed no obligation to Loblaw as notice is a precondition to the triggering of a duty to defend. Furthermore, it argues that relief from forfeiture will not apply to override the contractual provision contained in the AIG policy that prohibits an insured from voluntarily incurring any costs or liabilities except at its own expense.

[185] Although the application judge relied on *Monk*, that case concerned whether relief from forfeiture ought to be granted in respect of late notice for indemnity coverage under a homeowner's policy, not whether it could be granted. In *Monk*, the trial judge found that relief from forfeiture was available but declined to order it based on his findings regarding prejudice, disparity and the insured's unreasonable conduct. On appeal, this court upheld his determination.

[186] The precise issue in *Blue Mountain* was who should bear responsibility for the pre-tender defence costs incurred by the insureds before they gave the insurer notice of the claim. The insurer accepted that it owed a duty to defend once it received notice and assumed the defence. In addition, like AIG in the case under appeal, the insurer did not take issue with the legal defence steps already taken or with the defence counsel who was already acting. Like AIG, the insurer in *Blue Mountain* refused to pay the pre-tender costs that had been incurred prior to notice, which amounted to $588,000.

[187] The insurance policy in *Blue Mountain* contained: (i) a notice clause requiring the insureds to give the insurer prompt notice of litigation; (ii) a cooperation clause mandating the insureds' cooperation with the insurer; and (iii) a voluntary payment clause that precluded the insureds from incurring expenses related to the claim without the insurer's consent.

[188] The Court of Appeal for B.C. concluded that 1) the duty to defend arose on demand or notice, and 2) there had been no forfeiture of coverage because, although the insureds had breached the notice provision, the insurer had waived that breach and complied with its obligations to provide indemnification and a defence. Moreover, the pre-tender costs were incurred before the duty to defend arose and, under the voluntary payment clause, the insurer had no obligation to reimburse the insureds for these costs. The voluntary payment clause operated independently of the notice provision. The court rejected the insured's argument that the court could adjust the voluntary payment clause.

[189] I agree with the Court of Appeal for B.C. that the duty to defend arises on demand or notice. Otherwise, the insurer may have no knowledge of the claim it is obligated to defend or opportunity to exercise its contractual rights respecting this defence or other policy conditions and exclusions. Indeed, Loblaw does not argue to the contrary.

[190] In *ING Insurance Co. of Canada v. Federated Insurance Co. of Canada* (2005), 75 O.R. (3d) 457 (C.A.), at para. 27, this court affirmed that a duty to defend arises only when the insurer is given notice of the claim:

> The language of the policies ... dictate that a duty to defend will arise only where notice of a claim is given. An insurer can hardly have a duty to defend a claim of which it has had no notice.

[191] Although it was a case regarding contribution between insurers, the same principle applies here.

[192] On receipt of notice, AIG did not reject the contract. Rather, it reserved its rights and stated that liability did not attach until the SIR had been exhausted as provided for in the policy. It also sought copies of pleadings on an ongoing basis and an update on settlement discussions. These steps amounted to an acceptance of the contract.

[193] Here, AIG was actively seeking to enforce its contract, including the independent voluntary payment, SIR, and exclusion provisions. Furthermore, in oral submissions, counsel for AIG acknowledged that the SIR would be reduced by the approximately $220,000 in pre-tender costs. In these circumstances, there was no forfeiture and the application judge erred in concluding otherwise.

[194] This situation is different from those where an insurer on receiving late notice rejects the contract and refuses to defend and to pay pre-tender costs. In *GFL Infrastructure Group*, the insurers were found to have wrongfully denied a

duty to defend and were ordered to reimburse pre-notice defence costs. That case did not deal specifically with relief from forfeiture. In contrast, where the insurer has acknowledged its duty to defend and indemnify going forward subject to exhaustion of its SIR, there is nothing left to relieve against. Moreover, the voluntary payments clause, which operates as an independent commitment, simply reflects the parties' contract. There is no forfeiture and relief from forfeiture is therefore not engaged.

[195] In sum, I agree with AIG and RSA that Loblaw was not entitled to relief from forfeiture in this case. As such, I would allow the appeal on this issue. However, as conceded by AIG, Loblaw is entitled to deduct its pre-tender costs from the SIR that must be exhausted or paid under its policy. In the event that the trial of the issue described in paragraph 13 of the judgment of the application judge determines that the SIR has already been exhausted, the pre-tender costs will be for Loblaw's own account. This order and direction apply equally to RSA and the deductible under its policy.

(4) Defence Reporting Agreement and Ancillary Issues

[196] The fourth issue relates to the DRA. The respondents sought a declaration that only those insurers who sign the DRA be entitled to associate in the defence of the Class Actions and receive defence-side reporting. Such reporting would include information and documents subject to litigation privilege and/or solicitor-

client privilege as between the respondents and defence counsel ("Privileged Defence Information"). The respondents viewed such an agreement to be necessary because: (1) the various insurers insured different entities who may have conflicting interests; and (2) many of the insurers had issued reservations of rights with respect to intentional acts alleged in the underlying litigation.

[197] Aviva and Zurich both agreed to the DRA, and Liberty indicated a willingness to sign such an agreement. AIG, who is both a primary and an excess insurer, and the other excess insurers, Chubb, QBE, and Markel, were all opposed to the DRA. Markel brought a separate but related application for a declaration that, with the exception of coverage related inquiries or advice contained in solicitor-client privileged communications with SDM's coverage counsel, Markel was entitled to full unfettered disclosure of all relevant information, documentation, facts and reports in the possession, power or control of its insured, SDM and Sanis. It also raised other ancillary issues. The application judge stated at para. 155 that RSA did not expressly take a position on the proposed DRA.

[198] The application judge granted the respondents' application. The application judge ordered that only those insurers who entered into the DRA would be entitled to associate in the defence of the claims and receive Privileged Defence Information.[17] The application judge also dismissed Markel's application.

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[17] See para. 14 of the judgment of the application judge.

[199] All insurers who were opposed to the DRA appeal from the application judge's order. In addition, Markel appeals from the dismissal of its application.

(a) Facts Relating to the DRA

(i) The Policies

[200] The appellant Chubb issued excess liability policies to Loblaw from May 1, 1997 to January 1, 1998; SDM from April 1, 1995 to April 1, 1998 and February 1, 2000 to July 1, 2014; Sanis from February 1, 2000 to July 1, 2014; and to all three respondents from September 1, 2014 to January 1, 2019.

[201] The appellant QBE issued a series of excess policies to Teva Pharmaceutical Industries Ltd. and certain of its subsidiaries including Teva Canada Ltd. QBE did not issue coverage directly to the respondents, but they claim to have "additional insured" status under various QBE policies.

[202] Subject to policy interpretation and coverage defences, the Chubb and QBE policies represent approximately $900 million in potential indemnity for the respondents (Chubb approximately $800 million and QBE approximately $60 million USD).

[203] Markel issued excess liability policies to SDM and Sanis from July 1, 2010 to July 1, 2014, providing $100 million in coverage. It was agreed that Markel currently has no duty to defend.

[204] As mentioned, each of the Primary Insurers issued excess liability policies to one or more of the respondents from time to time. Most of the Excess Insurers, including QBE, have specifically reserved the right to deny coverage based on policy exclusions including intentional conduct. Chubb has issued a full reservation of rights and has not yet asserted a right to associate. AIG and Markel seek to associate in, rather than direct, the defence of the actions. QBE does not seek to associate in, or direct, the defence. It maintains only a defence reimbursement obligation.

(ii) Respondents' correspondence proposing the DRA

[205] On July 14, 2020, counsel for the respondents wrote to the appellants, noting that several of the insurers had reserved their rights to later deny coverage based on certain exclusions, including intentional act exclusions. He also noted that the respondents understood that many insurers had insured multiple entities under different policies issued over the period of the Class Actions, that the various insured entities may have conflicting interests, and that the insurers were managing their risks centrally at the most senior levels of their organizations. It was counsel's position that those insurers with conflicts arising from their coverage position or from conflicting interests of separate insured entities were not entitled to participate in the defence.

[206] While this may have entitled the respondents to require the appointment of independent counsel who would not report to the insurers, the respondents

proposed a DRA similar in substance for each of their insurers, both primary and excess, to achieve an appropriate balance between the rights of the insureds and the insurers. The respondents' concern was that the internal systems of most insurers were inadequate because although there were protections at the lower levels, all defence and coverage information eventually flowed to the same decision maker. In addition, Markel expressly acknowledged that it would use Privileged Defence Information obtained from defence counsel to assess and deny coverage.

(iii) The DRA

[207] The DRA was stated to allow the parties to work openly and cooperatively on the defence of the claims, which would include the sharing of Privileged Defence Information relating to the defence of the claims. The DRA established a two-level reporting system. The first dealt with Privileged Defence Information relating to the defence of the Class Actions. The second dealt with public facing information that was not privileged and confidential and which comprised pleadings, productions, transcripts of examinations, expert reports served on other parties, motion records and decisions and orders of the court ("Public Facing Information").

[208] All insurers would receive Public Facing Information from time to time as reasonably requested. Nothing in the DRA would restrict the insurers' right to receive Public Facing Information and to associate in the defence of the Class

Actions. However, Privileged Defence Information would be available only to those insurers who executed the DRA. The DRA required the insurer to maintain ethical screens to ensure that Privileged Defence Information is not received by any person other than the designated authorized representatives.

[209] In addition, in the event of a development that would require a substantial reserve change or a payment (such as the scheduling of a mediation or an anticipated offer to settle), the respondents would provide a “Reserve Report” to the insurer. It would consist of a liability and damages assessment that could be shared with non-authorized representatives of the insurer provided they had a higher financial authority than the authorized representative with the highest financial authority. The Reserve Report would be used solely to support a reserve and/or payment request in excess of the authorized representatives’ financial authority and for no other purpose including the determination of coverage for the claims.

[210] The insurer and its authorized representatives were not to use the Privileged Defence Information or the Reserve Report for any purpose other than the defence and/or settlement of the claims. The authorized representatives would not be involved in the assessment or determination of coverage issues or the defence of any other person or entity in relation to the Class Actions absent consent of the respondents.

[211] The parties agreed in the DRA that there is a common interest privilege with respect to Privileged Defence Information and any Reserve Report.

(b) The Application Judge's Reasons

[212] The application judge found that the DRA struck the right balance between the rights of the insured and the insurers. An insured's right to a defence and the insurer's right to control that defence can satisfactorily co-exist until counsel's mandate from the insurer can reasonably be said to conflict with their mandate to defend the insured in the civil action. If a reservation of rights arises because of coverage questions which depend upon the insured's own conduct that is in issue in the underlying litigation, a reasonable apprehension of a conflict of interest exists. On the other hand, where a reservation of rights is based on coverage disputes which have nothing to do with the issues being litigated in the underlying action, there is no reasonable apprehension of a conflict of interest requiring the retainer of independent counsel at the insurer's expense. Given her conclusion regarding the provision of Privileged Defence Information discussed below, the application judge determined she did not need to decide whether a reasonable apprehension of conflict on the part of counsel could arise in the context of an insurer exercising a right to associate.

[213] The application judge concluded that there were admitted party-based conflicts and coverage-based conflicts in relation to the insurers who opposed the

DRA (the “Non-DRA Insurers”). While the respondents were not seeking to appoint independent counsel, appropriate mechanisms to minimize such conflicts were necessary. She rejected the Non-DRA Insurers’ position that the reservations of rights did not necessarily give rise to a reasonable apprehension of conflicts of interest, as they were based at least in part on intentional conduct of the insureds that was in issue in the Class Actions. They also gave rise to a reasonable apprehension of conflict with respect to insurers who did not control the defence but who associated in the defence or who merely reimbursed defence costs. Furthermore, the reasonable apprehension of conflicts of interest were not limited to “steering the defence” but extended to the possession and potential misuse of confidential information, which applied to the insurers who merely associated in the defence or reimbursed defence costs. An insurer’s request for Privileged Defence Information that would cover issues with respect to which the insurer and insured were adverse in interest (allegations of intentional acts) and which the insurer could then use to the detriment of the insured, placed defence counsel in a conflict of interest.

[214] The application judge also concluded that in light of the conflicts, it was appropriate for the DRA to require “split-handling” between coverage and defence, and to provide for different levels of disclosure for each activity. The application judge noted that an insured has a duty to disclose material facts, including significant developments in the litigation and information that might void coverage.

However, this duty does not extend to communications related to these facts that are subject to litigation and/or solicitor-client privilege. The duty of good faith does not create an overriding right to litigation information that can be used without limit and for any purpose, no matter the circumstances. The duty of good faith is a reciprocal one, and an insurer cannot benefit from its conflicted position.

[215] Finally, the application judge had to decide whether the Non-DRA Insurers' ethical screens should be limited to handlers at the lower levels of the insurance companies or whether they should include all persons who receive and have access to Privileged Defence Information. She noted that all the Non-DRA Insurers had implemented ethical screens to deal with party-based conflicts because they insured more than one defendant in the Class Actions, but that QBE, Markel and AIG had not implemented ethical screens to deal with coverage-based conflicts. Chubb had implemented split-handling between coverage and defence but only at the handler level.

[216] She found that in the circumstances of this case, ethical screens limited to handlers were inadequate. The Non-DRA Insurers' split-file protocols did not constitute reasonable measures to ensure that no disclosure would occur between the separated two sides, be they two different insureds or defence and coverage. She stated at para. 194, that "If the same persons are on both sides of the screen, or if the information can quickly and easily flow to one person who has access to

information on both sides and can make decisions affecting both sides, then the ethical screen is inadequate and inefficient and fails to fulfill its raison d'être."

[217] The application judge observed that split-file protocols at the adjuster or handler level may be a practical solution in cases involving small amounts that are unlikely to exceed the settlement authority of the adjuster. However, this case involved multiple class actions seeking billions of dollars in damages and very significant defence costs. As the applicable legal test was a reasonable apprehension rather than a proven conflict, she rejected the arguments that there needed to be evidence of misuse and that employee codes of conduct mandating compliance with internal protocols were sufficient. She found that the respondents' proposal was a workable solution as, among other things, several insurers had already agreed to the proposed DRA.

(c) The Positions of the Parties

(i) The Appellants

1. AIG

[218] AIG submits that the application judge erred in finding that AIG was required to enter into a DRA as an insured has an ongoing obligation to provide all relevant information to an insurer even if it is non-public and detrimental to coverage issues. The application judge also erred in concluding that AIG's reservation of rights letter gave rise to an apprehension of a coverage conflict that would disentitle AIG to

such information. The focus should have been on impairment of the conduct of the defence. Lastly, no conflict of interest arises that requires a DRA for an insurer who is only associating in the defence.

[219] AIG maintains that it has implemented “split file” protocols to address and manage any “party conflicts” whereby, inter alia: (1) any conflict is identified and escalated; (2) an ethical wall is put in place; and (3) digital safeguards are maintained. Any breach of this protocol by a claims handler would be a breach of AIG’s Code of Conduct, and would be subject to disciplinary action. AIG also states that it offered to enter into a confidentiality agreement.

2. Chubb and QBE

[220] Chubb and QBE submit that the restrictions imposed on their ability to access and use Privileged Defence Information unnecessarily grant the respondents a license to ignore the most fundamental obligations under the excess policies which are to keep the insurers informed and to cooperate with the insurer.

[221] They state that there can be no refusal to disclose on the basis of privilege because the right to privilege is shared by the insured and the insurer – there is a tripartite relationship among defence counsel, the insured, and the insurer. The information is needed to allow the insurer to assess the insured’s liability and any contribution to a settlement.

[222] Chubb and QBE submit that the dual-client approach should be confirmed in Ontario. Defence counsel must be able to act to protect the interests of both insured and insurer in defending the underlying case, including when providing Privileged Defence Information to the insurer. Even with the reservation of rights delivered by the insurers, the sharing of this information does not give rise to adverse interests. By reason of the insured's agreement to cooperate with its insurer, the insured, to whom privilege of the information attaches, necessarily waives the same in favour of its liability insurer. That waiver prevents any conflict arising for defence counsel by the disclosure of confidential information to the insurer. Under the "common interest" doctrine, the assertion of privilege to preclude disclosure to a liability insurer by defence counsel is equally inappropriate. In those circumstances, the insured's communications with its defence counsel regarding the defence of the action, even if this may impact on coverage, cannot be said to be privileged as against the insurer.

[223] They also take issue with the DRA's requirement to maintain ethical screens that ensure that Privileged Defence Information is not received by or available to anyone at any level for the purpose of assessing or determining coverage under the excess policies. Moreover, they state that they have acceptable split-file protocols.

[224] Lastly, Chubb and QBE state that the application judge erred in relying on the fact that other insurers had signed the DRA as being relevant to the

interpretation of Chubb and QBE's contractual rights under their respective policies.

3. Markel

[225] Markel states that its core issue as an excess insurer is whether it retains its rights under the policies: a right to associate under a common interest privilege in the defence; and a right to receive full disclosure while reserving a right to deny indemnity based in part on conduct related allegations if these are ultimately proven at trial. Markel raises three arguments on this issue. First, it argues that it has a right under its policies to associate in the defence and that this right requires full cooperation and disclosure from its insured. This includes permitting Markel to reasonably investigate coverage and assess the scope of its $100 million interest in potential indemnity risk. Second, Markel submits that the application judge erred in failing to conclude that its split-file protocol was sufficient to address disclosure concerns since it does not seek to instruct and control defence counsel. Third, Markel submits that it has a common interest privilege in the disclosure that it requests. SDM and Sanis have separate coverage counsel and their information in that regard is privileged and not covered by Markel's disclosure request.

4. RSA

[226] RSA submits that the three respondents have disparate interests and may have different defences and yet they have not adopted ethical screens or any other

conflict management procedures amongst themselves. RSA only insures Loblaw and the application judge erred in failing to order that Loblaw be separately represented by unconflicted independent legal counsel.

(ii) The Respondents' Position

[227] The respondents submit that if ethical screens are to be used as an alternative to the appointment of independent counsel, they need to be effective and commensurate with the nature of the issues and interests to be protected. The first step in the analysis is whether a conflict needs to be addressed. The second step is to consider what measures should be adopted to address the conflict. In this case, the insureds would have been justified in seeking independent counsel, but they followed the directive of this court in *Markham* (where split-file handling was approved) and sought to strike a balance through the use of the DRA.

[228] The lawyers retained to defend the claims owe a primary duty of loyalty to the insured even if they are being paid by the insurer and a subsequent judgment may trigger the insurer's duty to indemnify. There are two main lines of American authority on whether an insurer is a client of defence counsel: one finding that an insurer is not a client of defence counsel (the "insured-as-sole-client" approach), and another finding that both insured and insurer are clients but that once the potential conflict of interest becomes "actual", any joint retainer must be terminated, absent client consent (the "dual-client" approach). The insured-as-sole-client approach is being adopted by a growing number of US jurisdictions.

[229] The respondents state that the application judge reasonably found that there were admitted party-based conflicts and that the reservations of rights letters created a reasonable apprehension of a conflict between the interests of the insureds and the Non-DRA Insurers. Thus, it does not matter which approach this court follows. That said, the “insured-as-sole-client” approach should be adopted. It is the only one consistent with this court’s observation that counsel owes a primary duty of loyalty to the insured.

[230] The respondents submit that *Brockton* does not stand for the proposition that the only conflict that warrants protection is the risk of the insurer steering the defence. Instead, it focused on whether defence counsel, by the nature of the retainer, is placed in a conflict of interest. The application judge correctly held that *Brockton* did not preclude her from finding that defence counsel are in a conflict when they must disclose Privileged Defence Information to the insurer against the insured’s interests.

[231] An insured’s duty to disclose material facts should not extend to privileged communications related to those material facts. The insurers’ policies do not expressly entitle them to use privileged documents to inform their coverage position. Absent clear language, a policy should not be interpreted in a manner that will cause a loss of privilege, and thereby put counsel in a conflict.

[232] The only way to ensure that privileged documents remain privileged is to forbid the insurers from using these documents to inform their coverage position. QBE and Chubb failed to tender any concrete evidence on whether their protocols meet industry standards or comply with their statutory and regulatory obligations.

[233] As for RSA's argument that there should be separate counsel for Loblaw, RSA has said it will not direct Loblaw's defence. It thus does not have the right to impose its views on this issue on the insurer who assumes Loblaw's defence, absent a conflict of interest between the insureds.

(d) Standard of Review

[234] Whether a reasonable apprehension of a conflict of interest exists, whether a particular reporting proposal adequately addresses that potential conflict, and whether different insureds must be separately represented are questions of mixed fact and law. They are therefore reviewable for palpable and overriding error: *Housen*, at para. 37.

(e) Analysis of DRA and Ancillary Issues

[235] The following issues must be determined:

i. Did the Application Judge err in finding a reasonable apprehension of a conflict of interest that required the insurers to enter into the DRA in order to associate and to obtain Privileged Defence Information and in holding that the Non-DRA Insurers' internal ethical screens were insufficient?

ii Did the application judge err in refusing RSA's request for a declaration that Loblaw be separately represented by independent counsel?

(i) Reasonable apprehension of conflict

[236] There is a certain tension in the relationship between an insured and its insurer in the context of the defence of an action. Over time, the law on duties and rights has evolved.

[237] Both parties owe each other a duty of utmost good faith and fair dealing and the insured also owes a duty of cooperation to its insurer. Pursuant to these duties, an insured has a general obligation to disclose all the facts that are material to the insured risk: *Canadian Indemnity v. Canadian Johns-Manville Co.*, [1990] 2 S.C.R. 549, at p. 579. The insured is also to give to the insurer "material information concerning significant developments in the litigation": *Canadian Newspapers Co. v. Kansa General Insurance Co.* (1996), 30 O.R. (3d) 257 (C.A.), at p. 23; see also *Bhasin v. Hrynew*, 2014 SCC 71, [2014] 3 S.C.R. 494, at para. 55. This encompasses information in the insured's possession that might void coverage: *Trial Lawyers Association of British Columbia v. Royal & Sun Alliance Insurance Company of Canada*, 2021 SCC 47, 463 D.L.R. (4th) 477, at para. 36.

[238] Certain of the Primary Insurer appellants have agreed to sign the DRA but some of the Excess Insurers have not. The application judge found party-based

conflicts and also that a reasonable apprehension of a conflict of interest arose from the reservation of rights delivered by insurers unless measures were implemented to protect Privileged Defence Information. This included those who only sought to associate in the defence.

[239] To fully understand the positions of the parties, it is helpful to examine the legal framework for a reasonable apprehension of a conflict of interest in the context of these appeals. This starts with a discussion of the duty to defend and the concept of a conflict-free defence.

[240] An insurer with a duty to defend has the right to conduct the defence: *Zurich of Canada*, at p. 2168. It also has the right to appoint and instruct counsel: *Brockton*, at para. 31. Nonetheless, defence counsel's primary responsibility is to represent the insured and act in its best interest in any liability action: *Parlee v. Pembridge Insurance Co.*, 2005 NBCA 49, 283 N.B.R. (2d) 75, at para. 17; *Hoang v. Vicentini*, 2015 ONCA 780, 57 C.C.L.I. (5th) 119, at para. 14.

[241] As described in *Brockton*, at para. 43, the right to control the defence is not absolute and the insurer may be required to surrender that control. Goudge J.A. described the analysis at para. 43:

> The issue is the degree of divergence of interest that must exist before the insurer can be required to surrender control of the defence and pay for counsel retained by the insured. The balance is between the insured's right to a full and fair defence of the civil action against it and the insurer's right to control that defence because of its

> potential ultimate obligation to indemnify. In my view, that balance is appropriately struck by requiring that there be, in the circumstances of the particular case, a reasonable apprehension of conflict of interest on the part of counsel appointed by the insurer before the insured is entitled to independent counsel at the insurer's expense. The question is whether counsel's mandate from the insurer can reasonably be said to conflict with his mandate to defend the insured in the civil action. Until that point is reached, the insured's right to a defence and the insurer's right to control that defence can satisfactorily co-exist.

[242] In 1984, the California Court of Appeal decision in *San Diego Federal Credit Union v. Cumis Ins. Society Inc.*,162 Cal. App. 3d 358 (1984), held that an insurer that defended a claim but reserved its rights based on possible noncoverage must give up control of the defence and pay for counsel chosen by the insured. Although the *Cumis* approach remains the law in some states, it was quickly walked back by the same court in *Foremost Ins. Co. v. Wilks*, 206 Cal. App. 3d 252 (1988), which clarified that the reservation of rights must arise because of coverage questions which depend on an aspect of the insured's own conduct that is at issue in the underlying litigation.

[243] The *Foremost* approach was adopted by the Court of Appeal of Quebec in *Zurich of Canada*. LeBel J.A. (as he then was) held that the proper focus is on whether the insurer puts counsel in a position of having conflicting mandates because of the divergent interests of the insured and insurer. *Zurich* and *Foremost* were followed in *Brockton*, where this court found, at paras. 43-47, that there was no reasonable apprehension of a conflict because, *inter alia*, the reservation of

rights was based on the monetary limits of the policy and its punitive/exemplary damages exclusions rather than conduct by the insured at issue in the litigation. Additionally, the insurer had appointed separate coverage and liability counsel. As a result, there was no conflicting mandate.

[244] In *Markham* at paras. 92-93, this court reiterated that a reservation of rights does not automatically meet the *Brockton* test:

[245] The mere fact that an insurer has reserved its rights on coverage does not cause the insurer to lose its right to control the defence and appoint counsel. The question is whether the circumstances of the case create a reasonable apprehension of conflict of interest if that counsel were to act for both the insurer and the insured in defending the action: *Brockton*, at paras. 39-40, 43, citing *Zurich of Canada v. Renaud & Jacob*, [1996] R.J.Q. 2160 (C.A.) at pp. 2168-69, per Lebel J.A. (as he then was).

> The onus is on the insured to establish a reasonable apprehension of conflict of interest on the part of the insurer: *Brockton*, at para. 43; *Wal-Mart v. Intact*, 2016 ONSC 4971, 133 O.R. (3d) 716; and *Brookfield Johnson Controls Canada LP v. Continental Casualty Company*, 2017 ONSC 5978.

[246] Ontario courts have found that where an insurer denied a duty to defend or reserved rights on coverage exceptions at issue in the litigation (e.g., intentional act exclusions), the insured was entitled to appoint independent counsel: see e.g., *Glassford v. TD Home and Auto Insurance Company* (2009), 94 O.R.

(3d) 630 (S.C.), at paras. 26-31; *Coakley v. Allstate Insurance Company of Canada* (2009), 73 C.C.L.I. (4th) 113 (Ont. S.C.), at paras. 25-34; *PCL Constructors Canada v. Lumbermens Casualty Company Kemper Canada* (2009), 76 C.C.L.I. (4th) 259 (Ont. S.C.), at paras. 72-97; *Markham (City) v. Intact Insurance Co.*, 2017 ONSC 3150, 68 C.C.L.I. (5th) 267, at paras. 51-55 (unrelated to *Markham* ONCA decision); and *Lefeuvre v. Boekee*, 2017 ONSC 6874, 74 C.C.L.I. (5th) 174, at paras. 20-22.

[247] To sum up:

- An insured and its insurer owe each other a duty of utmost good faith and the insured owes its insurer a duty of cooperation which includes the disclosure of facts material to the risk insured and of developments in the litigation: *Trial Lawyers*, at paras. 35-36; *Kansa General Insurance Co.*, at paras. 36, 44; *Canadian Indemnity*, at para. 58; and *Bhasin*, at para. 55.

- Where an insurer has a duty to defend, it has a *prima facie* right to appoint and instruct counsel and hence control and conduct the defence: *Brockton*, at para. 31; *Zurich of Canada*, at p. 2168.

- Though paid by the insurer, counsel's primary duty is to the insured: *Hoang*, at para. 14; *Parlee*, at para. 17.

- An insured is entitled to a conflict-free defence: *Brockton*, at paras. 41-43; *Pope and Talbot Ltd. Re.*, 2011 BCSC 548, 23 B.C.L.R. (5th) 318, at para. 7.

- An insurer's right to control the defence is not absolute; the presence of a reasonable apprehension of conflict of interest on the part of the insurer may permit the insured to select and instruct its own counsel if it so chooses: *Brockton*, at para. 43; *Hoang*, at para. 14.

- The issue is the degree of divergence that must exist before the insurer is required to surrender control and pay for counsel retained by the insured. The question is whether counsel's mandate from the insurer can reasonably be said to conflict with counsel's mandate to defend the insured in the civil action because of the divergent interests of the insurer and the insured: *Brockton*, at para. 43.

- The onus to establish a reasonable apprehension of a conflict of interest on the part of the insurer is on the insured: *Markham*, at para. 93; *Brockton*, at para. 43.

- A reservation of rights by an insurer does not automatically put counsel in a position of having conflicting mandates: *Brockton*, at paras. 42-43; *Markham*, at para. 92.

- If the insurer's reservation of rights arises because of coverage questions which depend on an aspect of the insured's own conduct that is in issue in the litigation, the onus may be met: *Brockton*, at paras. 42-43.

- Mechanisms short of independent counsel may be put in place to minimize conflicts of interest and provide meaningful protection: *Markham*, at para. 104.

[248] These principles encompass rights and obligations arising from the defence of an action. The Primary Insurers who have executed the DRA have all opted to control or participate in the respondents' defence. However, those who resist the DRA are primarily Excess Insurers who only seek to associate in the defence of the actions. The only exceptions are QBE, who does not control the defence and has disclaimed its right to associate, and Chubb who has not yet exercised its right to associate. In addition, AIG resists the DRA in both its capacity as Primary and Excess Insurer. Layered on top of this are the issues relating to reasonable apprehensions of conflicts.

[249] To understand the contours of this dispute, it is helpful to consider the context.

[250] I will start with the role of excess insurers. In *Trenton Cold Storage Ltd. v. St. Paul Fire and Marine Insurance Co.* (2001), 146 O.A.C. 348 (C.A.), a

contribution dispute between insurers, Charron J.A. described the distinction between primary and excess insurers, at para. 24:

> The distinction between primary and excess insurance is succinctly set out in *St. Paul Mercury Insurance Company v. Lexington Insurance Company*, 78 F. 3d. 202 (5th Cir. 1996) at footnote 23, quoting from *Emscor Mfg. Inc. v. Alliance Ins. Group*, 879 S.W. (2d) 894 at 903 (Tex. App. 1994, writ denied):
>
> > Primary insurance coverage is insurance coverage whereby, under the terms of the policy, liability attaches immediately upon the happening of the occurrence that gives rise to the liability. An excess policy is one that provides that the insurer is liable for the excess above and beyond that which may be collected on primary insurance. In a situation where there are primary and excess insurance coverages, the limits of the primary insurance must be exhausted before the primary carrier has a right to require the excess carrier to contribute to a settlement. In such a situation, the various insurance companies are not covering the same risk; rather, they are covering *separate and clearly defined layers of risk*. The remote position of an excess carrier greatly reduces its chance of exposure to a loss. [Emphasis in original.]

See also *Markham*, at paras. 50-52.

[251] The relevant policies in the record state:

- Markel Excess: “The Insurer may not be called upon to assume charge of the settlement or defence of any claim made, suit brought or proceeding instituted against the Insured; but the Insurer shall have the right and shall be given the opportunity to associate with the Insured in the defence and

control of any claim, suit or proceeding reasonably likely to involve the Insurer. In such event the Insured and the Insurer shall co-operate fully."

- RSA Excess: "The Insurer shall not be obligated to assume charge of the settlement or defence of any claims made or suits brought or proceedings instituted against the Insured. The Insurer shall have the right and shall be given the opportunity to associate with the Insured and its underlying Insurer or Insurers, in the control, defence or trial of any claims, suits or proceedings which, in the opinion of the Insurer, involves or appears reasonably likely to involve the Insurer. If the Insurer assumes such right and opportunity the Insurer shall not be obliged to continue to defend or participate in the defence of any claim or suit after the limits of insurance shown on the 'Coverage Summary' are exhausted."

- QBE Excess: "As respects any Claim or Claims for which indemnity is sought under this Policy and for which Claims have been notified under 6.4.1.1 and 6.4.1.3, the Underwriters shall be entitled to conduct in the name of the Insured the defence or settlement of any Claim or Claims and the Insured shall give such assistance to deal with Claims and to conduct legal proceedings arising therefrom as the Underwriters may reasonably require. No admission, offer, promise, payment or indemnity which would prejudice this insurance shall be made or given by or on behalf of the Insured without the Underwriters written consent, such consent shall not to be unreasonably delayed or withheld, except at the Insured's own cost, in which nothing contained herein shall be construed as limiting the indemnity which would otherwise have been available to the Insured but for the existence of this Condition."

- Chubb Excess: "We will not be obligated to assume charge of the investigation, settlement or defense of any claim made, or suit brought, or proceedings instituted against you. We will, however, have the right to participate in the investigation, settlement or defense of any suit or proceeding which relates to any occurrence that we feel may create liability on our part under the terms of this policy. We will not defend any suit after we have exhausted the applicable Limit of Insurance as stated in Item 4 of the Declarations."

[252] Turning to the right to associate, as the application judge noted, an insurer's right to associate in the defence has not been discussed in any detail in the case law. Although not dealing specifically with CGL insurance, guidance may be found

in § 23 of the *American Restatement of the Law of Liability Insurance* (Am. Law. Inst. 2019) definition of the right to associate in the defence. Unless otherwise stated in the insurance policy, the right to associate includes:

(i) the right to receive information from the insured and defence counsel, upon request, that is reasonably necessary to assess the insured's potential liability and to determine whether the defense is being conducted in a manner that is commensurate with that potential liability[18], and

(ii) a reasonable opportunity to be consulted on major decisions in the defense of the action that is consistent with the insurer's level of engagement with the defense of the action.

[253] As explained in the *Restatement*: "The right to associate allows an insurer to manage its exposure by giving the insurer the opportunity to exercise a voice in the defence of the legal action. The right to associate is not the right to direct the defence of the action. It is the right to be heard in the course of the defence and to obtain information reasonably necessary to be heard."[19]

[254] As mentioned, the application judge made a finding that there were both admitted party conflicts and coverage conflicts. None of the Non-DRA appellants

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[18] The Restatement goes on to identify exceptions consisting of information protected by attorney-client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured.

[19] See also *Unigard Sec. Ins Co. v. N.River Ins. Co., Inc.*, 79 N.Y. 2d 576 (N.Y. 1992), at pp. 583-85; *British Ins. Co. of Cayman v. Safety Nat'l Cas.,* 335 F.3d 205 (3d Cir. 2003) at pp. 214-15.

challenge the application judge's finding that there were admitted party-based conflicts. Indeed, this did not appear to be the focus of submissions.

[255] As to the issue of a reasonable apprehension of a coverage conflict, all Non-DRA Insurers reserved their rights with respect to intentional conduct with the exception of Chubb who provided a "full" reservation of rights. In support of the application judge's finding on this issue, the respondents rely on dicta from *Pope & Talbot Ltd., Re.*, at para. 7:

> The principle that insureds should receive a coverage neutral defence where the insurer has reserved its rights under the policy arises from the conflict of interest that exists when an insurer defends on a reservation of coverage rights basis. Two conflicts are manifest in that context:
>
> > (a) the insurer's natural desire to protect its own financial interests; and
> >
> > (b) the lawyer defending the insured may, at the expense of the insurer, become privy to confidential information relevant to the coverage issue that is only disclosed as a result of the lawyer's solicitor-client relationship with the insured.

[256] The discussion in *Commission scolaire de la Jonquiere c. Intact Compagnie d'assurance*, 2023 QCCA 124, is also of note. There, the Court of Appeal of Quebec recently discussed the risk of conflict inherent in liability insurance policies when an insurer takes the position that the insured's conduct is not covered by the policy. Although that case involved a claim by the insured against its insurer for coverage under the policy, the court's underlying rationale is germane to this case.

The court explained, at paras. 20-21 and 25-26, why silos between an insurer's coverage team and its defence team are necessary:

> A liability insurer is in reality a two-headed hydra, a dicephalous creature with a single corporate identity, but with one head handling the defence of the insured, and the other watching over the finances of the insurer and making certain it indemnifies only covered losses. Each of these heads must make decisions based on the interest it defends and the information it possesses.
>
> This separation must be preserved to give effect to the insurance contract. The insured is entitled to make full answer and defence at the insurer's expense, without fearing that its defence will be dictated by the insurer's financial interest. At the same time, to avoid damaging its financial performance and affecting all its insured, whether in terms of the coverage of certain risks or the setting of premiums, the insurer must indemnify only those losses that are covered. The principle of risk pooling, which is at the heart of the insurance industry, requires it. The insurer will pay only within the limits of the risk it has agreed to cover, based on the premium received. The potential for a conflict of interest is therefore very real, and the insurer must consequently put measures in place to ensure that it respects the coverage offered by the policy, while also providing a full answer and defence for its insured.
>
> …
>
> Therefore, to preserve the insured's right to make full answer and defence, it is essential for information received from the lawyer retained by the insurer to be accessible only to the head of the insurer handling the duty to defend. Nothing must spill over to the one overseeing decisions having to do with the refusal to indemnify.

[257] It will be rare that an early general reservation of rights that is almost standard form gives rise to a reasonable apprehension of conflict. However here, the reservations were specific to intentional conduct and the pleading of intentional conduct in the Class Actions is pervasive. In this regard, RSA's submission, as referenced at footnote 7, on the extent of the conduct-based claims in the Class Actions is informative.

[258] The question then becomes did the application judge err in finding that the reservation of rights gave rise to a reasonable apprehension of conflict and that measures were required to protect Privileged Defence Information in the context of the Excess Insurers who only associate in the defence.

[259] As can be seen from this discussion, the Non-DRA Insurers seeking to associate have the opportunity to "exercise a voice" and to be "heard". I accept that the Non-DRA Insurers in this case are in a much more remote position than a primary insurer with a duty to defend and who is instructing counsel. However, I am persuaded of the application judge's conclusion. In this case, without an effective ethical screen that silos Privileged Defence Information from the Non-DRA Insurers' coverage teams, the insurers' input and advice could be tailored to align with the coverage position that the insureds engaged in intentional conduct thereby eliminating the Excess Insurers' indemnity obligation. In the face of a reservation of rights on intentional conduct in the context of a right to associate,

defence counsel is put in the position of having conflicting mandates if they have to disclose Privileged Defence Information contrary to the interests of the insured.

[260] Put differently, the Non-DRA appellants have not established that the application judge erred in her findings that a reasonable apprehension of conflict existed in the circumstances.

[261] This analysis does not fully apply to QBE and Chubb. The respondents' notice of application sought a declaration that only those insurers who entered into the DRA be entitled to associate in the defence of the Class Actions and receive privileged information. However, neither QBE nor Chubb are seeking to associate. Accordingly, they are not required to sign the DRA.

[262] In the absence of a requirement to execute the DRA, two related issues arise: whether QBE and Chubb are entitled to use Privileged Defence Information to inform their coverage positions and the adequacy of their screens.

[263] QBE and Chubb argue that their insurance policies impose a duty of good faith on both the insurer and the insured and that the insured has a duty to disclose all relevant information to the insurer, a duty that is delegated to defence counsel. In addition, they rely on their policies to assert that, in QBE's case, the insured is to provide all such particulars and information as may reasonably be required, and in Chubb's case, the insurer is to receive the insured's full cooperation. They say this encompasses privileged information be it subject to solicitor-client privilege or

litigation privilege. QBE and Chubb contend that they are entitled to Privileged Defence Information for coverage purposes. This would include using that information against the insured. Moreover, Privileged Defence Information is protected by common interest privilege.

[264] To be clear, as a starting point, none of the non-DRA insurers are entitled to privileged coverage information (privileged information as between the respondents and their separate coverage counsel). What then of Privileged Defence Information?

[265] Generally speaking, an insurer and its insured have a common goal. They both wish to defeat the action that has been brought against the insured. The defence lawyer is retained, typically by the insurer, to protect their aligned interests. Graeme Mew and R. Reena Lalji, in "The Insurance Defence Lawyer's Conundrum: Conflicts of Interest and Ethical Dilemmas Between Insurer and Insured" (2003) 26:4 Adv. Q. 429, at p. 446, discuss the practice:

> In the vast majority of cases, the defence lawyer defends the insured acting on instructions and directions from the insurer. Unless there are limits issues, the insured is barely involved in the process other than as a witness…. Information gathered by the defence lawyer in the course of defending the insured is freely passed on to the insurer.

[266] In Canadian and American jurisprudence and commentary, various legal constructs are utilized in practice so as to permit the insurer to have access to privileged information. The relationship amongst the insured, the insurer and

defence counsel is tripartite in nature but, as mentioned, counsel's primary duty is to the insured. When the interests of the insured and the insurer are aligned, common interest privilege protects against production of privileged information to third parties.

[267] Gordon Hilliker discusses the dilemma of the use of privileged information by insurers for coverage purposes when the interests of the insured and the insurer are not fully aligned at § 5.182 of *Liability Insurance Law in Canada*, 7th ed., (Toronto: LexisNexis Canada Inc., 2020):

> In the event that the claims are separate and discrete then sole counsel defending the action on behalf of the insured could still report to and take instructions from the insurer with respect to the covered claim but would have to keep confidential from the insurer privileged information pertaining to the uncovered claim, which would have to be defended in a manner consistent with the insured's interests. The reason for keeping such information confidential from the insurer is that otherwise it could potentially be used by the insurer against the insured. For example, in the event that settlement negotiations with the claimant involved contributions from both the insurer and the insured then an insurer that was privy to their joint lawyer's file with respect to the uncovered claim would have an unfair and improper advantage.

[268] The author continues at § 5.212:

> The insurer is not, however, entitled to receive information that is outside the scope of the retainer and that may prejudice the insured's position with respect to coverage. Nor, absent the insured's informed consent, should defence counsel provide to the insurer privileged information that, while bearing on the liability issues, is

> coincidentally detrimental to the insured's coverage position.

[269] The Supreme Court addressed the importance of solicitor-client privilege in *Alberta (Information and Privacy Commissioner) v. University of Calgary*, 2016 SCC 53, [2016] 2 S.C.R. 555, at paras. 26 and 82:

> The importance of solicitor-client privilege to our justice system cannot be overstated. It is a legal privilege concerned with the protection of a relationship that has a central importance to the legal system as a whole. In *R. v. Gruenke*, 1991 CanLII 40 (SCC), [1991] 3 S.C.R. 263, Chief Justice Lamer described its rationale as follows:
>
> > The *prima facie* protection for solicitor-client communications is based on the fact that the relationship and the communications between solicitor and client are essential to the effective operation of the legal system. Such communications are inextricably linked with the very system which desires the disclosure of the communication. [Emphasis added; p. 289.]
>
> …
>
> This Court has found that solicitor-client privilege is both an evidentiary privilege and a substantive principle. In *Lavallee, Rackel & Heintz v. Canada (Attorney General)*, 2002 SCC 61, [2002] 3 S.C.R. 209, Arbour J. explained that "[s]olicitor-client privilege is a rule of evidence": para. 49. Similarly, in *Foster Wheeler Power Co. v. Société intermunicipale de gestion et d'élimination des déchets (SIGED) inc.*, 2004 SCC 18, [2004] 1 S.C.R. 456, the Court observed that the case law "establishes the fundamental importance of solicitor-client privilege as an evidentiary rule, a civil right of supreme importance and a principle of fundamental justice": para. 34 (emphasis added). In *Descôteaux v. Mierzwinski*, 1982

> CanLII 22 (SCC), [1982] 1 S.C.R. 860, Lamer J. described solicitor-client privilege as a "rule of evidence", which "had also since given rise to a substantive rule": pp. 872 and 875. Solicitor-client privilege is thus both a rule of evidence and a substantive rule. [Emphasis in original.]

[270] In *Lizotte v. Aviva Insurance Company of Canada*, 2016 SCC 52, [2016] 2 S.C.R. 521, Gascon J. also stressed the importance of litigation privilege at para. 4:

> I would dismiss the appeal. Although there are differences between solicitor-client privilege and litigation privilege, the latter is nonetheless a fundamental principle of the administration of justice that is central to the justice system both in Quebec and in the other provinces. It is a class privilege that exempts the communications and documents that fall within its scope from compulsory disclosure, except where one of the limited exceptions to non-disclosure applies.

[271] Litigation privilege is a protection only against the adversary and only until termination of the litigation: *General Accident Assurance Company et al. v. Chrusz et al*. (1999), 45 O.R. (3d) 321 (C.A.), at para. 43.

[272] In these appeals, we are dealing with excess insurers who do not seek to associate and reservations of rights, in Chubb's case, a "full" reservation and in QBE's case, a specific reservation of rights for intentional conduct. Understandably, QBE and Chubb wish to comprehend the merits of the Class Actions and determine their exposure. They invite me to make a blanket determination of their entitlement to all Privileged Defence Information and to

authorize them to use that information for coverage purposes. I decline to do so for the following reasons.

[273] First, I do not interpret the QBE or Chubb policies or the insured's obligation of good faith as mandating such entitlement and use. If they had wished to include these provisions in their respective insurance policies, they could have done so expressly. They did not.

[274] Second, while the respondents and QBE and Chubb share a common interest regarding the liability issues in the underlying action, they are not in a relationship of common interest on coverage issues. The cases of *Hoang*, *Parlee*, and *Commission scolaire de la Jonquiere* support the conclusion that a defence lawyer's primary duty of loyalty is to the insured when a reservation of rights based on the insured's conduct results in a coverage position that is adverse to the insured's interests.

[275] Third, I do not interpret relevant case law as requiring disclosure of all Privileged Defence Information. In *Trial Lawyers*, the insured had a duty to disclose facts material to the claim including facts that voided coverage, but not all privileged information. In *Fellowes, McNeil v. Kansa General International Insurance Co.* (2000), 138 O.A.C. 28 (C.A.), it is clear from the comments at paras. 62-63, that privileged information relating to coverage issues which arise in

the course of a solicitor-client relationship between defence counsel and the insured cannot be shared with the insurer.[20]

[276] A similar conclusion was more recently reached by the Quebec Court of Appeal in *Commission scolaire de la Jonquiere*. The insurers had defended a class action claim against the insureds pursuant to a reservation of rights. Following settlement of the class action, the insureds sought indemnity. By way of undertakings and requests for production, the insurer sought all communications exchanged between the insureds and defence counsel related to the analysis of the risks of the underlying litigation and the settlement negotiations. The insurer brought a motion to compel the insureds to produce not only counsel's analysis that was contemporaneous with the settlement negotiations, but also all of the opinions given by defence counsel since the beginning of the retainer. Without examining the specific documents, the motion judge ordered the insureds to give written answers to the questions posed and to provide all of the undertakings. He did not set out guidelines for the production or reserve the insureds' right to redact or object to certain documents.

[277] On the appeal from the motion judge's order, the court concluded at para. 25 that to preserve the insureds' right to make full answer and defence, information

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[20] In that decision, this court concluded that counsel should have alerted the insurer to a coverage defence because at the time in issue, counsel had only been retained to protect the insurer's interests and had not yet been retained to act for the insured. His duty was accordingly owed to the insurer alone.

received by counsel retained by the insurer should not be made available to the coverage side of the insurer. The court concluded that no blanket conclusion could be reached with respect to documents relating to the reasonableness of the settlement. Instead, these documents would have to be analyzed by the judge seized of the class action, who would decide whether they constitute information relevant to assessing the reasonableness of the settlement. With respect to the general request for all of the opinions given by defence counsel, the court concluded that the motion judge should not have permitted disclosure without qualification, especially without having first examined the documents:

> [39] In view of the double mandate of the lawyer hired by the insurer to defend its insured, there is no basis for concluding that the appellants waived professional secrecy or litigation privilege in respect of all possible exchanges they had with their lawyer. On the contrary, they were entitled to expect that the information exchanged with the lawyer was covered by professional secrecy and would not be disclosed to the head of the insurer that refused to indemnify them, even though the one handling the duty to defend was part of their circle of privilege.
>
> …
>
> [41] In a dispute on the duty to indemnify pitting the insurer against the insured, the former may not use accounts, opinions, reports, or other information obtained through the performance of its duty to defend, unless the latter has given a waiver. Accounts are submitted to the head of the insurer handling the duty to defend with an expectation of confidentiality. Nothing justifies disclosing this information to the head of the insurer handling the duty to indemnify.

[278] Fourth and importantly, disclosure of particular documents is inevitably a fact-specific exercise. I have declined to order QBE and Chubb to sign the DRA as they are not associating in the defence. However, I am not prepared to grant the blanket endorsement of disclosure and use of all Privileged Defence Information as requested by QBE and Chubb. Under the DRA, all insurers receive the pleadings, productions, transcripts of examinations, expert reports served on other parties, motion records and decisions and orders of the court. QBE and Chubb may reasonably request other information as well which I expect would include some Privileged Defence Information. As in the case of *Commission scolaire de la Jonquiere*, an attempt to define the scope of information that can be disclosed is premature at this juncture. I express no view on the precise documents QBE or Chubb might seek to review or the scope of privileged information to which QBE and Chubb might be entitled. The identification of privileged documents or information is not always a simple exercise. If directions are required in that regard, recourse may be had to the Superior Court. It is of course also open to the respondents and QBE and Chubb to negotiate whatever disclosure they consider appropriate at different stages of the litigation including settlement discussions.

[279] This brings me to the issue of screens.

[280] The application judge made a finding of fact that the screens established by the Non-DRA Insurers were inadequate and used Chubb's as an illustration. In

addressing all of the Non-DRA Insurer's split-file protocols, she stated at paras. 194-195:

> In my view, the Non-DRA Insurers' split-file protocols do not operate like ethical screens and do not constitute reasonable measures to ensure that no disclosure will occur between the separated two sides, be they two different insureds or defence and coverage. If the same persons are on both sides of the screen, or if the information can quickly and easily flow to one person who has access to information on both sides and can make decisions affecting both sides, then the ethical screen is inadequate and inefficient and fails to fulfill its raison d'être.
>
> The kind of "split-file" protocol that applies only at the adjuster or handler level may be a practical solution in a case involving small amounts that do not or are unlikely to exceed the settlement authority of the adjuster. Here, however, we are dealing with a number of class actions, potentially seeking billions of dollars in damages, with very significant defence costs. In light of the size of the exposure, it is my view that robust ethical screens are important in order to alleviate the conflicts and concerns identified above – the larger the exposure, the stronger the interest and the motivation to seek to reduce/eliminate one's exposure.

[281] It is clear from the application judge's reasons, at para. 191 and footnote 10, that she was satisfied with QBE's proposed protocol for party conflicts. That protocol provided that Privileged Defence Information would only be received by or available to persons designated as authorized representatives and no one else. She went on to find that QBE's proposed protocol did not provide for an ethical screen to deal with coverage-based conflicts. While QBE is not required to sign the DRA or establish an additional ethical screen because it has disclaimed its

right to associate in the defence, for the reasons set out above, the scope of Privileged Defence Information to which QBE might be entitled should not be determined at this stage.

[282] As for Chubb, the application judge was dissatisfied with all of Chubb's screens. Chubb must address the deficiencies in its party screen. Otherwise, it is in the same situation as QBE.

[283] In conclusion, neither QBE nor Chubb is required to enter into the DRA as they do not seek to associate. This conclusion is premised on the basis of no future exercise by Chubb of its right to associate.

[284] In conclusion, I would allow the appeal of QBE and Chubb to the extent that there is no requirement for them to execute the DRA. However, Chubb must address the shortcomings in its party screen as identified by the application judge.

[285] To sum up with respect to the other Non-DRA Insurers, *Brockton* and *Markham* when viewed together suggest that the necessary measures that courts may impose when a reasonable apprehension of conflict exists should be viewed on a continuum, ranging from the insured's right to independent counsel paid by the insurer to some form of split-file protocol. As the application judge correctly observed, the adequacy of the measures must be tailored to the circumstances of the case.

[286] In this case, should the Class Actions be successful, there is a clear risk that the excess layers of insurance could be pierced. While an ethical screen limited to handlers at the lower level may be appropriate with respect to smaller claims, in cases such as these billion-dollar Class Actions, handlers at the lower level may not have sufficient decision-making authority and may be required to consult individuals higher in the corporate decision-making pyramid. Accordingly, in the context of their appeals, a split-file protocol that reaches farther up that pyramid is justified. In my view, the DRA proposed by the respondents is a reasonable response to address the unique challenges presented by these Class Actions.

[287] I would also add that such a determination is not influenced by the fact that the Primary Insurers, for the most part, have agreed to the DRA.

[288] The application judge made no palpable or overriding error in concluding that the DRA struck the right balance between the rights of the insureds and the insurers. It follows that I would dismiss the appeals of the Non-DRA appellants with the exception of QBE and Chubb, which I would allow to the extent described.

(ii) RSA is not entitled to a declaration that Loblaw be separately represented

[289] Lastly, I would reject the request for independent counsel for Loblaw. First, RSA is not directing the Loblaw defence and it is not for it to impose its position on the insurers who are. Second, there is currently no evidence of any conflict between Loblaw, Sanis, and SDM. That said, this determination does not preclude

a conflict arising in the future. If it should arise, the issue could be addressed on a proper evidentiary record.

D. DISPOSITION

[290] In conclusion, first I would allow the appeals with respect to the judgment as it relates to the selection of a single insurer for each of the respondents.

[291] I would order that paragraph 7 of the judgment be set aside and judgment be granted as follows:

> THIS COURT DECLARES that, subject to the exhaustion of the applicable SIRs or deductibles, the appellants shall pay all reasonable costs associated with the defence of the respondents.
>
> With respect to payment of defence costs: that responsibility shall be allocated as follows in accordance with the appellants' respective *pro rata* time-on-risk:
>
> Shoppers Drug Mart: Liberty - 20%, - Aviva 60%, and Zurich - 20%
>
> Sanis: Zurich – 50%, and Aviva 50%
>
> Loblaw: RSA – 3%, AIG – 6%, and Zurich – 91%.
>
> (b) The appellants may seek a different calculation of defence costs at a later stage based on the evidence at trial, findings on interlocutory motions, or subsequent court order.[21]

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[21] In their Notices of Appeal, the Primary Insurers requested that the judgment be subject to the court's consideration of the defence obligations of Teva and its insurers. However, no submissions were made on the issue and accordingly I would decline to add that qualification. In any event, the application judge declared that she remained seized of the determination of the Teva issues.

[292] I would order that paragraphs 9 and 10 of the judgment be set aside.

[293] I would further order that paragraph 12 be set aside and judgment granted as follows:

> THIS COURT DECLARES that the obligation to contribute to defence costs on a *pro rata* time-on-risk basis is subject to the respondents' exhaustion of any applicable self-insured retentions and deductibles.
>
> The *pro rata* time-on-risk formula applies to the exhaustion of the applicable SIRs and deductibles;
>
> Until the trial of an issue determines whether the self-insured retentions or deductible of Liberty, AIG and RSA have been exhausted, the respondents shall pay the percentage of defence costs allocated to those policies based on the *pro rata* time-on-risk formula.
>
> The sums payable as between the respondents and Liberty, AIG and RSA will be adjusted as required following the trial of the issue.

[294] I would allow the appeals of AIG and RSA with respect to relief from forfeiture. In the event that the trial of an issue described in paragraph 13 of the Judgment determines that the SIR and/or the deductible has already been exhausted, the pre-tender costs will be for Loblaw's own account.

[295] I would dismiss the appeals with respect to the DRA. I would allow the appeal of QBE and Chubb insofar as it relates to execution of the DRA. I would also dismiss Markel's appeal of its companion application.

[296] In the absence of an agreement on costs, the parties are to make brief written submissions.

Released: February 27, 2024 SCP