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INSURANCE BAD FAITH LITIGATION:

Recent Developments and Interesting Issues Arising from the Supreme Court of Canada Decisions in *Whiten* and *Fidler*

by

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INSURANCE BAD FAITH LITIGATION:

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1. INTRODUCTION

In *Whiten v. Pilot Insurance* (2002)[1] and again in *Fidler v. SunLife Assurance* (2006)[2] the Supreme Court of Canada held that, as a matter of law, a breach by the insurer of its contractual duty to act in good faith is itself an independent "actionable wrong" (beyond the denial of coverage) sufficient to found an award of punitive damages in appropriate cases. In the *Whiten* case, the court restored a jury award of one million dollars punitive damages in that regard and since that time the floodgates have opened. Runaway juries have even made punitive damage awards as high as 2.5 million dollars against insurers (albeit later overturned by the appeal court).[3]

Today, coverage enforcement lawsuits invariably include what have become almost standard form allegations of bad faith claims handling and claim substantial punitive and mental distress damages on that account. In some (very rare) instances the claim may be justified, or at least arguable, but in many others it merely represents a litigation tactic designed to induce settlements through the combination of 1) potentially substantial awards by sympathetic unsophisticated juries and 2) the increased cost and inconvenience arising from extensive discovery into corporate finances, administration and claims handling.

[1] 2002 SCC 18
[2] 2006 SCC 30
[3] *Plester v. Wawanesa Insurance* [2006] O.J. No. 2139 (Ont. CA)

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It is now five years since the *Whiten* decision and a review of both basic principles and subsequent case law is in order.

2. THE ORIGINS OF THE GOOD FAITH OBLIGATION

Bad faith litigation, and runaway jury awards of multi-million dollar punitive damages, has its origins in the United States. Interestingly enough, the same sort of bad faith litigation does not exist in the United Kingdom, the place where today's modern insurance industry originated.

It should be remembered that in the United States the Restatement of Contracts provides "Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement."[4] In addition, unlike Canada, most states have enacted statutes or regulations expressly governing insurance claims and proscribing certain unfair or deceptive claims handling practices. Both form the basis for bad faith litigation south of the border.

Unlike the United States, in Canada the law of contract does not generally imply any mutual obligation of good faith and fair dealing. In the absence of an express term to that effect, an extremely rare occurrence and certainly not one customarily found in insurance policies, there are three bases whereby the court may impose implied terms[5]: 1) based on custom or usage; 2) as the legal incident of a particular class or kind of contract; or 3) based on the presumed intention of the parties where the implied term must be necessary to give business efficacy to a contract or as otherwise meeting the "officious bystander" test as a term which the parties would say, if questioned, that they had obviously assumed.

[4] "Restatement of the Law, Second, Contracts" § 205, American Law Institute, 1981
[5] as stated in *MJB Enterprises Ltd. v. Defence Construction (1951) Ltd.* [1999] 1 S.C.R. 619 at para. 27

In *Schlussel v. Maier*[6] Harvey J. reviewed various recent appellate rulings on the issue and concluded (at para. 129) that:

> "In my opinion, it is therefore not possible to endorse the view that a general duty of good faith exists in law. The duty of good faith, where it exists, is a matter of fact to be found in the express terms of the contract or derived by implication from the reasonable expectations of the parties."

In an insurance case, *Fredrikson v. I.C.B.C.*[7], Esson C.J. observed,

> " . . . our law does not at present recognize, as a general doctrine, that an obligation of good faith and fair dealing is imported into all contractual dealings . . ."

So what, then, is the rationale for imposing any obligation of good faith and fair dealing on an insured or insurer? In Ivamy, *General Principles of Insurance Law*, the author declares (at p. 136):

> "It is a fundamental principle of insurance law that the utmost good faith must be observed by each party."

So too has the Supreme Court of Canada declared,

> "The '*uberrima fides*' doctrine is a long standing tenet of insurance law which holds parties to an insurance contract to a standard of utmost good faith in their dealing,"8

and also that,

> "A contract of insurance is *uberrima fides*; utmost good faith must be observed by both parties [and this is] a fundamental principle of insurance law which has been applied for over 200 years."9

The above declarations of mutual good faith obligations are all in the context of the insured's obligation to disclose to underwriters all matters material to the risk at the inception of coverage.

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6 [2001] B.C.J. No. 42 (BCSC)
7 (1990) 42 C.C.L.I. 250 (BCSC)
8 *Coronation Insurance Co. v. Taku Air Transport* [1991] 3 S.C.R. 622 per Cory J.
9 *Ford v. Dominion of Canada General Insurance* [1991] 1 S.C.R. 374 per Cory J. adopting and commenting on Philp J.'s judgment in the Man. CA

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Such cases invariably cite, and the reference in the above quote to "over 200 years" refers to, the 1766 decision of Lord Mansfield in *Carter v. Boehm*[10]. In that case the insured had obtained insurance against the loss of a certain manufacturing settlement named Fort Marlborough which, despite its name, was not a military fortification designed to withstand attacks from anything other than the native tribes of Sumatra. The state and condition of the Fort had not been disclosed to the insurer and after it was subsequently taken by French troops, the insurer denied the claim based on a failure to disclose the weakness and vulnerability of the Fort in the application for insurance. Although he made various exceptions to the rule (as noted by the Supreme Court of Canada in the *Taku* and *Ford* cases, supra), Lord Mansfield wrote:

> "Insurance is a contract upon speculation.
>
> The special facts upon which the contingent chances to be computed, lie most commonly in the knowledge of the insured only; the underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risque as if it did not exist.
>
> The keeping back of such circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through a mistake, without any fraudulent intention; yet still the underwriter is deceived, and the policy is void; because of the risque run is really different from the risque understood and intended to be run, at the time of the agreement.
>
> Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of that fact, and his believing the contrary."

And so it is clear there exists a good faith obligation in respect of disclosure at policy inception. But how does this morph into an obligation of good faith and fair dealing in respect of claims under the policy or have any application whatever beyond the underwriting process? In *Fredrikson v. I.C.B.C.*, supra, one of the very few "bad faith refusal to settle" cases against a Canadian liability insurer, Esson C.J. noted:

> " . . . our law does not at present recognize, as a general doctrine, that an obligation of good faith and fair dealing is imported into all contractual dealings . . .
>
> Insurance contracts are said to be contracts uberrimae fidei. Although that language is often used in the most general way, the obligation of utmost good faith has historically been imposed only upon the insured at the point of formation of the contract. Because the material facts are entirely

[10] (1766) 97 E.R. 1162

> within the knowledge of the applicant for insurance, and because the insurer is therefore vulnerable to any concealment, the law imposes a duty of full disclosure . . ."

Similarly, in *Tumbers Video Ltd. v. INA Insurance Co.*[11] the B.C. Court of Appeal upheld the dismissal of a fraudulent claim under a fire insurance policy but also observed:

> "The trial judge also referred to the concept of the utmost good faith – uberrimae fidei – and said that the appellant had failed in that obligation to its insurer. The concept of uberrimae fidei comes into play in an insurance setting at the time of the formation of the contract of insurance. It plays no part when it comes to an allegation of fraud in the proof of loss."

At the time of writing this article, the Supreme Court of Canada has not actually articulated any rationale for imposing an obligation of good faith and fair dealing in respect of claims handling. In the two cases considered to date addressing bad faith damages, *Whiten*[12] and *Fidler*[13], the court simply accepted the proposition without analysis. In *Whiten* the defendant insurer itself "acknowledge[d] that an insurer is under a duty of good faith and fair dealing" and "that this is a contractual duty"[14]. In *Fidler* the court simply averted to the "contractual duty to act in good faith," and then went on to adopt "the legal standard" for same:

> "In Whiten, this Court set out the principles that govern the award of punitive damages and affirmed that in breach of contract cases, in addition to the requirement that the conduct constitute a marked departure from ordinary standards of decency, it must be independently actionable. Where the breach in question is a denial of insurance benefits, a breach by the insurer of the contractual duty to act in good faith will meet this requirement. The threshold issue that arises, therefore, is whether the appellant breached not only its contractual obligation to pay the long-term disability benefit, but also the independent contractual obligation to deal with the respondent's claim in good faith. On this threshold issue, the legal standard to which SunLife and other insurers are held is correctly described by O'Connor J.A. in 702535 Ontario Inc. v. Lloyds of London (2000) 184 D.L.R. (4th) 687 (Ont. CA), at para. 29,
>
> > The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain

[11] (1991) 4 C.C.L.I. (2d) 200 (BCCA)
[12] 2002 SCC 18
[13] 2006 SCC 30
[14] per Binnie J. at para. 79

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> bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith."15

It is possible, perhaps probable, that the issue whether there even exists an obligation of good faith claims handling is now academic but perhaps some brave soul will mount such a challenge to the Supreme Court of Canada in the future.

3. THIRD PARTY LIABILITY CLAIMS: WHAT ARE THE "GOOD FAITH" OBLIGATIONS?

There have been very few successful bad faith lawsuits against liability insurers in Canada.[16] Of course, like most litigation, the vast majority of such cases settle before trial. Nevertheless, the absence of reported Canadian case law in this area provides an astonishing comparison with the U.S. experience.

The traditional bad faith case against a liability insurer is for failing to settle within policy limits. Pursuant to the policy provisions, the insurer completely controls the defence of the claim against the insured, including, for the most part, any decision to settle. If the case is taken to trial and judgment is granted in excess of the policy limits, unhappy insureds (or their assignees [the plaintiff judgment creditor] or subrogees [their excess insurer]) may sue the insurer for "bad faith failure to settle" the claim within policy limits.

In *Pelky v. Hudson Bay Insurance*[17] the plaintiff offered to settle for policy limits. Defence counsel failed to communicate that offer to the insurer, let alone the insured. Trial judgment was

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15 at para. 63
16 *Pelky v. Hudson Bay Insurance* [1982] I.L.R. 1-1493 (Ont. H.C.); *Dillon v. Guardian Insurance Company Limited* (1983) 2 C.C.L.I. (Ont. H.C.J.); *Shea v. Manitoba Public Insurance Corp.* (1991) 1 C.C.L.I. (2d) 61 (B.C.S.C.)
17 supra

granted in an amount three times higher than policy limits. The insureds successfully sued both the insurer and the solicitor for failing to settle.

In this case the court referred to the U.S. authorities regarding "bad faith failure to settle" but ultimately founded the insurer's liability on agency principles. Defence counsel was the insurer's agent and hence the insurer was vicariously liable for the former's negligence (failure to act on the offer of settlement). However, the insurer was entitled to complete indemnity from defence counsel for that vicarious liability.

In *Dillon v. Guardian Insurance Company*[18] defence counsel conveyed the pre-trial policy limits settlement offer to the insurer but was instructed to nevertheless proceed to trial. No consultation with the insured took place. The insured later sued both the insurer and defence counsel for failing to settle the claim within policy limits and the insurer also issued a third party proceeding against the lawyer. The action against the insurer was allowed but the claims against defence counsel were dismissed.

In this case the Court referred to three different standards of liability in the USA "failure to settle" cases. The Court found persuasive the arguments in favour of "absolute liability" where a pre-trial policy limits settlement offer had been rejected but ultimately did not decide the issue because the insurer was "liable by any standard". The claim against the lawyer was dismissed on the grounds that he had properly communicated the offer and his views on the same to the insurer and it was the latter's decision to proceed to trial.

Fredrikson v. I.C.B.C.[19] is the next notable case in the area and is one where the claim against the liability insurer for "bad faith refusal to settle within policy limits" was actually dismissed. Chief Justice Esson analyzed the relevant law as follows:

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[18] supra
[19] (1990) 42 C.C.L.I. 250 (B.C.S.C.)

"It has been established law in the United States for over half a century that a liability insurer can become liable to indemnify its insured in excess of the limits of coverage by "bad faith refusal to settle". This cause of action, which has spawned an enormous number of reported cases in the United States, has hardly ever been relied upon in any Canadian jurisdiction or elsewhere in the Commonwealth . . .

Clearly there is no single rule in the United States on what is necessary to establish liability for judgments in excess of policy limits. The courts of some states notably California tend to be very hard on insurers. Other courts, notably those of New York are much less so and have defined "bad faith" within quite narrow limits. There is a wide disparity among the courts of various states in their approach to defining the nature of the conduct which breaches the duty and in defining the nature of the duty. In some jurisdictions, including New York, the plaintiff must establish that the plaintiff was guilty of wrongdoing because of dishonest purpose or moral obliquity. Other courts look to the question whether or not the insurer properly took into account the interest of the insured at the time of refusing the settlement offer but, again, there is a wide disparity in determining what is proper consideration. Some jurisdictions hold that the insurer may treat its interests as paramount, some that the interests of the insured are to be considered paramount and others, which appear to be in the majority, hold the interests are to be considered "equally" or "fairly". Under such formulae, the court will look to a number of factors to determine whether the insurer has acted in bad faith . . . (1) failure to adequately investigate the grounds for the claim against its insured; (2) failure to advise the insured of settlement decisions that could adversely effect his interests; (3) failure to regard the advice of counsel or other agents; (4) failure to settle when the probability of success at trial is low and the risk of personal liability to the insured is high; and (5) failure to institute or participate in settlement negotiations.

My modest sampling of the authorities reveals much inconsistency in the degree of stringency by which the tests are applied. Some courts will find a failure to adequately investigate flowing from quite minor and innocent shortcomings – others require something like a reckless disregard for the interests of the insured. Some courts require the plaintiff to establish bad faith by "clear, satisfactory and convincing evidence", others hold a "mere preponderance" to be enough. In other courts, "negligence" rather than bad faith is said to be enough to establish liability. This approach defines negligence as an absence of that care which a reasonable person would exercise in the management of his own affairs, but does not appear to require that a causal link be established between the want of care and the result of the action. Many cases appear to reduce the question to one whether the decision of the insurer to refuse a settlement offer was "reasonable". In determining what is reasonable, the general approach seems to be to weigh the same factors which are used to determine bad faith. In some jurisdictions, negligence is not regarded as a separate ground of liability but as a factor to be considered when determining the existence of bad faith.

Clearly, it is an area of law which is in a state of uncertainty, and in which the outcome of cases is governed in a high degree by the court's subjective view of what is fair and what is reasonable.

. . . Whatever the pros and cons of that debate, I think it is correct to say that [Canadian] law does not at present recognize, as a general doctrine, that an obligation of good faith and fair dealing is imported into all contractual dealings.

. . . To sum up I am not persuaded that it would be either analytically correct or in any sense in the interests of justice to import into [Canadian] law the general doctrine of "bad faith refusal to settle" in any of its forms.

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> That is not to say that liability insurers are under no obligation to consider the interests of their insured in deciding whether to settle. Where there is a potential for a judgment over the limits, the interests of the insured are significant. The insurer has assumed by contract the power of deciding whether to settle. Although . . . I would not find the insurer to be under a fiduciary duty . . . it is clear that certain of the fundamental elements which give rise to fiduciary duty are present in the relationship of insurer and insured . . . Although the insurer is not subject to the strict duty of a fiduciary, it must nevertheless exercise its power having regard to the interests of insured, and in a manner entailing, in some sense, an obligation of good faith . . .
>
> But what is the nature of that duty? . . . I.C.B.C., which does not suggest that it was under no duty to Fredrikson, submits that the essence of the duty upon it was one of honesty. I think that may well be right."

One of the counsel for I.C.B.C. in the *Fredrikson* case, suggests the *Fredrikson* decision establishes the following principles, among others:

- the insurer's deliberations are to be assessed as whole, and not in hindsight;
- the insured's concurrence in refusing to settle the tort actions supports the prospects for successfully defending the subsequent bad faith claim;
- so long as suitably experienced defence counsel are appointed, insurers will not be held liable for defence counsel's errors;
- insurers are not obliged to fund independent advice for insureds facing a risk of excess liability because inadequate coverage limits;
- the opportunity to settle a defensible case for the policy limits necessarily produces a conflict of interest between insurer and insured, is a situation where the insurer does not owe fiduciary duties to the insured and the insurer is not required to abandon their separate interest in the presence of excess risk; and
- insurers will not be held absolutely or strictly liable for refusing to pay the policy limit to settle a case in which judgment is ultimately taken for a greater amount.20

The next, perhaps most important, Canadian decision dealing with liability for judgments in excess of policy limits is *Shea v. M.P.I.C.*[21] In this case the bad faith refusal to settle claim was upheld against the insurer and the latter was held liable to pay the insurance shortfall of some $830,000. In a carefully reasoned, 90-page judgment Justice Finch (now Chief Justice of British

[20] R. Berrow, "*The Law of Insurer Bad Faith in British Columbia: An Update*", B.C.L.E., February 1995
[21] (1991), 1 C.C.L.I. (2d) 61 (B.C.S.C.)

Columbia) undertook a 30-page review of the case law respecting a liability insurer's duty to its insureds and then concluded:

> "I would summarize my view of the law touching on the insurer's duty to its insureds in the circumstances of this case as follows:
>
> 1. The relationship between the insurer and insured is a commercial one, in which the parties have their own rights and obligations;
>
> 2. Within the commercial relationship, special duties may arise over and above the universal duty of honesty, which do not reach the fiduciary duty of standard of selflessness and loyalty;
>
> 3. The exclusive discretionary power to settle liability claims given by statute to the insurer in this case, places the insured at the mercy of the insurer;
>
> 4. The insured's position of vulnerability imposes on the insurer duties (a) of good faith and fair dealing, (b) to give at least as much consideration to the insured's interest as it does to its own interests, and (c) to disclose with reasonable promptitude to the insured all material information touching upon the insured's position in the litigation, and in the settlement negotiations;
>
> 5. The fact that the insured is at the mercy of the insurer for the purposes of settlement negotiations gives rise to a justified expectation in the insured that the insurer will not act contrary to the interests of the insured, or will, at least, fully advise the insured of its intention to do so;
>
> 6. While the commercial nature of the relationship permits an insurer to assert or defend interests which are opposed to or are inconsistent with, the interests of its insured, the duty to deal fairly and in good faith requires the insurer to advise the insured that conflicting interests exist, and of the nature and extent of the conflict;
>
> 7. The insurer's statutory obligation to defend its insured imposes on the insurer, where conflicting interests arise, a duty to instruct counsel to treat the interests of the insured equally with its own; and where one counsel cannot adequately represent both conflicting interests, an obligation to instruct separate counsel to act solely for the insureds, at the insurer's own cost;
>
> 8. The insurer's duty to defend includes the obligation to defend on the issue of damages, and to attempt to minimize by all lawful means the amount of any judgment awarded against the insured…..
>
> 9. Defence preparations and settlement negotiations must take place in a timely way, and, where last minute negotiations are required, advance planning must be made to ensure that the insured's interests are given equal protection with those of the insurer."

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In the *Shea* case an issue had arisen whether court order interest and accident benefits were payable in addition to the liability limits of the policy. The case could have been settled for payment of the policy limits and an agreement between the competing insurers to litigate the coverage issues. This would have avoided the possibility of any excess judgment against the insureds. Instead, the insurer insisted upon a settlement involving a consent judgment equal to the liability limits alone. When this was refused, the matter went to trial and the very substantial excess judgment resulted. The court concluded the insurer had failed to act properly and required it to pay the full excess amount.

Where no coverage issues or policy limits considerations arise, the liability insurer can handle the claim pretty much as it wishes. In *Mara v. Blake*[22] the British Columbia Court of Appeal permitted the insurer to appoint one counsel to represent four separate insureds in one consolidated lawsuit by the same plaintiff and involving four separate motor vehicle accidents. The court observed:

> "The courts have on many occasions recognized the unique nature of the insured-insurer relationship, in which the insurer, although bound to deal with the insured in good faith, is ultimately entitled as a matter of contract to decide upon what course is to be taken in the conduct of an action, notwithstanding that the insured may vigorously object . . .
>
> Each [insured] has granted to the insurer the exclusive right to control and conduct the defence to the action against him. Subject to the duty of good faith, the insurer alone is entitled to appoint and instruct counsel, to settle within the limits of the policy notwithstanding that the insured may object, or to defend the claim notwithstanding that the insured may wish to settle. Essentially, by taking up the policy of insurance, the insured has agreed that, subject to "good faith" remedies, his interest (at least in non-financial terms) and his wishes will be subordinated to those of the insurer in return for the latter's obligation to indemnify him for damages arising from the final award or settlement made against him."

Generally speaking, problems only arise in these cases where the claim threatens policy limits or where other coverage issues might affect the insured's entitlement to indemnity.[23] In such cases, sophisticated claim handling is required. Insurers can usually avoid bad faith liability by

[22] (1996) 23 B.C.L.R. (3rd) 225 (BCCA)
[23] For an analysis of the problems posed by partial coverage situations, see Kent, "*Preventative Paperwork: Non-Waiver Agreements, Reservation of Rights Letters and the Defence of Claims in Questionable Coverage Situations*", [1995] 17 Advocates' Quarterly 399-450 (an updated version is also accessible on the internet at http://www.cwilson.com/pubs/insurance/npk2).

ensuring the appointment of experienced and competent defence counsel and, most importantly, by effective management of communications with the insured. Where irreconcilable differences emerge, experienced coverage counsel should be retained by both parties.

4. FIRST PARTY COVERAGES: WHAT ARE THE GOOD FAITH OBLIGATIONS?

Allegations of bad faith handling of first party property or disability coverages ultimately entail a microscopic examination of the conduct and motives of every person involved in the claims process. But it is important to remember that the mere denial of a claim later determined to be covered, or failure to meet just one or two of several perceived elements of good faith handling, does not necessarily mean there has been a breach of any overall duty of good faith. As the Supreme Court of Canada said in *Fidler*[24],

> "An insurer will not necessarily be in breach of the duty of good faith by incorrectly denying a claim that is eventually conceded, or judicially determined, to be legitimate . . . the question instead is whether the denial was the result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claims process." *(emphasis added)*

The extract from the *702535 Ontario Inc.* case[25] cited in *Fidler* does not include all of the observations by the Ontario Court of Appeal, which had been:

> "The duty of good faith requires an insurer to act promptly and fairly when investigating, assessing and attempting to resolve claims made by its insureds.
>
> The first part of this duty speaks to the timeliness in which a claim is processed by the insurer. Although an insurer may be responsible to pay interest on a claim paid after delay, delay in payment may nevertheless operate to the disadvantage of an insured. The insured, having suffered a loss, will frequently be under financial pressure to settle the claim as soon as possible in order to address the situation that underlies the claim. The duty of good faith obliges the insurer to act with reasonable promptness during each step of the claims process. Included in this duty is the obligation to pay a claim in a timely manner when there is no reasonable basis to contest coverage or to withhold payment . . .

[24] at para. 71
[25] (2000) 184 D.L.R. (4th) 687 (Ont. CA)

> The duty of good faith also requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of the claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith.
>
> What constituted bad faith will depend on the circumstances in each case. A court considering whether the duty has been breached will look at the conduct of the insurer throughout the claims process to determine whether in light of the circumstances, as they then existed, the insurer acted fairly and promptly in responding to the claim."

In the *702535 Ontario* case, the property insurer withheld payment of the claim arising from a hotel fire on grounds that, among other things, there was overlapping coverage with another insurer and therefore it was liable only for a proportionate share of the actual loss. The court ruled that the insurer's failure to pay at least 50 percent of the loss within a reasonable time after submission of the formal Proof of Loss was a breach of the duty to respond to the claim in good faith. However, the court also ruled that the delayed payment did not result in any provable loss and therefore the claim for both compensatory and punitive damages on this account was dismissed.

In *Kogan v. Chubb Insurance*,[26] another case where a property insurer raised the defence of arson, the court declared:

> "In brief, the insurer's duty to act fairly and in good faith towards its insured is as follows:
>
> 1. The obligation of good faith implicit in any contractual relationship is to refrain from nullifying without reasonable justification the reasonable expectation of the other party created by the contract;
>
> 2. The insurer owes the insured a duty of fairness and a duty to be prompt in handling and assessing the loss;
>
> 3. The insurer owed the insured a duty of fair dealing which includes payment in a timely fashion. Failure to do so may constitute a breach of contract;

[26] (2001) 27 C.C.L.I. (3rd) 16 (Ont. S.C.J.)

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> 4. In fulfilling its contractual obligations, an insurer must give as much consideration to the insured's welfare as it gives to its own interests. The insurer cannot do anything to injure the insured's rights to receive the benefits under the policy;
>
> 5. The insured is dependent upon the insurer to undertake an adequate investigation and proper evaluation of the claim expeditiously. An insured is entitled to receive correct information, a fair interpretation of the policy and the prompt payment of a meritorious claim. The insurer may not treat the insured as an adversary whose interests may be disregarded. This implies the reasonable and competent investigation of the claim."

In *Kogan* the court went on to hold that "Where the insurer and/or adjuster acts unreasonably by effectively presupposing arson as the cause of the fire and taking steps to fortify this conclusion rather than objectively assessing the evidence in order to draw a reasonable conclusion therefrom, the label of bad faith will be justified and punitive damages should be awarded." The ruling is troublesome for a couple reasons. First, the independent adjuster was named as a defendant in the case along with the insurer and judgment was granted against both defendants without any analysis of the legal basis for the adjuster's liability. Second, the court itself acknowledged "However one looks at all the evidence, it certainly is logical to conclude that a suspicious fire did occur in the early morning hours in question" and that there was no explanation for empty bottles of a known accelerant at the scene. Punitive damages of $100,000 were nonetheless considered appropriate.

The *Whiten v. Pilot Insurance*[27] case is a much more extreme example of an unjustifiable arson defence. ICPB reported that the insurer "wouldn't have a leg to stand on as far as declining the claim" was concerned. The independent adjuster had observed that "with the physical evidence we have, there is little or no basis to deny this claim." But the insurer's representatives were suspicious of the insured's attempts to refinance mortgage payments which were in arrears and the defence of arson was pursued all the way through to trial with the assistance of defence counsel whose conduct was also subject to considerable criticism. The Supreme Court of Canada judgment deals almost exclusively with the issue of punitive damages and there are only a few references to the duty of good faith as follows:

[27] (2002) 35 C.C.L.I. (3d) 1 (S.C.C.)

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> ". . . An insurer is entirely within its rights to thoroughly investigate a claim and exercise caution in evaluating the circumstances. It is not required to accept the initial views of its investigators. It is perfectly entitled to pursue further inquiries . . . the problem here is that Pilot embarked upon a "train of thought" [arson prompted by possible financial difficulties] as early as Feb. 25, 1994 that led to the arson trial, with nothing to go on except that the fact that its policy holder had money problems.
>
> The "train of thought" . . . kept going long after the requirements of due diligence or prudent practice had been exhausted. There is a difference between due diligence and willful tunnel vision. The jury obviously considered this case to be an outrageous example of the latter."

The dissent in *Whiten v. Pilot Insurance* related to punitive damage issues and not to the good faith obligations of an insurer which were stated to be:

> "The insurer must compensate in a timely manner. It has the right, even the duty, to investigate claims, but must do so fairly and diligently."

In 2002, the Ontario Court of Appeal affirmed a $200,000 punitive damage award against an insurer even though the facts were "less extreme" than the *Whiten* case. In *Khazzaka v. Commercial Union Assurance*[28] both the Fire Department and the police thoroughly investigated the incident without any suspicion of arson but the insurer developed and pursued its own theory of arson through to trial. The Court of Appeal commented:

> "The [insurer] had a duty to treat the insured fairly. It was not unfair to consult the Fire Department and police and to refuse to accept their opinions without independent investigation. It began to be unfair conduct when the insurer persisted in denying the claim when no credible basis for alleging arson arose from that investigation. It was clearly unfair to concoct evidence of the presence of gasoline to support a defence, which may have been the jury's finding. Unfairness multiplies as all obstacles to the viability of the defence of arson are turned aside without concern for the insured's rights and well-being. The unfairness is further exaggerated when the defence is pursued through a trial even while the evidence of its supporters, in the trial judge's word, "crumbled" beneath them. Unfairness compounded over and over again amounts to conduct that merits the condemnation of the court when visited by an insurer that owes a duty of good faith to its insured.
>
> The [insurer] cannot excuse itself by hiring reputable independent agents. They owe no duty to the insured. But the insurer does, and its obligation continues through trial. I see it as no unreasonable burden on an insurer who alleges that the insured has committed a crime to closely oversee the conduct of that defence and assure itself at regular intervals that the insured who paid premiums for coverage is always being treated fairly."

[28] [2002] O.J. 3110 (C.A.)

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Allegations of arson were again the basis for two respective punitive damage awards of $100,000 and $350,000 against the insurer in *Plester v. Wawanesa Mutual Insurance*[29]. There the Ontario Court of Appeal noted that a delay of seven months in denying a claim is not in itself evidence of bad faith, nor was a 50 percent settlement proposal and the retaining of counsel. However, the court considered there to be a sufficient basis to support the jury's finding of punitive damages, primarily in respect of the inconclusive nature of the investigation. The case for arson against the insured's father was nonexistent and the case for arson against the insureds themselves "did not pass much beyond suspicion" and "was a very long shot."

Disability insurance is also providing a fertile ground for bad faith allegations and claims for exorbitant punitive damages.

In *Asselstine v. Manufacturers Life Insurance*[30] a majority of the B.C. Court of Appeal affirmed an aggravated damages award of $35,000 and a punitive damages award of $150,000 for bad faith denial of disability benefits. The case has interesting liability twists inasmuch as,

- the employer (UBC) extended a disability insurance plan funded entirely by employees and the administration of which had been contracted out to Manulife;
- at the trial court level both Manulife and UBC were held jointly liable for the damage awards; however
- the Court of Appeal unanimously held that Manulife could have no liability to the plaintiff inasmuch as there was no contract between the two establishing any cause of action; and
- although the result meant a principal (the employer UBC) would be held liable for punitive damages on account of misconduct of its agent (plan administrator Manulife), objection to such vicarious liability had not been argued at trial and could therefore not be raised on appeal.

[29] [2006] O.J. No. 2139 (CA); note another $500,000 punitive damage award was made in a recent Ontario arson case, *Sagl v. Chubb Insurance* [2007] O.J. No. 3311
[30] 2005 BCCA 292

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The Court of Appeal was not prepared to interfere with the trial judge's finding of bad faith, observing that the latter "was moved by the indifference of the defendants to the predicament of the plaintiff" and wanted to ensure "that disability insurers understand the law will not countenance bad faith administration of their policies." Although the claims adjudicator was faced with conflicting medical information as to the claimant's condition (including a report from the claimant's treating specialist which said she could work), the trial judge nonetheless identified a number of perceived errors cumulatively amounting to bad faith, including:

- undue emphasis on unreliable and incomplete reports;
- viewing the plaintiff with suspicion and deeming her self reporting to be suspect;
- steadfastly maintaining a denial notwithstanding compelling medical evidence regarding the plaintiff's condition;
- failing to be balanced in the assessment of the claim; and
- failure to appreciate and apply the correct legal test for total disability to the circumstances.

Cases like Asselstine provide little meaningful guidance for claims adjudicators. The Supreme Court of Canada has affirmed that insurers can make wrong decisions without breaching the duty of good faith:

> "An insurer will not necessarily be in breach of the duty of good faith by incorrectly denying a claim that is eventually conceded, or judicially determined, to be legitimate."[31]

While the court also said "each case revolves around its own facts"[32] the difficult question is when does the insurer's assessment become so unbalanced or unfair as to amount to a breach of good faith, let alone a breach of such magnitude that it warrants a punitive damage award. In *Asselstine*, the claims adjudicator was confronting conflicting information and medical reports and although the ultimate denial of benefits may have been an incorrect decision, imposing punitive damages in such circumstances seems very harsh.

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[31] *Fidler v. SunLife Assurance* 2006 SCC 30 at para. 71
[32] supra, para. 72

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Perhaps, however, the *Fidler* decision is an indication that the pendulum is swinging back to some degree. The trial judge had awarded $20,000 in aggravated damages but refused to make a finding of bad faith and denied the claim for punitive damages. The B.C. Court of Appeal overturned the decision concluding that the disability insurer had demonstrated bad faith claims handling sufficient to warrant an award of $100,000 in punitive damages. The Supreme Court of Canada restored the trial decision holding that while the insurer's conduct was "extremely troubling" and "to say the least inappropriate," the trial judge had properly assessed and weighed the evidence and his conclusions that there had not been a bad faith handling of the claim were not unreasonable.

In *Fidler*, the plaintiff suffered from chronic fatigue syndrome and fibromyalgia. The insurer paid long term disability benefits for a number of years but ultimately terminated same, following video surveillance which allegedly established "activities incompatible with the alleged disability." The claimant's physician issued reports confirming the existence of total disability although an independent medical examination suggested she was "increasingly able to consider returning to work." The majority of the Court of Appeal held that the insurer's conduct amounted to bad faith noting in particular the absence of any meaningful medical evidence to justify a denial, the insurer's internal memoranda containing exaggerations and factual misstatements, as well as the insurer's refusal to disclose the surveillance video on which it relied to deny the claim.

These are difficult cases involving matters of judgment. In a 2003 article advocating the viability of bad faith claims in tort (as opposed to merely a breach of contract)[33], one author has suggested the constituent elements of good faith claims handling includes at least the following:

1. investigate the claim from both the insurer's and insured's point of view;
2. ensure the fact investigation has been thorough and that judgment on the claim is not made prematurely;

[33] Debenham, "*Coming Armed with Spiers: Insuring Good Faith Processing of Policy Claims in the Post-Whiten Age*", [2003] 27 Advocates' Quarterly, pp. 5-47

3. evaluate the facts in an impartial, objective manner, weighing carefully the elements both supporting and not supporting the claim;
4. evaluate the facts as a whole and avoid any tendency to isolate events out of context;
5. be wary of unreliable hearsay or unsubstantiated opinions;
6. be open to conducting additional inquiries and evaluating new information as may be necessary to meet the requirement of thorough investigation;
7. if independent medical examination is required, ensure the examiner is supplied with complete medical records and data and where possible avoid the use of (potentially unreliable) summaries;
8. ensure the examiner is aware of the applicable policy provisions and the manner in which the substantive interpretation issues have been addressed by the courts;
9. provide the insured with an accurate and fair explanation of the policy terms and the claims procedures;
10. keep an open mind . . . be prepared to re-evaluate as things develop and the factual picture changes;
11. do not impose burdensome paper processing requirements to support payment of non-contentious parts of claims;
12. pay the undisputed parts of claims promptly without ransom for full releases or other advantageous conditions.

While each case must be decided on its own facts, the claims very often involve matters of judgment on complex issues and "gray" areas, and the case law sometimes provides little guidance in that regard. For example, it is hard to articulate why a denial of benefits in light of conflicting medical evidence amounts to bad faith in the *Asselstine* case whereas in *Fidler* the absence of supporting medical evidence and reliance on inconclusive surveillance does not. Given this lack of clarity and given also the potential for substantial punitive damage awards in these cases, there is little wonder that almost any and every denial of coverage these days tends to attract allegations of bad faith.

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5. IS BAD FAITH A TWO-WAY STREET?

In our discussions of the good faith obligation in insurance contracts[34], it was pointed out that, albeit in the context of misrepresentation and disclosure of information at the underwriting stage of the process, the obligation was nonetheless mutual. Good faith obligations on the part of insureds have also been invoked by the courts in the context of fraudulent claims as well. Hence in *Andrusiw v. Aetna Life Insurance*[35] the court held that a punitive damage award of $20,000 against the insured was appropriate on account of the insured's breach of utmost good faith.

Ivamy, *General Principles of Insurance Law*, declares (at p. 136):

> "It is a fundamental principle of insurance law that the utmost good faith must be observed by each party." *(emphasis added)*

So too the Supreme Court of Canada has declared,

> "A contract of insurance is *uberrima fides*: utmost good faith must be observed by both parties."[36] *(emphasis added)*

And in *Whiten v. Pilot Insurance Co.*[37] the court expressly cited the *Andrusiw* case as an example of an insurer claiming punitive damages against the insured for breach of the mutual "good faith" obligation in insurance contracts and set out the observations of the trial judge in that case to the following effect:

> "A great deal has been made in the case law, to which this court was referred, of the fact that insurers *vis-à-vis* their insureds are in a superior bargaining position and one which places the

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[34] supra, pp. 2 - 6

[35] (2001) 289 A.R. 1 (QB). To the same effect see *Industrial Alliance Insurance and Financial Services Inc. v. Skowron* [2006] O.J. No. 2554 (Ont. SCJ), and *Kursar v. BCAA Insurance Corp.* 2007 BCSC 983 and 2007 BCSC 1583 where punitive damages of $20,000 and $40,000 respectively were awarded against the insured. However NB the contrary sentiment expressed by the B.C. Court of Appeal in *Tumbers Video Ltd. v. INA Insurance Co.* (1991) 4 C.C.L.I. (2d) 200 to the effect that the concept of *uberrimae fidei* comes into play in an insurance setting only at the time of contract formation and plays no part in the context of alleged fraudulent claims.

[36] *Ford v. Dominion of Canada General Insurance* [1991] 1 S.C.R. 374 per Cory J. adopting Philp J.'s judgment in the Man. CA

[37] 2002 SCC 18

> insureds in positions of dependency and vulnerability. Equally, insurers must not be looked upon as fair game. It is a two-way street founded upon the principle of utmost good faith arising from the very nature of the contract."

But beyond the context of misrepresentation and fraud, both of which result in the voiding/denial of the coverage/claim, is the good faith principle really a two-way street? If an insurer breaches its obligation of good faith claims handling, is it a defence or a factor mitigating damages that the insured too has been less than entirely forthright or honest in his dealings with the insurer?

It is not difficult to imagine conduct on the part of an insured which falls short of outright fraud but which might be said to violate an obligation of good faith, including:

- orchestrating matters to "set up" the insurer for bad faith in respect of claims exceeding policy limits;
- assisting in the manipulation of pleadings so as to bring a matter otherwise uninsured back into coverage in order to trigger a liability insurer's involvement in the defence and settlement of the claim;
- failing to give notice of claims or failing to cooperate in providing information, documents or witnesses;
- acting so as to impair subrogation rights;
- exaggerating symptoms or failing to fully disclose all relevant information to treating physicians;

There is very little literature dealing with bad faith on the part of an insured (as opposed to an insurer). The most informative and articulate Canadian article on the subject is R.V. Buller, "*Reverse Bad Faith: Plaintiffs in Glass Houses.*"[38] While Mr. Buller is in-house counsel for SunLife Assurance Company and hence could be argued to have less than an entirely balanced perspective, he contends quite rightly that "reverse bad faith" claims (claims of bad faith conduct by insureds, as opposed to insurers) should be "less rare and anomalous" and that they have "a

[38] (2005) 30 Adv. Q. 163 (hereinafter "Buller")

legitimate and important role to play in insurance litigation."[39] His article concentrates on the good faith elements pertaining to first party claims, but there is no reason why similar considerations would not apply to insureds making claims on third party liability coverages in a policy as well.

Buller suggests that the constituent elements of an insured's duty of good faith in claiming benefits or pursuing coverage under a policy are derived from two basic principles of 1) presenting information promptly and fairly and 2) taking reasonable steps to mitigate loss. More fundamentally, however, perhaps a better test, ironically the same standard the marked departure from which can trigger punitive damages, is the simple standard of honest and decent behaviour.[40]

Viewed through this lens, it is not difficult to see why the insured's deceit in the Andrusiw case (telling the insurer he was still disabled when he was in fact running a prosperous business) would amount to a breach of good faith (and in that instance, an award of $20,000 in punitive damages and an order to repay $260,000 in disability benefits). But would it not equally be bad faith for insureds to do any of the things listed on the previous page? Buller points out, quite rightly, that if insurers can be held liable in bad faith for the conduct of their agents such as independent adjusters, investigators, independent medical examiners etc. then so too the insured should have an obligation to "closely oversee"[41] its own "agents" such as doctors, family members and even their own legal counsel.[42]

In the United States there is some debate whether "reverse bad faith" or "comparative bad faith" (i.e. the existence of bad faith on the part of the insured as a basis for providing a defence or

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[39] at p. 164
[40] Recall Esson C.J.'s observation that "it may well be right" to say that "the essence of the duty is one of honesty": *Fredrikson v. I.C.B.C.*, (1990) 42 C.C.L.I. 250 (BCSC).
[41] the words come from *Khazzaka v. Commercial Union Assurance* (2002) 43 C.C.L.I. (3d) (Ont. CA) a pp. 395-6, a case where the insurer was said not to be able to "excuse itself by hiring reputable independent agents" in the context of an arson claim
[42] Buller, op. cit., at p. 182

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cross claim on the part of the insurer) is even available.[43] The defence had first been recognized in California in 1985 in *California Casualty General Insurance Co. v. Superior Court*[44] where the insurer defended a bad faith claim on the grounds that the insured unduly delayed submitting information to process her claim, which in turn had resulted in the insurer's failure to settle. The court undertook an analysis in tort which included the principle of comparative fault and held that the insurer's obligation to pay the bad faith claim should be reduced by the percentage of fault placed upon the insured (i.e. the insured's bad faith was an affirmative defence).

However, in 2000 the California Supreme Court abrogated the earlier ruling in a case called *Kransco v. American Empire Surplus Lines Ins. Co.*[45] There the lower court had concluded that the insured's false interrogatory answers were as much the cause of the excess verdict in the case as the insurer's failure to settle. Indeed, the insured was found 90 percent at fault for the outcome and the insurer's bad faith exposure was reduced to that extent. On appeal, however, the California Supreme Court held that the relationship between the insured and insurer was "inherently unequal" and in such circumstances, as a matter of law, the defence of comparative fault was not available as an offset.

Notwithstanding *Kransco*, the concept of "reverse bad faith" is still very much alive in the United States. In Pennsylvania, for example, there are two recent decisions where the court refused to strike out pleadings raising, in one instance, the affirmative defence of reverse bad faith and, in the other, a counterclaim based on collusion. In *Javorski v. Nationwide Mutual Insurance Company*[46] the court ruled that an insured's bad faith conduct could be scrutinized with a view to militating against a finding of bad faith against the insurer and the motion to strike out the latter's statement of defence was dismissed. Similarly, in *Kvaerner U.S. Inc. v. Kemper*

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[43] see Weihmuller, "*The Current State of Comparative Bad Faith*," (2003) Mealey's Litigation Report: Insurance Bad Faith, Vol. 16, #24 which concludes, "The concept of unequal duties of good faith and fair dealing between the insurer and the insured seems to be the prevailing state of the law. This inequality will likely prevent any further acceptance of the concept of comparative bad faith, as unequal duties cannot offset each other . . . the days of comparative bad faith seem to have ended."
[44] 173 Cal. App. 3d. 274
[45] (2000) 23 Cal. 4th 390 (Cal. SC)
[46] U.S. Dist. Ct. No. 3:06-CV-1071 (November 30, 2006)

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Environmental Limited[47] the excess insurers allege that the insured had entered into a collusive settlement with the plaintiff so as to access and maximize recovery under the excess insurance coverage. The insured filed a motion to dismiss the counterclaims arguing that insureds, unlike insurers, have no duty of good faith and fair dealing pursuant to an insurance contract. The court dismissed the application, observing there was "no cogent reason why the implied contractual duty of good faith should not be reciprocal" and that insurers were entitled to sue insureds for breach of such of duties in appropriate cases. To hold otherwise "would give insureds impunity to act in bad faith towards their insurers [and] there is no legal support for such an unwise and unsound proposition."

As indicated earlier, it is difficult to find Canadian authority which applies the concept of "reverse bad faith" in anything other than the context of an insured's deceit, fraud or misrepresentation. One example is *Wachal v. Crown Life Insurance Co.*,[48] a case decided before *Whiten*, which held that the plaintiff's conduct in exaggerating her physical ailments following receipt of the insurer's video surveillance "seriously undermined her credibility" and "significantly contributed to the decision to terminate disability benefits, [and hence] an award of punitive damages against the defendant is not warranted in the circumstances of this case."[49]

Buller goes so far as to suggest that "the concept of reverse bad faith" should also be applied to the conduct of the insured and even his counsel in the course of the coverage enforcement litigation. The *Whiten* and *Khazzaka* cases are cited as examples where the insurer's post-litigation conduct was taken into account in determining the existence of bad faith and exposure to punitive damages and Buller quite rightly observes,

> "The reciprocal application of *Whiten* and *Khazzaka* results in insureds' post-litigation conduct also being held to the standard of good faith. Thus, for example, insureds who lie or exaggerate on discovery, or otherwise fail to disclose relevant information during litigation, whether or not those actions occur through counsel, will have committed breaches of good faith for which punitive damages may be sought by the insurer. Insureds' conduct, and that of their counsel,

[47] U.S. Dist. Ct. No. 2:06-CV-403 (October 26, 2006)
[48] [1999] M.J. No. 366 (Man. QB)
[49] at para. 104

> ought to be held under the same good-faith microscope as the conduct of insurers. This microscope should extend to unfounded allegations made by the insured against the insurer. Plaintiffs claiming insurance benefits commonly attack the integrity of insurance companies by alleging multiple acts of bad faith; often this is done on a "boilerplate" basis without any evidence for the truth of the allegations. Just as the courts in *Whiten* and *Khazzaka* were concerned with, and punished, unfounded allegations of arson, so courts should be concerned with, and punished, unfounded allegations of bad faith made by insureds . . . boilerplate allegations of bad faith, if pursued through the discovery process, will be costly and cumbersome for insurers no matter what the outcome . . . insureds who burden insurers with unjustified fishing expeditions into their claims practices should be considered to be acting in bad faith."[50]

From a practical point of view, however, it will be difficult to rely on bad faith litigation tactics by an insured for an award of punitive damages. In most cases, there is no counterclaim by the insurer against the insured and hence no framework within which punitive damages might be awarded. Hence, the most likely outcome in such situations is a punitive award of costs against the insured and even against the insured's counsel personally. This is precisely what happened in *Chaplin v. SunLife Assurance*[51] where the insured made completely unfounded allegations of corporate immorality and dishonesty against the insurer who was alleged to have a "corporate strategy to avoid payment of disability claims, and claims employees who received bonuses for their participation in the scheme from claims money saved."

A similar result ensued in the more recent case of *Standard Life Assurance v. Elliott*.[52] There, the insurer brought action to recover an overpayment of LTD benefits alleged to have been paid by mistake. The insured defended the claim but also issued a third party claim against every individual past and present employee of Standard Life who had ever handled her file. Standard Life, which admitted any vicarious responsibility it might have for the acts of its employees, brought application to have the third party proceeding dismissed. The court granted the motion, noting there was no proper cause of action in law against the individuals and in an endorsement issued July 21, 2006 Justice Molloy held,

> "I also agree that the third party claim is a blatant abuse of process in which the defendant has personally sued every employee who had anything to do with her claim going back more than a

[50] Op. Cit., supra, at pp. 185-187
[51] 2004 BCSC 116, leave to appeal denied 2004 BCCA 361
[52] [2007] O.J. No. 2031 (Ont. SCJ)

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> decade. I can only conclude they were added for the purpose of getting discovery and production of documents against employees as well as against the company . . . . 'procedural advantage' is not a proper basis to add a host of individual third parties and that is the most innocuous characterization of the tactic".

Costs were subsequently awarded against both the insured and her counsel, jointly and severally, on a substantial indemnity basis. The court observed,

> "I would not go so far as to say that Mr. Masters did act in bad faith . . . that said, in my view his conduct went well beyond what was necessary to protect the interests of his client. He waged a war of attrition against the insurer company, intending to make it so expensive for the insurer to litigate his client's claim that they would simply give up . . . I am satisfied that Mr. Masters was using the Rules as a weapon in his war against the insurer, rather than as a mechanism for obtaining a fair and just result for his client. He deliberately caused excessive costs to be incurred without reasonable cause in order to put pressure on the insurance company. Even though his client approved what he did, I do not see her as the instigator. She was following her counsel's advice."[53]

The law respecting "reverse bad faith" has yet to develop in Canada. In situations where there has been mutual breach of respective good faith obligations, whether in the presentation or handling of the claim or subsequent litigation, the concept of reciprocity (i.e. the proverbial two-way street) should be applied to engage the following spectrum of relief:

- dismissal altogether of the claim for coverage;
- contributory fault and therefore proportionate reduction of compensatory damages;
- elimination of any basis for a punitive damage award against the insurer, or alternatively reduction of the award in light of the "proportionality" principle espoused in the *Whiten* case;
- in appropriate cases (failure to mitigate) proportionate reduction of the benefits payable under the policy[54]; and/or

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[53] supra at para. 30

[54] NB the comments of Madam Justice Prowse in *Eddie v. Unum Life Insurance Co.* 1999 BCCA 507 at para. 77: "counsel did not provide us with any authority for the proposition that mitigation of damages is a relevant consideration in actions for breach of a policy of disability insurance. After a cursory search, I have not found any cases which support this proposition. Nor is it clear what the effect of a finding of a failure to mitigate would be. Would the court simply reduce the monthly benefits payable under the policy? Fortunately, it is not necessary to resolve that nice question in this appeal . . ." Such case law does exist however, both in terms of reducing and terminating benefits. See e.g. *Riehl v. Pennsylvania Life* [2002] A.J. No. 80 (Alta. QB), *Flewwelling v. Blue Cross Life* [1999] A.J. No. 381 (Alta. QB).

- the exercise of the court's discretion in respect of the award of costs.

It remains to be seen how these matters will develop in the future.

6. CLAIMS FOR PUNITIVE DAMAGES

(a) Only Exceptional Cases

While both the *Whiten*[55] and *Fidler*[56] cases established that the insurer's breach of any implied duty of good faith claims handling is a necessary precondition for any award of punitive damages, it does not follow that such awards are automatic. There is a two-step analysis which must be undertaken:

1. Beyond establishing a denial of coverage was an incorrect judgment call, was the denial also "the result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claims process"[57]; and
2. If so, was the insurer's conduct so exceptionally bad, so egregious that an award of punitive damages is warranted?

Unless both conditions are met, punitive damages will not be awarded (although this does not hold true insofar as compensatory mental distress damages are concerned). In the *Fidler* case, the court unanimously restored the trial judgment holding that the incorrect denial of a claim did not necessarily amount to bad faith and, in that case, in the absence of bad faith there was "no need to go further" in terms of considering whether punitive damages were warranted. However, the two-step analysis was more expressly articulated by Mr. Justice Lowry in *Asselstine v. Manulife*[58] where he observed,

> "Thus it is not every breach of good faith that will give rise to an award of punitive damages. It is first necessary to consider whether the insurer has been delinquent or has conducted the assessment of a claim in a manner that was unfair to the insured. If so, the insurer will have

[55] 2002 SCC 18
[56] 2006 SCC 30
[57] *Fidler*, supra, at para. 71
[58] 2005 BCCA 292

> breached the implied obligation of good faith and will be liable to compensate the insured for any consequential damages that they may have suffered. It is then necessary to consider whether the insurer's conduct is so egregious that an award of punitive damages is warranted."

In *Whiten* the Supreme Court emphasized "even at the risk of some repetition for emphasis" that "1. punitive damages are very much the exception rather than the rule, and 2. they are imposed only if there has been high-handed, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from the ordinary standards of decent behaviour."[59]

Given the propensity for juries to be sympathetic towards substantial awards, if there is an absence of a sufficient legal or evidentiary basis for an award, counsel in jury trials should consider the possibility of obtaining a directed verdict or otherwise removing the issue from the jury altogether. Such an approach was recently endorsed by the B.C. Court of Appeal in *Stewart v. Knoll North America Corp*[60], a wrongful dismissal case where the punitive damages claim was not permitted to go to the jury at the end of the case on the basis that "there was no basis on which the conduct of the employer could be said to be so extreme, harsh, vindictive, reprehensible or malicious as to warrant punishment." (at para. 32).

(b) No Vicarious Liability

Another very recent and very novel twist in the bad faith case law is the question of whether there is any proper legal basis upon which an employer (i.e. the insurer) can be burdened with an award of punitive damages for the conduct of its employees. It is a threshold legal issue which should not be overlooked in these cases, and thus far, there is only one insurance decision case which has directly addressed the matter.

The *Asselstine v. Manulife* case[61] involved an employer (UBC) and a separate claims administration agent (Manulife) in charge of administering a self-funded employee benefits plan.

[59] at para. 94, emphasis in the original
[60] 2007 BCCA 11, see also *McKinley v. B.C. Tel*, 2001 SCC 38 which expressly endorsed the same procedure in another wrongful dismissal case.
[61] 2005 BCCA 292

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The trial court awarded aggravated damages of $35,000 and punitive damages of $150,000, imposing joint liability for bad faith claims handling upon both the employer and the administration agent. On appeal, the different roles of the two defendants was examined in closer detail. The B.C. Court of Appeal unanimously overturned the award against the administration agent (Manulife) on the grounds that there was no contract as between the claimant and the agent and therefore no basis for any cause of action. The question then arose whether the employer, UBC, would nonetheless remain liable for the punitive damage award even though it was the claims agent whose conduct was being impugned.

The majority held that, because this issue had not been argued at trial, it could not be considered on appeal. It characterized the dissenting judge's analysis of the issue as "comprehensive and scholarly" but a point that was not available "on the record." The dissenting opinion was that of Mr. Justice Lowry who noted the question of vicarious liability for punitive damages "does not appear to have been considered directly in Canadian jurisprudence."

Mr. Justice Lowry held,

- "Punitive damages are not to be awarded against a principal for the egregious misconduct of an agent on a purely vicarious basis";
- "Punitive damages cannot be awarded against an employer who is entirely blameless";
- "An award of punitive damages against an employer [should only be made] where there is some kind of complicity on the part of the employer. This complicity may be direct, as where the doing and manner of the servant's act was authorized or subsequently ratified, or was at a managerial level such that the act must be taken to have been the act of the employer. Responsibility may also be indirect, such as where the employer recklessly employed an unfit person . . . or where the employee's training is inadequate for the task assigned";
- "Some measure of blameworthiness must be evident on the part of an employer in order to be held liable in punitive damages for the conduct of its employee."

This type of defence will invite close scrutiny of hiring, training and claims management practices within the insurance company. In appropriate cases, however, it may provide a

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complete legal defence as well as another basis upon which the claim for punitive damages might be removed from a jury.

(c) Quantum of Punitive Damages

Of course, *Whiten v. Pilot Insurance*[62] has set out the principles respecting how punitive damages should be claimed, how they should be assessed and how any jury hearing the case should be charged. On these points, the court ruled:

- The facts said to justify punitive damages should be pleaded with some particularity in the plaintiff's Statement of Claim ("boilerplate" allegations should be challenged and particulars demanded);
- Punitive damages are very much the exception rather than the rule and should be imposed only if there has been high-handed, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from ordinary standards of decent behaviour;
- Quantum of punitive damages should be governed by the principle of "proportionality" having regard to factors such as the harm caused, the degree of misconduct, the relative vulnerability of the parties and any profit gained by the defendant, and other fines or penalties that might have already been imposed;
- The purpose of the punitive damage award is not to compensate the plaintiff but rather to impose retribution, deterrence of others and to express the community's condemnation of the conduct;
- The punitive damages are awarded only where compensatory damages are insufficient to accomplish these objectives, and they should be in an amount no greater than necessary to rationally accomplish these purposes (noting that the damages are retained by the plaintiff as a "windfall" and noting also that moderate awards of punitive damages are generally sufficient);
- All of the above points should be conveyed to any jury by the trial judge and if counsel can agree on a "bracket" or range of an appropriate award, this information should also be given to the jury; and
- While deterrence is an important role for punitive damages, disclosure of a defendant's financial information (net worth) before liability is established may wrongly influence the court to find liability when none exists and pre-trial discovery of such matters would unnecessarily prolong the proceedings and prematurely switch the focus from compensation to the defendant's capacity to absorb punishment; if the court is concerned

[62] 2002 SCC 18

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that the claim for punitive damages may affect the fairness of the liability trial, separate proceedings on liability and quantum may be appropriate.

The $1 million award of punitive damages in the *Whiten* case remains the largest such award sustained in an insurance bad faith case in Canada. The court indicated that, while it would not itself have awarded punitive damages in that amount, the award was nevertheless "within the rational limits within which a jury must be allowed to operate." Some juries, however, have demonstrated an inclination to substantially increase such awards. In *Pereira and Mazza v. Hamilton Township Farmers Mutual Fire Insurance Co.*[63] the jury made punitive damage awards of $2 million and $500,000 respectively, although both were overturned on appeal as being excessive and unsupportable on the facts. A jury award of $750,000 was also overturned by the Ontario Court of Appeal in *Laplante v. Grenville Patron Mutual Fire Insurance Co.*[64] but jury awards of $350,000 and $100,000 respectively were unanimously upheld by the same court in *Plester v. Wawanesa Mutual Insurance Co.*[65]

All of the above cases involved property policies. It is interesting to note that, in comparison, the relatively few punitive damage awards which have been made against disability insurers have been in somewhat more modest amounts. The punitive damage award made by the B.C. Court of Appeal in the *Fidler* case, which was overturned by the Supreme Court of Canada, was $100,000. The award in *Asselstine v. Manulife*[66], which was upheld by the majority of the B.C. Court of Appeal, was $150,000 as was the jury award in *Astels v. Canada Life Assurance*[67].

Even where the courts of appeal have affirmed a substantial award of punitive damages in these cases, they have almost invariably noted that the award is at the high end of the permitted

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63 [2006] O.J. No. 1508 (Ont. CA)
64 [2002] O.J. No. 3588 (Ont. CA)
65 [2006] O.J. No. 2139 (Ont. CA); a $200,000 punitive damage award was also upheld by the Court of Appeal in *Khazzaka v. Commercial Union Assurance* [2002] O.J. No. 3110 (Ont. CA)
66 2005 BCCA 292
67 BCSC New Westminster Registry No. S-87491, September 2006. Note the Ontario Superior Court of Justice also awarded $200,000 punitive damages along with $75,000 aggravated damages in another disability benefits case, *Clarfield v. Crown Life Insurance,* (2000) 23 C.C.L.I. (3d) 266.

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spectrum and that they themselves would not likely have awarded as much. The *Whiten* case indicated a range for an appropriate award could be provided to a jury provided the parties consented. It remains to be seen whether, in order to reign in excessive jury awards (and to avoid quantum appeals), the law will develop so as to allow range of awards to be suggested to the jury even in the absence of the parties' consent.[68]

7. CLAIMS FOR MENTAL DISTRESS DAMAGES

In what is now the seminal case on the subject, the Supreme Court of Canada in *Fidler v. SunLife Assurance Co.*[69] has affirmed that damages for mental distress can be awarded in certain breach of contract cases, and that policies of disability insurance is one category of contract in which such awards may be warranted. The court affirmed an award of $20,000 under that heading. In the result, claims for such damages will now invariably be made (and probably frequently awarded) in all disability insurance litigation and perhaps other types of insurance coverage litigation too.

Ms. Fidler was a bank receptionist covered by a group LTD policy. She developed chronic fatigue syndrome and fibromyalgia and received LTD benefits for six years. Video surveillance at that time then detailed a number of activities which the insurer considered inconsistent with Ms. Fidler's inability to perform light or sedentary work. There was medical evidence that she was not yet capable of doing any work but the insurer relied on its own consultants and experts to maintain a denial of benefits. Shortly before the trial began, the insurer reversed its denial of coverage and paid Ms. Fidler all of the arrears plus interest. The trial and subsequent appeals therefore proceeded on the question of whether an award of damages for mental distress was appropriate and whether punitive damages were also warranted.

[68] In British Columbia there is a divergence of opinion on the propriety of such a direction. See *Foreman v. Foster* [2001] B.C.J. No. 94 (CA) and *Brisson v. Brisson* [2002] B.C.J. No. 1154 (CA).
[69] 2006 SCC 30

The court took pains to distinguish between 1) damages for mental distress arising out of a breach of contract and 2) "true aggravated damages." The latter are not awarded for breach of contract but rather rest on an accompanying but separate cause of action – usually in tort – for things like defamation, oppression, intentional infliction of mental distress, and the like. These latter damages, which are compensatory not punitive in nature, may theoretically be available in insurance coverage disputes but in practice would be exceedingly rare.

Much more common, however, will be claims for damages for mental distress as a consequence of the breach of contract itself. The court emphasized,

> "Not all mental distress associated with the breach of contract is compensable. In normal commercial contracts, the likelihood of a breach of contract causing mental distress is not ordinarily within the reasonable contemplation of the parties. It is not unusual that a breach of contract will leave the wronged party feeling frustrated or angry. The law does not award damages for such incidental frustration."[70]

However, the court also observed,

> "We conclude that damages for mental distress for breach of contract may, in appropriate cases, be awarded . . . the aim of compensatory damages is to restore the wronged party to the position he or she would have been in had the contract not been broken . . . the measure of these damages is, of course, subject to remoteness principles. There is no reason why this should not include damages for mental distress, where such damages were in the reasonable contemplation of the parties at the time the contract was made . . . The court must be satisfied:
>
> 1. that an object of the contract was to secure a psychological benefit that brings mental distress upon breach within the reasonable contemplation of the parties; and
>
> 2. that the degree of mental suffering caused by the breach was of a degree sufficient to warrant compensation.
>
> These questions require sensitivity to the particular facts of each case."[71]

Having established that damages for mental distress are indeed available in certain cases, the court then had to decide,

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[70] at para. 45
[71] paras. 44 and 47

> "whether an object of this disability insurance contract was to secure a psychological benefit that brought the prospect of mental distress upon breach within the reasonable contemplation of the parties at the time the contract was made? In our view it was. The bargain was that in return for the payment of premiums, the insurer would pay the plaintiff benefits in the case of disability. This is not a mere commercial contract. It is rather a contract for benefits that are both tangible, such as payments, and intangible, such as knowledge of income security in the event of disability. If disability occurs and the insurer does not pay when it ought to have done so in accordance with the terms of the policy, the insurer has breached this reasonable expectation of security . . . mental distress is an effect which parties to a disability insurance contract may reasonably contemplate may flow from a failure to pay the required benefits. The intangible benefit provided by such a contract is the prospect of continued financial security when a persons disability makes working, and therefore receiving an income, no longer possible. If benefits are unfairly denied, it may not be possible to meet ordinarily living expenses. This financial pressure on top of the loss of work and the existence of a disability, is likely to heighten an insured's anxiety and stress. Moreover, once disabled, an insured faces the difficulty of finding an economic substitute for the loss of income caused by the denial of benefits . . . People enter into disability insurance contracts to protect themselves from this very financial and emotional stress and insecurity. An unwarranted delay in receiving this protection can be extremely stressful. Ms. Fidler's damages for mental distress flow from SunLife's breach of contract."[72]

The award of mental distress damages in *Fidler* was $20,000. In *Asselstine v. Manulife*[73] the award of damage for mental distress was $35,000, an amount which was challenged but nonetheless upheld on appeal, with Mr. Justice Lowry observing,

> "Awards for mental distress have generally been between $10,000 and $20,000: *Warrington v. Great West Life Assurance Co.* (1996) 139 D.L.R. (4th) 18 (BCCA); *Eddie v. Unum Life Insurance Co. of America* (1999) 66 B.C.L.R. (3d) 1 (BCCA); *Evans v. Crown Life Insurance Co.* (1996) 25 B.C.L.R. (3d) 234 (BCSC); *Fidler v. SunLife Assurance Co. of Canada* 2004 BCCA 273 . . . I question whether this case warrants an award of aggravated damages that is 75 percent greater than awards of that kind in similar cases. The award should not be seen as an upward trend in such damages justifying increased awards. But that said, I do not consider the amount of $15,000 beyond what appears to be the upper end of awards of aggravated damages in cases of this kind to be so great that this court should interfere with what the judge who tried the case found to be appropriate compensation for Ms. Asselstine."[74] (*emphasis added)*

There have actually been cases outside B.C. where damages for mental distress have been in much more substantial amounts. In each of *Clarfield v. Crown Life Insurance*[75] and *Fowler v.*

[72] paras. 56-58
[73] 2005 BCCA 292
[74] paras. 18-20
[75] (2000) 23 C.C.L.I. (3d) 266 (Ont. SCJ)

Maritime Life Assurance Co.[76] the superior courts of Ontario and Newfoundland respectively each awarded "aggravated damages" of $75,000. In *Plester v. Wawanesa Mutual Insurance*[77],a property insurance case, the Ontario Court of Appeal reduced the jury's aggravated damages award from $175,000 to $50,000. In B.C., the highest such award is $35,000 which was the amount awarded in both *Asselstine* and also a subsequent jury case, *Astels v. Canada Life Assurance*[78]. Like punitive damages, this is an area where appropriate direction to the jury regarding the proper range of damages is warranted, whether with or without the consent of the parties.

It is an interesting question whether damages for mental distress should also be available for breaches (denials of coverage) in respect of contracts other than disability policies[79]. Many of the observations made in *Fidler* would be equally applicable to most other types of "consumer" (personal lines) insurance such as homeowners policies or auto policies. Indeed, in *Whiten v. Pilot Insurance*[80], although there was no award for mental distress damages, the Supreme Court of Canada characterized the homeowners policy in issue in that case as a "peace of mind contract" and factored that into the punitive damage assessment as follows,

> " . . . In most commercial situations, particularly where the cause of action is contractual, . . . most participants enter the marketplace knowing it is fueled by the aggressive pursuit of self-interest. Here, on the other hand, we are dealing with a homeowners' "peace of mind" contract . . .
>
> Insurance contracts . . . are sold in the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim. Deterrence is required. The obligation of good faith dealing means the [insured's] peace of mind should have been [the insurer's] objective, and her vulnerability ought not to have been aggravated as a negotiating tactic. It is this relationship of reliance and vulnerability that was outrageously exploited by [the insurer] in this case. The jury, it appears, decided a powerful message of retribution, deterrence and denunciation had to be sent to the [insurer] and they sent it."

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[76] (2002) N.J. No. 217 (Nfld. SC)
[77] [2006] O.J. No. 2139 (Ont. CA)
[78] BCSC New Westminster Registry No. S-87491, September 2006
[79] As noted above, the Ont. CA made a $50,000 award in *Plester*, a property insurance case, but this pre-dated the *Fidler* analysis.
[80] 2002 SCC 18

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There are no discernible principles in the case law to date respecting how to assess quantum of mental distress damages in breach of insurance contract cases. It is not clear why *Clarfield* warranted $75,000 whereas *Asselstine* was less than 50 percent of that amount and *Fidler* only 25 percent. It is reasonable to assume, however, particularly in those cases where the denial of coverage is not so egregious as to warrant punitive damages, there will probably be an upward trend in the amount of such awards in the future.

8. IS BAD FAITH CLAIMS HANDLING A TORT?

Both the *Whiten* and *Fidler* cases were argued (and decided) in contract and based on breaches of express or implied terms in that contract. Neither case was called upon to decide whether bad faith claims handling is any species of tort (although *Fidler* did allude to the possibility of corollary torts providing a basis for an award of aggravated damages in appropriate cases).

In the United States, most jurisdictions treat bad faith claims as a tort in addition to a breach of contract claim. While there is some commentary to the same effect sprinkled in the Canadian case law, it is an approach that has not gained widespread acceptance.

In the *Asselstine*[81] case it will be recalled that the plaintiff sued both her employer (UBC) and the independent disability plan administrator (Manulife). The claim was treated as a breach of contract claim and tort was not argued. Ultimately, the Court of Appeal dismissed the case against the claims administrator on the basis that there was no contract between it and the claimant and therefore no basis for any cause of action. (Note that similar joint liability was also imposed upon both the insurer and the independent adjuster by the trial court in *Kogan v. Chubb Insurance*[82].)

[81] 2005 BCCA 292
[82] (2001) 27 C.C.L.I. (3d) 16 (Ont. SCJ)

The availability of a cause of action in tort raises the possibility of extending the claim beyond the contracting parties and would result in suits against the claims personnel employed by the insurance company, independent adjusters, investigators, legal counsel, and other "agents" of the insurer.

But what exactly might be the tort? Negligence?[83] Wrongful interference with contractual relations or economic interests?[84] A new tort altogether?

Thus far, there is only one appeal court which has addressed this issue head on, namely the New Brunswick Court of Appeal in *Walsh v. Nicholls and CGU Insurance Company*[85]. In that case the plaintiff sued not only the auto insurer for no-fault accident benefits under the standard auto policy but also alleged personal liability in tort against the employee-adjuster who had denied the claim. The allegations of fault included the usual "boilerplate" array, including failing to adequately investigate, failing to fairly interpret the policy, treating the insured as an adversary, and so on. The trial court granted the insurer's motion to strike the action against the employee on the basis that there was no cause of action against her but the Court of Appeal reversed that ruling and restored the claim. Speaking for the unanimous court, Chief Justice Drapeau ruled,

- "It is settled law, at least in this Province, that insurers owe a duty of good faith and fair dealing to their insured, the breach of which may give rise to their liability in both contract and tort";
- "The decisions of our court recognizing the insurer's liability in tort for breach of the duty of good faith and fair dealing are in synch with Australian and American cases on point";
- "In this Province, lack of privity with the insured may not be a sound basis for insulating adjusters against tort liability for their bad faith and unfair dealing";
- "Extending the tort of bad faith and unfair dealing to adjusters would certainly not be heretical . . . nor would it amount to a radical shift in the law";

[83] Does it meet the "two-step" criteria of *Kamloops v. Nielson* [1984] S.C.J. No. 29, as refined in *Cooper v. Hobart* [2001] S.C.J. No. 76 and *Childs v. Desormeaux* [2006] S.C.J. No. 18?
[84] Would the *Said v. Butt* exception apply?
[85] 2004 NBCA 59

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- However, "Justice can be achieved without extending the tort of bad faith and unfair dealing to adjusters; the tort of intentional procurement of breach of contract strikes me as being up to the task";

- "In its modern formulation, the tort of intentional procurement of breach of contract certainly appears to be an apt means of redress in any case where, as here, the insured alleges an unjustified denial of benefits due to adjuster bad faith. Of course, should experience show that assessment to be inaccurate, this court would not hesitate to revisit the issue. It might then consider extending the reach of the tort of bad faith and unfair dealing to adjusters if that option commended itself as a suitable vehicle to ensure proper respect for the time-honoured principle that 'a violation of legal right committed knowingly is a cause of action.'"

In the result, the court restored the tort claim against the adjuster but it also "bifurcated" the action i.e. ordered that the issue of coverage under the policy be tried first with all of the other issues (including the tort claim and related discovery) be dealt with at a later date.

In coming to its decision, the New Brunswick Court of Appeal considered, with some deference, the article written by David Debenham, referred to earlier in this paper[86] which advocated "treating bad faith as an independent cause of action, separate from any other cause of action in tort, including the tort of inducing breach of contract." In his view, this would be "attractive to insureds seeking adequate redress" by virtue of the "benefits of suing adjusters, claims managers, investigators and other agents of the insurer personally as part of a claim for bad faith denial of insurance benefits."[87]

In Ontario, there has been judicial disagreement at the trial court level respecting the availability of a cause of action against employees, adjusters or other agents of the insurer.[88] However, the most recent trend has been to strike out such claims and even characterize them as an abuse of

[86] "Coming Armed with Spiers", supra, Footnote 33
[87] supra, at pp. 7-8
[88] see *Spiers v. Zurich Insurance Co.* (2001) 45 O.R. (3d) 726 (SCJ), leave to appeal to Div. Ct. refused [1999] O.J. No. 4912; *Future Health Inc. v. Allstate Insurance* (2000) 29 C.C.L.I. (3d) 59 (Ont. SCJ); *Bush v. Continental Insurance Co.* [2001] O.J. No. 3315 (SCJ); *Burke v. Buss* [2002] O.J. No. 2938 (SCJ); *Standard Life Assurance v. Elliott* [2007] O.J. No. 2031 recently followed in B.C. in *Pearlman v. Manufacturers Life Insurance Co.* 2007 BCSC 1440

process brought solely for procedural advantage warranting an award of costs not only against the insured but also against the insured's solicitor[89].

Of course if the obligation of good faith is indeed a "two-way street", one can see the potential for spiraling into a whirlpool of cross-claims and procedural confusion, especially if one adopts the approach suggested by Buller:

> "However, if insureds may personally sue individual insurance adjusters for the tort of breach of duty of good faith, then, by the reciprocity inherent in that duty, individual insurance adjusters will likely have the capacity to sue individual insureds who have behaved badly towards them for breach of the duty of good faith. Since such breaches can found claims for aggravated damages as well as punitive damages, and since individual insurance adjusters can and do suffer from mental distress as a result of an insured's actions, individual insurance adjusters would be able to match the insured's claim for aggravated damages with a reverse bad-faith claim for aggravated damages against the insured. The courts will have to bear in mind that sauce for the goose is sauce for the gander."[90]

Thus far, the courts are tending to limit bad faith claims to the implied terms of, and the actual parties to, the insurance contract. The remedies endorsed by the Supreme Court of Canada in *Whiten* and *Fidler* would seem to indicate that is a sufficient approach. It remains to be seen whether insureds and their counsel will seek to expand the horizon by advancing claims in tort.

9. CONCLUSION

By recognizing the potential for recovery of substantial punitive damages as well as significant awards for mental distress, the *Whiten* and *Fidler* cases have effectively opened the floodgates to such claims. It remains to be seen if liability for bad faith claims handling can also be properly imposed upon employees, independent adjusters, investigators and other agents of the insurer, whether under the rubric of tort or otherwise. One can anticipate that insurers will try very hard to restrict punitive damage awards to those truly exceptional cases where they are warranted and that it may become more frequent to allege "reverse bad faith" and seek costs sanctions against

[89] *Standard Life Assurance v. Elliott*, supra
[90] Buller, Op. Cit., at pp. 171-2

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insureds (and their counsel) who pursue such claims in the absence of any supporting evidence and simply as litigation tactics.

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Decisions in *Whiten* and *Fidler*
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