CANADIAN DEFENCE LAWYERS
SEMINAR

FIRST PARTY CASES : TRIAL TACTICS

by

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TESTIMONY PREPARATION

It is exceptionally important to prepare insurance company representatives carefully prior to testimony.

We are astounded that many defence counsel will prepare their clients for Examinations for Discovery on the “morning of”.

One of the key messages we wish to relate in this presentation and this paper is the need for thorough preparation.

Typically insurance representatives do not want to testify at Discovery or at trial.

If there are significant issues, then one should consider a multi day preparation that would include general tips, a review of the issues in litigation, followed by a mock examination and cross examination and then a “unpackaging” where a review is done of the questions and the answers.

Legal counsel have a strong ethical obligation here not to coach witnesses, but it is certainly fair “and incumbent upon counsel” to go over in great detail the questions and answers that likely will come up.

One routinely sees insurance company representatives testify who seem to be ill prepared.

The major difference of course between Discoveries and trial is at the latter. We are trying to convince the Trier of fact that our position is correct. At Discoveries, of course, we are simply trying to communicate the facts in an accurate and honest manner.

Long before any trial attendance (and well before Discoveries) there must be a very critical look at the file to make sure that the claims representatives are fully comfortable testifying under oath as to what transpired on the file to support the denial of whatever benefit is in issue.

Extensive review and preparation of the file is probably the most important.

Individuals who are fully comfortable with the file material will make the most persuasive witnesses.

There is nothing wrong with a claims representative creating simple notes to cue responses depending on the area in question.

For example, if there is question on Income Replacement termination, it is fine for an insurance company witness to have on a piece of paper (that they created) a list of the documents that the insurance company used to support its position.

The key to any such documents is that the defence is fully comfortable in showing those to the Judge, the jury and the opposition.

Any documents that have been created to aid testimony are “fair game” for questioning counsel to see.

Many of the files that we handle now are extremely large and we think written “crib notes” are fine to use.

These must be created and drafted by the witness however as it would look very bad in front of a jury if they were created by legal counsel.

In terms of witness appearance, first impressions are heavily affected by non verbal cues.

Testifying witnesses must have the “courage of their convictions” and be prepared to look at the jury directly in the eye and clearly and concisely state why a benefit is not being paid.

A witness’ “physicality” can project a favourable or an unfavourable impression at trial.

Generally speaking, jurors will be attracted to friendlier receptive and approachable looking witnesses as opposed to those who are cross or suspicious looking. Eye contact is always important.

Taking a witness to an actual Court Room is well recommended if that individual has not testified before.

In bad faith cases, it is very important that the witness have a clear understanding about what the duty of good faith and fair dealing entails.

Although it may be a legal question, a defence insurance counsel should be fully prepared to allow the insurance representative to answer questions about the duty of good faith since this duty is strongly associated with claims decision making.

Some insurance representatives, for example, may be tempted to equate the duty of good faith to a customer service type concept ("putting the customer first always").

Needless to say that is not at all the duty of good faith. If insurance companies always "put their customers first" then they could never deny a benefit.

It is quite important that the insurance company representatives understand that the duty of good faith involves concepts of fair and balanced treatment and considering all of the evidence before making a decision.

Some insurance company representatives might be tempted to state that they take independent medicals (for example) because they have the right under the Statutory Accident Benefits Schedule.

Those witnesses would be better advised to show some type of disparity of the evidence in the file that raise the question in the mind of the insurance company thereby necessitating the intervention of an independent medical.

The same goes for surveillance.

Other questions that should be discussed prior to testimony include the following:

- "Did you disbelieve the insured or doubt him or her?"

This is a tricky question because an insurance company representative might not want to state that they thought their insured was lying, but on the other hand, if this question is answered in the negative, then it makes it look as though the insurance company was suspicious and did not believe its own insured.

One possible answer would be to point out the adjusters' roles to verify and validate claims, assemble evidence, weigh it and make a decision.

- "Do you accept that the Plaintiff was in pain, he was injured and he needs treatment?"

Again the company representative must have a clear understanding as to why the benefits that are in dispute are not being paid (the SABS require impairment not pain).

The witness must be prepared carefully so as to not look too harsh and to focus on the issues before the Court.

Another question that can be tricky is:

- "Can pain disable claimants?"

The witness must feel very comfortable in pointing out that in Statutory Accident Benefits cases, the SABS require impairment not pain as a trigger to pay the benefits.

Many times insurance files are handled by a number of different adjusters.

It is very important that the adjuster testifying feels comfortable with all the claims decisions that were made on the file and if that person does not feel comfortable, that should be discussed and reviewed well in advance of the trial.

It would be very unfortunate indeed if an insurance company representative admitted on the witness stand that a previous adjuster had made a significant error.

On this point, it is also important to note that no claims file is perfect.

Small errors can easily be admitted without looking argumentative.

If the errors are more significant, then the insurance company has to look at whether it should be trying this particular case.

It is very important that the insurance representatives understand the importance of being honest and straightforward in their testimony without exception and that legal counsel who are preparing those witnesses are only there to discuss the evidence that might come up and we cannot coach the witnesses.

The purpose of the commentary in this paper is to encourage defence counsel to thoroughly review these issues so that there are no surprises at trial.

SAFE HARBOURS, ANCHORS

On most files (even very large document heavy files) there are usually six to twelve key documents whose interpretation by the Court will lead to the trial result.

For example, the insurance company may have a Section 42 Independent Medical Report that is counteracted by a Plaintiff Medical/Legal Report. Even on very large sized files there are often a limited number of these types of critical

reports. Most times insurance company denials on First Party cases are based upon such critical reports.

An effective technique in testimony preparation is to isolate those key anchor documents or “safe harbours” for the witness who is testifying.

These documents (such as independent medicals, surveillance reports, and rehab reports) usually need to be accepted if the insurance company position will be upheld at trial.

If the witness is pressed on cross examination he or she should recall what the anchor documents or safe harbours are on the file to harken back to them.

For example, if the witness is being cross examined on contrary medical evidence, contrary medical tests, contrary evidence indicating disability, the witness can refer back to the safe harbour where the anchor document that is used to terminate the benefits and simply point out to the Court that that is the basis of the company’s position.

The witness should feel comfortable while clearly referring to those documents and looking at the cross examiner directly in the eyes with the courage of all of his or hers convictions.

If the witness does not have that courage then another witness needs to be found or perhaps the case should not be before a jury.

The reference to safe harbours makes testifying witnesses much more comfortable.

Although the file may be comprised of many bankers’ boxes, the concept of the “safe harbour” seems to make the file smaller and easier to manage.

WEIGHING OF MEDICAL EVIDENCE

One very tricky area for insurance company representatives is the weighing of medical evidence in an injury case.

The concept of the duty of good faith incorporates giving the benefit of the doubt to the insured.

If there are two diametrically opposed medical reports, what will the insurance company representative say at trial as to why the insurance company preferred the defence doctor to the plaintiff doctor?

Here some work needs to be done in preparation.

Looking for differences in the physical examinations, medical records available to each doctor, under the qualifications of each doctor, the timing of the reports and other similar issues is vital.

Many plaintiff lawyers will believe that an insurance company will simply accept the defence medical physician almost always over the plaintiff medical report. It is very important that that message not be inadvertently transmitted in a trial.

During the trial, the insurance company representative should feel free to take as much time as they want to review the file if any particular documents are being referred to.

Cross examining counsel often will want to move quickly from subject to subject and it is very important that the insurance representative take his or her time to review the documents and answer in a thoughtful and careful manner even if a recess is required.

COMPANY MOTTOS

Insurance company representatives should discuss with their counsel how they would respond as the cross examining counsel concludes with an attack based on the insurance company motto.

The various insurance company mottos in this paper will not be set out, but we all know the most popular ones.

This type of cross examination typically would be a “cheap trick”, but one would not want the insurance company representative surprised at trial on this.

CLOSING COMMENTS- Preparation of Witnesses

Extensive preparation is most important with regard to preparation of a witness for trial, but there are a few tricky areas as we have tried to set out here that can be discussed.

The more thorough the preparation, the more comfortable a witness will appear and the greater likelihood of a defence verdict.

CASES- Insurance Company Trial Testimony

The importance of the preparation of insurance adjusters for trial and the claims handling of insurance adjusters is outlined in the two important cases that have been summarized and they are as follows:

1. *Clarfield v. Crown Life Insurance Co. 50 O.R. (3d) 696 (Ontario Superior Court of Justice)*
2. *Whiten v. Pilot Insurance Company 2002 S.C.C. 18 (Supreme Court of Canada)*

Clarfield v. Crown Life Insurance Co. 50 O.R. (3d) 696 (Ontario Superior Court of Justice)

Facts

- In 1992, the Plaintiff Clarfield was earning an income of over $200,000.00 per year and purchased income replacement plus disability insurance policy from Crown Life Insurance.

- In September 1996, Clarfield started a business that failed and became depressed.

- In September 1997, the Plaintiff completed a claim for disability insurance benefits.

- Clarfield had no income for the year ended September 19, 1997.

- His family physician completed a Statement of Disability wherein she described him as being incapable of working and diagnosed him as suffering from a major affective disorder.

- The doctor indicated the illness began in February 1997 and Clarfield was incapacitated in July 1997.

- In October 1997, the psychiatrist stated that he had high anxiety, disassociation, and restricted working at that time.

- In November 1997, the Plaintiff elected to have his prior average monthly income calculated according to his two best consecutive years in the previous five years as entitled under the policy.

- In December 1997, a psychiatrist provided a full medical report indicating that the Plaintiff had entered into a training program in financial planning.

- Crown Life delayed consideration of Clarfield's claim and in January 1998 denied the claim on the grounds that he was not totally disabled and he did not earn income in the months before his claim.

- This letter enclosed a cheque of $4,800.00 for the period ending January 24, 1998. It explained that the Plaintiff was asked to sign the bottom of the letter indicating his agreement with the terms. There was no mention of his residual disability benefits.

- The policy allowed an insured to be employed for the final three years of the previous five.

- Crown Life had a general policy not to pay disability benefits to claimants who had no income at the time of their disability, however they had paid Clarfield some benefits but warned him that he might have to pay some benefits back.

- After the claim was denied Clarfield put his home up for sale and was anxious to return to work.

- This reimbursement, stated the Plaintiff, was paid on an extra-contractual basis and the Defendant reminded the Plaintiff that he might have to pay those benefits back.

- Clarfield's doctor told him to do less stressful work.

- In February 1998, he obtained work with Nesbit Burns and commenced a six month training course.

- The Plaintiff brought an action on the policy and claimed for aggravated and exemplary damages. The Defendant relied on two things, first the psychiatrist GAF scores in concluding that the Plaintiff was not disabled, second they focused on the fact that the Plaintiff was earning no income when he made the claim and that the claim, if allowed was likely to be a large one.

Issues

- Was Clarfield entitled to aggravated and punitive damages based upon the conduct of Crown Life Insurance.

Held

- Clarfield was awarded benefits under the policy and aggravated damages of $75,000.00 and punitive damages of $200,000.00.

- It was found that Clarfield was totally disabled within the meaning of the policy from August 1997 until the commencement of his training program and that he continued to be continually disabled at the time of the trial based upon the medical evidence.

Commentary

- Justice Juriansz stated at paragraph 22:

> The thorough cross-examinations of Crown Life's staff made it abundantly apparent to me that they did not entertain the prospect that Mr. Clarfield might have a claim for residual disability benefits because he was earning no income in the months preceding his disability claim.

- This seemed to coincide with the letter dated October 1, 1997 which Crown Life sent to Mr. Clarfield which made no mention of residual benefits.

- The claims adjudicator seemed quite unaware that under the policy an insured could be unemployed for the final three years of the previous five years and still have a prior average monthly income that should be used to determine an entitlement to residual benefits.

- The judge highlights some of the claims handling at paragraph 40 which states:

> The claims adjudicator and her supervisor were not medically trained. The supervisor said, in discovery testimony read in at trial, that the claims adjudicator may not even have had the in-house course on medical terminology at the time she processed this claim. It seems to me that they simply and unduly focused on the GAF score, without an appreciation of the nature and duration of the illness and the fluctuating course of recovery from it. They did not seek to understand the doctors' reports as a whole. For example, while Dr. Birnbaum's report dated December 22, 1997 indicated a GAF score of "80," a good score, it also indicated significant findings on three of the other four axes."

- Paragraph 41 stated "The claims adjudicator relied strongly on the statement in Dr. Birnbaum's report dated March 9, 1998, that Mr. Clarfield's "current mental status is recovered and normal with a GAF score of 90." Ms. Walker testified that Dr. Birnbaum, in a telephone conversation on April 20, 1998, said Mr. Clarfield was "totally recovered". Dr. Birnbaum did not recall the phone call, but explained that "total recovery" from a major psychiatric illness does not mean one is ready to return to work. He compared Mr. Clarfield's recovery from his disassociated state to a patient who has come out of a coma. In both cases they have recovered but require convalescence, and are not ready to return to work.

- Justice Juriansz commented on the claims handling with respect to medical reports at paragraph 42 when it was stated,

> It seems to me that if an insurer wishes to focus on one aspect of medical reports in assessing claims, that aspect should be the doctors' opinion as to whether the insured is medically capable of returning to work. If the defendant is skeptical of the insured's doctor's opinion, then it may have its own medical experts review the medical files and examine the insured.

- Paragraph 63 stated:

> I have indicated my finding that the medical information was clear that Mr. Clarfield was totally disabled at the end of the elimination period and at the time Crown Life refused his claim on January 9, 1998. As well, Crown Life's failure even to consider Mr. Clarfield's entitlement to residual disability benefits was not based on a reasonable interpretation of its obligations under the policy. There was no evidence to support Mr. Clarfield's counsel's argument that Crown Life would not have been as skeptical of a claim for residual benefits for a physical illness, such as cancer or heart disease, as it was of this claim based on a mental disability. However, this does not detract from the fact it processed the claim with complete disregard for the policy's express provisions.

- In looking at claims handling, it was noted at paragraph 68, Ms. Walker agreed that she overrode the claim adjudicator's recommendation that benefits be paid as she expected that Clarfield could return to work shortly. This was a handwritten response that was dated December 12, 1997 which makes it clear that as of the date of the note, she was satisfied that Clarfield could not work which was after the end of the elimination period. Yet, she instructed the claims adjudicator to "only issue an extra-contractual payment right now".

- The judge had problems with the January 9, 1998 letter which stated that medically there were no objective findings to support total disability. The judge felt that it was unfair in several respects. First, the statement that the medical evidence was not accurate because as of that date the insurer had no medical certification that the insured was able to return to work. Second, when Clarfield was asked to indicate by his signature not merely that he acknowledged the insurer's position but that he agreed with the terms of the letter, which stated that there was no entitlement to benefits and there was no medical to support total disability. This was done despite the fact that there was no evidence of that that Crown Life had.

- Counsel for Crown Life attempted to create distance between the claims adjudicator and her supervisor on the one side and the company on the other by squaring them as "fairly unsophisticated ladies from Regina". The judge did not buy this and stated at paragraph 72 that "However, I find there confidence that they were acting in accordance with the company's approach was warranted. In any event, the company is responsible for the decisions made by the staff it hires, trains and supervises."

Damages

- Aggravated damages were paid as Mr. Clarfield suffered increased anxiety, stress, and financial pressure, both from the rejection of claim and from the delay in dealing with it. Mr. Clarfield while in dire need of money was afraid to cash cheques because he would not be able to afford to pay the money back if reimbursement was demanded and the January 8, 1998 letter confused him and he suffered great anxiety over whether he should sign it. He needed the money but he did not cash the payments until the

insurance broker assured him that Crown Life would not seek reimbursement.

- Looking at punitive damages, the judge outlined paragraph 94-100:

Insurer's Conduct

It is an insurer's duty to act in good faith in its handling of its insured's claim. The claims handling of an insured's file with disregard for acting in good faith can contribute aggravated damages. This was shown in paragraphs 94 to 97 where it stated:

> [94] All the matters which I discussed above in concluding that the insurer breached its duty to act in good faith, and in the assessment of aggravated damages, are relevant here. The defendant did not make a decision on the insured's claim in a timely fashion, even though the medical information on file clearly indicated he was totally disabled. The insurer did not arrive at its decision in a balanced and reasonable manner. The memos between Ms. Folk and Ms. Walker indicate they were unduly concerned about getting Mr. Clarfield "off-claim," should they recognize his claim.
>
> **[95] The defendant not only failed to consider a claim for residual benefits, but failed to inform the insured of its decision or of its reasoning for the decision. I find this significant because an insured who is not given notice of an adverse decision cannot contest it. If Crown Life had advised Mr. Clarfield that it had decided he was not entitled to residual benefits, he may have been prompted to look at his policy or consult a lawyer. An insured who is not advised of the reasoning for a decision cannot mount an argument against it. Whether by design or not, Crown Life's conduct had the effect of concealing from Mr. Clarfield its interpretation and application of the Prior Average Monthly Income provision of the policy.**
>
> [96] I agree with Mr. Clarfield's counsel that Crown Life's mode of making payments "extra-contractually," requiring the insured agree to the terms of its letter as a condition for receiving those payments, and reminding him it could seek reimbursement when he raised questions about its decision, constituted a "condemnable form of negotiating with a disabled person." Counsel argued that Crown Life used the payments as a "bargaining chip" to intimidate Mr. Clarfield from advancing his claim. There was no misunderstanding, as Ms. Walker admitted that Mr. Clarfield was asked to sign away rights. It is reprehensible for an insurer to insist that the financially vulnerable insured compromise his claim under the policy as a condition of receiving the benefits to which he was entitled.
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> [97] Furthermore, there was evidence that can only lead to the conclusion that the insurer's deleterious conduct is not confined to this case.

Judicial Commentary on the Testimony of Claims Adjuster

The preparation of an insurance adjuster for testimony at trial is vital and will have an impact on whether punitive and aggravated damages are awarded to an insured.

Justice Juriansz commented on the adjusters' testimony at paragraphs 98 through 100.

[98] The claims adjudicator said she could not recall "ever, ever paying any benefit to someone who wasn't working at the time and became disabled because the whole intent is of this policy is income replacement for your work if you can't work." [sic] She was evasive and equivocating when cross-examined at length as to whether there were any company instructions or directives that said there could be no entitlement to residual disability benefits if the claimant had not been earning income in the six months or 12 months before becoming disabled. She sidestepped several versions of this question. One version made the compound inquiry whether that was the philosophy of the company and whether there was something in writing that said that. She replied "nothing in writing, no." I understood her to affirm that indeed it was the philosophy of the company. She finally did say that there was no internal memorandum directed to her as a claims adjudicator stating Crown Life would not pay residual disability benefits in such circumstances. She was adamant that it mattered if claimants do not earn income in the months before becoming disabled. She said she was not the only one to whom this mattered. She said her supervisor felt the same way. She was so confident of her understanding that she testified that it was pointless to calculate the insured's Prior Average Monthly Income because he was not earning income at the time he became disabled.

[99] The supervisor, in her long and torturous cross-examination, was extremely hesitant and unforthcoming. She often remained silent for long periods while she pondered her answers to questions. Her view was the same as the claims adjudicator's, and it was entrenched and confident. The viewpoint of the claims adjudicator and the Senior Supervisor of Individual Claims must be attributed to the company. If the testimony of the claims adjudicator is to be taken literally, the defendant's conduct is as frequent as the submission of any claim of an insured who was not earning income at the time he or she became disabled.

[100] The supervisor said claims adjudicators are trained to obtain signatures of the insured as a condition of receiving extra-contractual payments. She said there was a written memorandum from the company's legal department that required that this be done. She said the claims adjudicator had made a mistake by not insisting on a signature for the payment made on December 12, 1997. She described obtaining signatures as a "formal procedure" based on precedents in the claims department. I took this to mean that the format of such letters in other cases is much like the one in this case, which required the insurer to sign away rights.

Whiten v. Pilot Insurance Company 2002 S.C.C. 18 (Supreme Court of Canada)

Facts

- Daphne Whiten and her husband discovered a fire in their house in January 1994.

- Her husband gave slippers to his daughter and suffered frost bite to his feet as it was -18 degrees Celsius outside.

- The fire destroyed their home.

- Pilot Insurance made a single payment of $5,000.00 for living expenses and covered the rent of a cottage for $650.00 per month for a few months and then cut them off without telling the family.

- The origin of the fire was never discovered but everyone who investigated the fire in the six months after it occurred concluded it was accidental.

- The first persons to investigate the fire were the fire chief and the fire fighters called to the scene.

- The fire chief thought, and was eventually shown to be correct, that the fire was caused at a single point of origin by a malfunctioning kerosene heater in the porch of the addition to their house.

- An experienced independent insurance adjuster, Derek Francis, was brought in to investigate the loss and he interviewed the Whitens who admitted that they were unemployed and had financial difficulties.

- Francis interviewed the fire fighters about the fire’s speed which is a key indicator of arson.

- Both the physical evidence and the Whiten’s conduct satisfied Francis that the fire was accidental and on February 3, 1994 he reported to Pilot “there is no suspicion of arson on behalf of the insured’s or any members of their family".

- Francis made further investigations in which he determined the Whiten's mortgage payments were in arrears and refinancing was being arranged.

- It appears that the senior claims examiner, Chris Porter, was already moving towards the conclusion that the claim should be disputed based on suspicions of the family's financial problems.

- In a letter dated February 25, 1994, Francis wrote to Pilot Insurance:

> As outlined in my 2nd report with the physical evidence we have and the fact that the insured was attempting to arrange financing through another source and pay off the existing mortgage, there is little or no base [sic] to deny this claim. I certainly agree with your train of thought and if we did not have the physical evidence and the information from the insured's solicitor that he was arranging financing for the Whitens, then my recommendations would certainly be opposite to what they are today. Unfortunately we must deal with the facts on hand and proceed with the adjustment accordingly in my opinion. [Emphasis added.] (Para 7)

- Pilot did not agree that there was little or no basis to deny this claim although at this stage they had no evidence to support a defence of arson. They refused to accept Francis' recommendations and decided to deny the claim.

- Pilot did not tell Francis why they would not pay the claim and Francis in turn did not advise the Whitens of what was happening.

- It appears that Pilot requested the Insurance Crime Prevention Bureau to review the analysis of Pilot's investigator.

- On February 25, 1994 the Bureau reported that "we wouldn't have a leg to stand on as far as declining the claim".

- In March 1994, Pilot's head office instructed Francis to tell the landlord of the cottage that the appellant was renting that they were no longer going to pay the rent. He communicated this to the landlord but never told the appellant.

- It also appears that Francis, on April 28, 1994, stated that the Whitens came unannounced and unexpected to scene of the fire to sort through debris to see if they could salvage anything which was out of character for someone who might be involved in a suspicious fire.

- Pilot also retained an engineering expert, Hugh Carter. In his initial report of January 28, 1994 he concluded that the fire was accidental. He gave two further reports in which he stated the same opinion.

- Carter then received a letter dated May 4, 1994 from Pilot's counsel, Donald Crabbe which adverted to the arson theory:

> One wonders whether the Whitens, even if they did not set the fire, sat back and allowed it to achieve a level that was convenient to them.
>
> We need to be on top of this matter and to do it quickly. The other side has retained a lawyer and they are making noises of bad faith. The matter has to be revisited in its entirety, stripped down to the bare facts and rebuilt. (Para 13)

- The Statement of Claim was issued on May 27, 1994.

- On June 7, 1994, after a further site investigation, Carter did meet with Donald Crabbe, and after the meeting he reclassified the fire as "suspicious, possibly incendiary".

- He stated at paragraph 15 that Pilot now concedes that Crabbe likely influenced Carter to influence his opinion.

- It appears that there was a reference in one letter to two previous fires, one that occurred at a cottage owned by the Whiten's son-in-law and rented out to a Mrs. Titro and one in another house previously occupied by Mrs. Titro. There was no apparent connection to the appellant or her family.

- At the Court of Appeal, Pilot conceded the evidence about the two fires was irrelevant and inadmissible.

- It appears that on June 9, 1994 a letter written by Pilot raised concerns about the Whitens hiring competent counsel. It was pointed out as opinion by the Supreme Court Justices that “the jury must have asked itself why an insurer dealing in good faith with a policy holder would express “concern” to its own lawyer that she had hired competent counsel”.

- With respect to Pilot and counsel’s conduct comments were made in paragraph 21 and 22:

> **21** Thereafter, Pilot retained a forensic engineer, a fire investigator and a firefighter. Pilot did not disclose Francis's exculpatory reports to any of these individuals, but instead, through Donald Crabbe, furnished them with information about the speed of the fire that the trial judge characterized as misleading if not inaccurate. The firefighter insisted that the fire was likely accidental but the other two experts gave opinions that provided some support for an arson defence. One of them, Richard Kooren, based his opinion on the existence of signs of a fire accelerant. Crabbe wrote on May 11, 1995:
>
> Aside from the burn pattern under the washer, Richard Kooren sees liquid accelerant burn patterns on the annex floor which are not innocent. However, these observations are not made by [Pilot's initial expert] Hugh Carter.
>
> Pilot also conceded at the Court of Appeal that these inculpatory opinions were influenced by Crabbe.
>
> **22** The trial judge commented unfavourably about Crabbe's role in this litigation. He felt that his "enthusiasm for his client's case appears to have caused him to exceed the permissible limits which ought to confine a lawyer in the preparation of witnesses". At the Court of Appeal and in this Court, Pilot conceded that these comments were justified, but added:
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> ... Pilot, not its counsel, made the decision to deny the claim and Pilot was fully aware, because it was a recipient of the letters, of counsel's "enthusiasm". Pilot recognizes that it bears the responsibility for what occurred.

- The jury awarded compensatory damages and $1,000,000.00 in punitive damages. A majority Court of Appeal allowed the appeal in part and reduced punitive damages awarded to $100,000.00

Issue

- Were the Whitens entitled to punitive damages?

- Should the jury award of $1,000,000.00 in punitive damages be restored or should any award of punitive damages be dismissed?

Held

- The Supreme Court of Canada judgment restored the $1,000,000.00 jury verdict.

Commentary

- The claims handling in the matter and the steps that were taken by the adjuster and the retention of experts was focused on by the judges at all levels in this matter.

- It was found that the denial of the claim was forced onto the insured's in an attempt to try to make an unfair settlement.

- Conduct was planned, deliberate and continued for over two years while the Whiten's financial situation became increasingly desperate.

- Whiten upheld the test in *Hill v. Church of Scientology of Toronto [1995] 2 S.C.R. 130 at para. 190* which stated that the test thus limits the award to misconduct that represents a marked departure from ordinary standards of decent behaviour.

- In paragraph 94 Justice Binnie appears to summarize where punitive damages against insurers can be awarded.

- With respect to the investigation to the claim Justice Binnie stated at paragraph 102:

> The respondent claims that 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. I agree with these points. The problem here is that

> Pilot embarked on a "train of thought" as early as February 25, 1994 (see para. 7 above) that led to the arson trial, with nothing to go on except the fact that its policy holder had money problems.

- **Justice Binnie focused on the "train of thought" that was mentioned in the letter to Pilot from Derek Francis located at paragraph 103 and noted that there was a difference between due diligence and wilful tunnel vision. Justice Binnie stated that an award of punitive damages, leaving aside the issue of quantum was a rational response on the jury's part to the evidence.**

- Justice Binnie stated that the more reprehensible the conduct, the higher the rational limits to the potential award.

- The level of blameworthiness may be influenced by many factors but some of the factors noted in the selection of Canadian cases include:

    1. Whether the misconduct was planned and deliberate.
    2. The intent and motive of the Defendant.
    3. Whether the Defendant persisted in outrageous conduct over a lengthy period of time.
    4. Whether the Defendant concealed or attempted to cover up its misconduct.
    5. The Defendant's awareness that what he or she was doing was wrong.
    6. Whether the Defendant profited from his misconduct.
    7. Whether the interest violated by the misconduct was known to be deeply personal to the Plaintiff or a thing that was irreplaceable.

- Justice Binnie stated at paragraph 82 that an independent actionable wrong is required but it can be found in breach of a distinct and separate contractual provision such as fiduciary obligation.

- At paragraph 73 it stated that when allocating punitive damages one must focus on the Defendant's misconduct not on the Plaintiff's loss.

- The contractual obligations that Pilot had were to pay the claim and Pilot was also under a distinct and separate obligation to pay or to deal with its policy holders in good faith.

- A breach of contractual duties of good faith was thus independent of and in addition to the breach or contractual duty to pay the loss.

- It was agreed by Justice Binnie that the jury, with the $1,000,000.00 verdict, decided a powerful message of denunciation, retribution and deterrence had to be sent to Pilot.

- The obligation of good faith dealings means the appellant's peace of mind should have been Pilot's objective and Whiten's vulnerability ought not to have been aggravated as a negotiating tactic. (Paragraph 129)

- The reasons for an award of punitive damages is outlined in the facts with the multiple reports sent to Pilot, stating that there was little or no basis to deny the claim, the fact that they did not follow the independent adjuster's advice and the Insurance Crime Prevention Bureau investigator who also stated that there was no claim.

- There is no doubt that an insurance company such as Pilot does have any obligation and right to investigate all claims however they have a duty to investigate claims in a fair and diligent matter.

Special Case : Preserving the Collateral Offset

There are two important recent cases that deal with preserving the accident benefits' insurer's collateral offset that merit some discussion in considering trial tactics

Cromwell v. Liberty Mutual Insurance Co. 89 O.R. (3d) 352 (Ontario Superior Court of Justice)

Facts

- This was a motion by Cromwell for partial summary judgment to compel Liberty Mutual to pay IRBs which Cromwell alleged were wrongfully withheld.

- Cromwell was injured in a motor accident in 1998. Crowell had long term disability benefits with Sun Life and accident benefits with Liberty Mutual.

- Cromwell had a claim against Sun Life and the claim was settled in December 2003 for $15,000.00 representing arrears due under the policy and $160,000.00 viewed by Sun Life as representing future payments and costs.

- In July 2003, she also received an advance payment of $78,485.00.

- In July 2003, the Defendant wrote to the Plaintiff and took the position that Sun Life's advance payments were collateral benefits which resulted in overpayment which it was entitled to recoup pursuant to s.47 of the SABS.

- The Plaintiff's weekly entitlement to IRBs was $311.49 per week and payment began on December 13, 1998.

- IRBs were terminated by the Defendant on various occasions but were reinstated and the Plaintiff received benefits in the amount of $15.47 per week up to the time of the trial.

- From June 17, 2000 to May 30, 2003 the Defendant had paid a total amount of $47,971.00 in IRB payments.

- On July 4, 2003, the Defendant wrote to the Plaintiff and confirmed it was aware of the advance payment made by Sun Life on which the Plaintiff was required to pay income tax as well as the taxable amount of the LTD benefit.

- Liberty Mutual took the position that it would be entitled to deduct the net monthly LTD payment from the IRB payments pursuant to s.7 of the SABS.

- The Defendant stated that it intended to recoup all IRB payments paid now that the Plaintiff had received collateral benefits.

- The over payment claimed by Liberty Mutual was $68,708.19 and stated that they would deduct 20% of the amount of benefit from each payment and would be charging interest under s.47(6) of the SABS on the amount it was entitled to recoup until the full amount had been repaid.

Issues

- Is the Sun Life LTD policy an indemnity policy permitting the Defendant to a collateral benefit deduction for the past Sun Life settlement under s.7 of the SABS?

- Is the Defendant entitled to deduct from the monthly IRBs an amount equal to the monthly payment due under the Sun Life LTD policy as a result of the $160,000.00 portion of the Plaintiff's settlement with Sun Life being future payments of collateral benefits within the meaning of s.7 of the SABS?

Held

- It was held that the Sun Life long term disability policy was an indemnity policy.

- Liberty Mutual was entitled to deduct from income replacement benefits the disability benefits received under the Sun Life policy.

- All benefit payments made between July 4, 2002 and July 4, 2003 by Liberty Mutual could be reclaimed. **However, Liberty Mutual was not entitled to a deduction of the $160,000.00 lump sum payment received from Sun Life as it could not be classified as a payment.**

- Sun Life was not obliged under the terms of its policy to pay a lump sum with respect to future payments.

Commentary

- It does not appear that there was any evidence that the lump sum paid was calculated to take into account the future value of those payments.

- It appears that it was arrived at on the basis of the amount of money available under the authority of the person authorizing the settlement.

- What seems to be the turning point here is the content of the releases that were completed and executed in this matter.

- The release that was executed by Cromwell from Sun Life released claims for mental stress and aggravated and punitive damages.

- As these were not income based payments, the Defendant was not entitled to do a deduction with respect to the $160,000.00 lump sum payment.

- The Full and Final Release did not include any claim for future benefits but merely claims for past benefits plus punitive and aggravated damages as well as damages for mental distress as a result of Sun Life having refused to pay benefits under the policy.

- This would appear to bar Liberty Mutual from being entitled to this as a collateral benefit.

- It does not appear that there was enough evidence for Justice Lofchik in this case to properly determine what the long term disability benefit payment was for.

- This matter shows the importance of prior to settling an accident benefits claim of subpoenaing the long term disability benefits file to determine exactly the intentions of the parties involved when settling long term disability benefit claims.

Vanderkop v. Personal Insurance Co. of Canada [2008] O.J. No. 1937 (Ontario Superior Court of Justice)

Facts

- The Plaintiff Jokelee Vanderkop was injured in a motor vehicle accident on February 17, 1997.

- Vanderkop's accident benefits carrier was The Personal Insurance Company and she had a group policy of insurance with Manulife which included long term disability benefits.

- The Manulife LTD benefit was to pay for monthly loss of income benefits assuming eligibility entitlement requirements were met.

- Vanderkop, 52 weeks prior to the accident, earned $64,265.00.

- From 1997 to 1998, Vanderkop was off and on at work and on November 17, 1998 had used up all of her sick leave credits. She was a teacher.

- In January 2001, the Defendant was provided with a Dr. Fulton report and from this report The Personal paid Vanderkop IRB benefits overdue since January 31, 1998 in the amount of $107,068.23 plus interest calculated at 2% per month compounded monthly in the amount of $27,292.43.

- On November 27, 2002, there was a private mediation between Manulife, The Personal and the Defendant in the Plaintiff's tort claim.

- Up to the mediation the Defendant was still paying IRB benefits in the amount of $653.90.

- At the mediation Vanderkop entered into a settlement with Manulife where she released all entitlement to past present and future benefits under the Manulife policy for a payment of $57,500.00.

- "At the mediation The Personal did nothing to encourage the Plaintiff to enter into the Manulife settlement nor anything that could reasonably be interpreted by the Plaintiff to mean that they endorsed or approved the Manulife settlement." (paragraph 54)

- "At the time the Plaintiff entered into the Manulife settlement the present value of past, present and future benefits potentially available to her under the Manulife Policy provided that she qualified and in the absence of any offset or third party liability rights in favour of Manulife was later calculated to be in excess of $700,000.00." (paragraph 54)

- The Plaintiff was unaware of this quantification at the time of the Manulife settlement and it was not disclosed by Manulife or her lawyer.

- Vanderkop also executed Minutes of Settlement with The Personal to settle the income replacement benefits in the amount of $10,000.00. This

settlement was not finalized as Vanderkop voided settlement during the statutory cooling off period.

- Notice was given by The Personal to Ms. Vanderkop in a letter outlining that according to s.7(1)(ii) of the SABS, the insurer could deduct net weekly benefits for the loss of income that was not being received by the person but are payable to the person as a result of the accident under the law of any jurisdiction or under any income continuation plan.

- The Personal also warned Vanderkop that if she proceeded with the Manulife settlement it might be an improvident settlement prejudicing The Personal.

- The Personal stopped paying IRB benefits due to the settlement with Manulife.

- This notice was given in an OCF-9 on August 20, 2003, eight to nine months after the mediation.

- Vanderkop refused to carry out the terms of the settlement entered into with Manulife and commenced an action against her former counsel for damages.

- On October 31, 2005 an Order was made for Vanderkop to carry out the terms of the settlement entered into on November 27, 2002 with Manulife. The Court of Appeal refused the appeal of the Plaintiff.

Issue

- Are the settlement funds $57,500.00 recoverable?

Held

- The Personal was not entitled to the collateral benefit of the long term disability benefits pay off.

- “The Minutes of Settlement entered into after mediation provides the sum of $57,500.00 as the payment of all past, present and future claims. This

would include the claim for aggravated and punitive damages and damages for mental distress claimed in the amount of $100,000.00 in the Statement of Claim filed by the Plaintiff."

- "Based on these facts I conclude that the monies paid pursuant to the settlement cannot be characterized as "*net weekly payments for loss of income that are not being received by the person as a result of the accident".* Rather, the funds represent a lump sum payment arrived at after a lawsuit was commenced and negotiated as a compromise. (see *Tsiaprailis v. Canada, 2005 S.C.C. *8)* (paragraph 81)

- "There is no allocation of the lump sum as among the various heads of damage claimed. Under these circumstances I find the Defendant is not entitled to any deduction for a payment in respect of the lump sum settlement payment made by Manulife."(paragraph 82)

Commentary

- It would be my recommendation that the Full and Final Release would have to be specific to income replacement benefits or some sort of income loss payment for it to be covered as a collateral benefit.

- It would be my recommendation for an insurance company to exercise its rights under s.33 of the SABS to get the full LTD benefit file and perhaps move for production of the complete file under Rule 30.10 of the *Rules of Civil Procedure.*

- Also, consideration should be given in conducting an Examination Under Oath of a non-party under Rules 30.10 of the *Rules of Civil Procedure.*

- Upon receipt of the file, you would want to investigate to determine conclusively how a lump sum cash out of the long term disability policy was calculated.

- This may involve more than just obtaining a Full and Final Release between the long term disability carrier and a Plaintiff as they could "allocate" the settlement as they see fit in order to prejudice the accident benefits carrier.

- It would be important to examine the reserve information and the internal calculations made by an LTD carrier as to see how the settlement lump sum was reached and determine if any legal opinions were given with respect to that issue.

- Further, you could see how the Plaintiff strategically manoeuvred to maximize LTD cash outs and not have to deduct it by the way they structure their Full and Final Release settlements