

“AVOIDING THE BAD FAITH SPIN - PRACTICAL CLAIMS HANDLING STRATEGIES FOR IDENTIFYING, RETAINING AND USING EXPERTS”

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INTRODUCTION

In 1996 the insurance industry received a wake-up call when the Jury in *Whitten v. Pilot Insurance Company* returned a \$1 million punitive damage verdict and the presiding Judge referred to the Jury award as “entirely reasonable”. The Supreme Court of Canada Judgment restoring the \$1 million Jury verdict, ensured that bad faith litigation against insurers will be pursued in earnest. The proverbial “pot of gold at the end of the rainbow” now attracts the very best of legal counsel to aggressively pursue these claims with ingenuity and vigor. Jury awards for punitive damages against insurers have now reached heights of \$2 million. Many of these decisions turn upon inferences that Juries draw from various pieces of circumstantial evidence. Rare is the situation where there is a single piece of evidence, or “smoking gun”, proving bad faith. Strong plaintiff counsel will “spin” or focus the evidence in a manner which invites the Jury to conclude that the insurer had dishonourable motives in the manner in which it handled the claim.

As the use of experts is an important part of any claims handling strategy, steps taken or not taken in identification, retention and use of experts will come under scrutiny by plaintiff’s counsel. The challenge for an insurer is to not only actually handle the file consistent with its good faith obligations, but to conduct itself and maintain its file in a manner which minimizes the opportunities for plaintiff’s counsel to put a negative spin on the insurer’s conduct.

This presentation will highlight, by extrapolation from various reported punitive damage cases, “problem areas” for insurers in defending cases and suggest litigation strategies to minimize bad faith exposures.

CASE LAW

***Vorvis v. Insurance Corp. of British Columbia*, [1989] 1 S.C.R. 1085**

This decision upheld the notion that punitive damages could be awarded in breach of contract situations. In setting out the general circumstances in which this occurs, the court stated:

For an award of punitive damage to be made, two requirements must be met: First, the defendants must have committed an independent or separate actionable wrong causing damage to the plaintiff; and second, the defendants’ conduct must be sufficiently ‘harsh, vindictive, reprehensible and malicious’...or ‘so malicious, oppressive and highhanded that it offends the court’s sense of decency’.

***Whitten v. Pilot Insurance Company*, [2002] S.C.J. No. 19**

In this case the Supreme Court of Canada affirmed the notion that an insurer's breach of the duty of good faith is a separate "actionable wrong" within the meaning of the *Vorvis* rule, such that insurers could be liable for punitive damages in appropriate circumstances. There is much in this decision of Justice Binnie, but the following quote summarizes the general situations in which punitive damages against insurers can be awarded.

- (1) Punitive damages are very much the exception rather than the rule.
- (2) Imposed only if there has been a highhanded, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from the ordinary standards of decent behaviour.
- (3) Where they are awarded, punitive damages should be assessed in an amount reasonably proportionate to such factors as the harm caused, the degree of misconduct, the relative vulnerability of the plaintiff and any advantage or profit gained by the defendant.
- (4) Having regard to any other fines or penalties suffered by the defendant for the misconduct in question.
- (5) Punitive damages are generally given only where the misconduct would otherwise be unpunished or where other penalties are or are likely to be inadequate to achieve the objectives of retribution, deterrent and denunciation.
- (6) The purpose is not to compensate the plaintiff, but
- (7) To give a defendant his or her just dessert (retribution), to deter the defendant and others from similar misconduct in the future (deterrents), and to mark the community's collective condemnation (denunciation) of what happened.
- (8) Punitive damages are awarded only where compensatory damage, which to some extent are punitive, are insufficient to accomplish these objectives, and
- (9) They are given in an amount that is no greater than necessary to rationally accomplish their purpose.
- (10) While normally the state would be the recipient of any fine or penalty for misconduct, the plaintiff will keep punitive damages as a "windfall" in addition to compensatory damages.
- (11) Judges and Juries in our system have usually found that moderate awards of punitive damages, which inevitably carry a stigma in the broader community are generally sufficient.

An award of punitive damages must serve a “rational purpose”. This is both with respect to whether an award should be given at all as well as the quantum.

The Supreme Court recognized that an insurer is entitled to investigate a claim, including the appropriate use of experts, but if that investigation is not proportionate to the circumstances, that can support an entitlement to punitive damages. The court stated:

The respondent claims that an insurer is entirely within its rights to thoroughly investigate a claim and exercise caution in evaluating the circumstance. He has not agreed 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”...that led to the arson trial, with nothing to go on except 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 wilful tunnel of vision.

Putting that quotation in factual context, the independent adjuster initially hired by Pilot reached a conclusion, after investigating the matter, that there was little or no basis to deny the claim. Pilot did not accept the conclusions of this independent adjuster even though it had no evidence to support a defence of arson. Moreover, Pilot rejected a similar conclusion by the Insurance Crime Prevention Bureau investigator. What followed were meetings and communications between Pilot's counsel and their Origin and Cause expert, followed by the Origin and Cause expert changing his opinion with respect to the cause of the fire to support an arson defence. The nature of this evidence led the court to conclude that it supported the inference that these communications likely influenced the Origin and Cause investigator to change his opinion.

The court ultimately concluded that the Jury was entitled to reach a conclusion on the evidence that the arson defence was contrived for the purpose of forcing the plaintiff, who was in precarious financial circumstances, to make an unfair settlement that was far less than what she was entitled to. The evidence which was commented on by the court has justifying that conclusion was:

- That Pilot did not follow the recommendation of its independent adjuster or the investigator from the Insurance Crime Prevention Bureau and did not offer any explanation for why.
- Pilot retained an Origin and Cause expert, but did not send that expert all relevant evidence and in fact, provided the expert with information which may have been “misleading if not inaccurate”.
- There were a number of communications between Pilot's counsel and the expert which likely influenced the expert to change his opinion to support an arson defence.
- Alternative living expense payments were discontinued in circumstances where there was poor communication to the insured.
- The court noted that insurer “has the right, even the duty, to investigate claims, but it must do so fairly and diligently”.

702535 Ontario Inc. v. Non Marine Underwriters, Lloyds of London [2000] O.J. No. 866 (Ont. C.A.)

This is a decision of the Ontario Court of Appeal that was delivered prior to the Supreme Court of Canada Judgment in *Whitten v. Pilot* being released. At issue was whether an insurer should be obligated to pay punitive damages when it failed to pay two claims of the named insured's mortgagees within 60 days as provided for in Statutory Condition 12 of the fire insurance contract. The Trial Court, although finding in favour of the insured on the contractual issues, declined to award punitive damages and the insured appealed. The Appellate Court dismissed the plaintiff's appeal, but made a number of comments regarding the insurer's duty of good faith. Specifically,

The duty of good faith requires an insurer to act both 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....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 withhold payment....

The duty of good faith also requires the 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 a 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.

The 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.

The Court of Appeal concluded that the insurer had breached its duty of good faith which was owed to the mortgagees by failing to pay the claim in a reasonable time-frame. The court concluded that the insurer had no reasonable basis to deny the claim to the mortgagees in its entirety because of the particular wording of the insurance contract and the *Insurance Act*. The court did not, however, support an award of punitive damages because, notwithstanding the breach of the duty of good faith, the conduct was not sufficiently harsh to justify punitive damages. A mitigating factor was that the insurer responded in a reasonable manner, paying money to the mortgagees, plus interest, once ordered to pay.

Kahzzaka (cob E.S.M. Auto Body) v. Commercial Union Assurance Co. of Canada [2002] O.J. No. 3110 (Ont. C.A.)

In this case the Ontario Court of Appeal was called upon to review a Jury award of \$200,000.00 for punitive damages in a case where the insurer denied a claim for damages to an auto body shop on the basis of arson. The facts commented upon the Court of Appeal were such that they concluded that the Jury was entitled to draw an inference that the claims examiner and Origin and Cause expert had unreasonably pursued the arson case without a reasonable evidentiary foundation to do so. It was also noted that the Origin and Cause expert's testimony was "utterly demolished" at trial. The critical passages from the Judgment are:

In my view the evidence of the Jury may have accepted and the reasonable inferences therefrom clearly establish a rational purpose for an award of punitive damages....Here, the roots extend back to the early investigation, surface at trial and are supplemented by the nature of the testimony. The appellant had a duty to treat the insured fairly. It was not unfair to consult the Fire Department and police and 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 multiples as all obstacles to the viability of the defence of arson are turned aside without concern for the insured's rights and wellbeing. 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 words "crumpled" beneath him. 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 appellant cannot excuse itself by hiring reputable independent agents. They owe no duty to the insured but the insurer does, and its obligation continues to trial. I see it as no reasonable 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 as always being treated fairly.

This case illustrates the importance of the insurer having a sensible investigation plan that is soundly based upon the evidence; the importance of continually reviewing that evidence and the claims decision. An initially sound investigative plan or claims decision is not sufficient to immunize an insurer from a punitive damage award. The insurer must continually evaluate the merits of its position right up until judgment. An insurer is not entitled to pursue its claims denial through judgment when there is no reasonable evidence to support that denial.

The case also illustrates the importance of the insurer continually scrutinizing the experts that it relies upon. While an insurer may not have the expertise to evaluate the soundness of the expert's opinion, it does have the ability to ascertain whether the expert is appropriately qualified, whether that expert has considered all relevant evidence and whether the expert has dealt with evidence favourably to the insured in a sensible fashion.

***Bullock v. Trafalgar Insurance Co. of Canada* [1996] O.J. No. 2566 (Gen. Div.)**

This is an older General Division case released prior to the Supreme Court of Canada's decision in *Whitten v. Pilot Insurance* and the other Court of Appeal decisions referred to herein. This case does illustrate, however, the point that an insurer has an obligation to continually evaluate the evidence and has a duty to abandon its off-coverage position or refusal to pay and settle the claim should their position no longer be viable on the evidence. In this case, the Plaintiff owned an automobile which burst into flames and was completely destroyed when being driven out of a parking lot. The insurer took the position that the fire was arson. It hired an independent investigator and an Origin and Cause expert which supported the arson defence. The insured then provided reasonable explanations for the circumstances relied upon by the insurer in support of its arson defence. The insurer did attempt to settle with the plaintiff, but refused to abandon its arson defence and the matter went to trial. The court found in favour of the plaintiff on the contractual claim and also found the insurer had breached the duty of good faith. The court, however, did not award punitive damages because of the level of compensatory damages and costs provided. It is questionable whether this case would have been decided differently today in light of the comments made by the Ontario Court of Appeal in *Kahzaka*. The following excerpts from the head note illustrates the court's finding on the bad faith issue.

Trafalgar had acted in good faith in initially denying the claim based upon Pizzey's investigation report. None of the defendants bore any malice towards the plaintiff. However, once the plaintiff came forward with the results of his own investigation, there was no longer any reasonable defence available to Trafalgar. There was no reasonable basis for its conduct after that date. From all of the evidence, the plaintiff had nothing to do with the fire. While the insurer had later ascertained that it had no probable defence, he refused to withdraw the allegation of wrongdoing by the plaintiff. The insurer had breached its duty of good faith. The obligation to act in good faith then imposed a duty on the insurer to attempt to settle the claim without continuing litigation.

Justice Cumming reviewed the respective interests and expectations of the insurer and insured in the following terms:

The insured is dependent upon the insurer to undertake an adequate investigation and prompt evaluation of a claim expeditiously. As well, an insured is entitled to receive correct information, a fair interpretation of the policy and prompt payment of a claim when it has merit. Scrutiny and challenge of doubtful claims is consistent with the insurer's contractual commitment to pay claims relating to covered, and not excluded risks. However, the insurer may not treat the insured as an adversary whose interest may be disregarded. This encompasses a duty to settle claims without litigation in appropriate cases: This implies a reasonable and competent investigation to determine whether a claim will be honoured.

***Ferme Gérald Laplante & Fils Ltée v. Grenville Patron Mutual Fire Insurance Company* [2002] 61 O.R. (ed) 481 (Ont. C.A.)**

This case involved a fire at a dairy barn operation. There were complex valuation and policy interpretation issues. The plaintiff was completely successful at trial on the contractual matters and a

Jury awarded \$750,000.00 in punitive damages. The issue on appeal was whether the punitive damage award should be upheld. The Court of Appeal overturned the punitive damage award. The Court of Appeal again recognized the right and duty of the insurer to investigate the claim and that the duty of good faith required the insurer to act promptly and fairly in every step of the claims process. Here, the insurer had a reasonable evidentiary basis for its position. Hence there was no breach of the duty of good faith. In addition, the court commented favourably on how the insurer conducted itself. The following quote is illustrative:

Grenville never denied coverage under the policy. It commenced its investigation of the claim and assessment of the loss immediately. The claim was handled from the start by experienced and senior representatives. Laplante's representatives agreed in their evidence that Bellinger had been helpful to them and that their dealings, on the whole, had been fairly amicable. They agreed that a fair amount of time had been spent in an attempt to settle the issues between the parties. Grenville paid promptly for those items of loss with respect to which there was no issue.

The court also noted that, on the evidence, it was speculation for the plaintiff to contend that the insurer had abused its position of power and purposely set out to force the plaintiff into an unreasonable settlement. In other words, the only reasonable inference to be taken from the evidence was that the steps the insurer took were motivated by a desire to pursue a legitimate claims investigation and not for some other ulterior purpose.

Barker (cob Mike Barker Auto Sales) v. Zurich Insurance Company [2001] O.J. No. 358 (Ont C.A.)

In this case the plaintiff had purchased a pickup truck from an automobile wrecker. The vehicle had been a prior writeoff. There was less than satisfactory documentation to support the repairs. The vehicle disappeared in mysterious circumstances. When it was recovered the insured, contrary to the wishes of the insurer, took possession of the vehicle and proceeded to dismantle it thereby preventing the insurer from completely investigating the claim. At trial, the Jury found in favour of the plaintiff insured on a contractual claim and awarded punitive damages of \$200,000.00. Zurich ultimately paid the contractual claim without prejudice to its appeal. The issue on appeal was whether the punitive damage claim should stand. The Court of Appeal concluded that Zurich had a reasonable basis to deny the claim and hence the punitive damage award was set aside. This case is somewhat extreme on its facts, but illustrates the importance of an insurer having a reasonable factual foundation for its position.

GENERAL PRINCIPLES APPLICABLE TO GOOD FAITH CLAIMS HANDLING

Based upon a review of the case law the following general propositions can be drawn with respect to good faith claims handling:

- Although the insurer has the right/duty to investigate a claim, such investigation must be reasonably supportable on the evidence.

- An investigation not justified on the facts which delays the insurer's processing of the claim may be considered a breach of the insurer's obligation to investigate fairly and promptly.
- Unexplained delay, particularly where the insured is under financial hardship, is capable of supporting a conclusion that the insurer is acting in bad faith.
- The insurer is under an obligation to continually evaluate its position and pay the claim promptly if there is no longer a reasonable basis to decline payment.
- The insurer must exercise a reasonable amount of due diligence in relying upon its agents or experts. Failure to make sure that experts are appropriately qualified or have considered all relevant information can lead to a conclusion that it was not reasonable to rely upon that expert's opinion to continue to support a denial of payment to the insured.
- The insurer's duty to continually evaluate the claim continues up until judgment. At trial, if the evidential underpinnings for the insurer's denial completely crumple, it may be necessary to abandon the defence altogether.
- An insurer can reduce the risk of punitive damages by:
 - (a) Giving consideration to advance payments to soften any financial hardship occasioned by delay due to investigation;
 - (b) Providing reasonable assistance to the insured as the case may direct;
 - (c) Accurate and timely communication to the insured regarding the status of the investigation and reasons for delay in payment;
 - (d) Prompt payment of the claim, including, where appropriate, interest where the factual underpinnings of an insurer's denial become untenable.

PROBLEM AREAS AND CLAIMS HANDLING STRATEGIES

Is the Investigation Plan Reasonable?

It is critical to remember that plaintiff counsel will try and spin the evidence to convince a Jury to infer that the insurer has not been fair or prompt in its claims handling. Plaintiff counsel will seek to exploit any step of the investigation that is not reasonably supported on the evidence as an indication of bad faith delay. They will suggest, in these circumstances, that the insurer's motives were disingenuous towards the insured.

Any claims file which does not clearly tailor an investigation strategy to the particular facts, or which does not show the strategy being constantly evaluated, is open to attack. Take for example, a situation where property has been destroyed by arson and the insured submits a claim. No one would doubt the insurer's right to investigate issues of motive. The initial investigation plan to conduct an Equifax search would be entirely supportable on those facts. If, however, the Equifax search revealed that the insured was not under any imminent financial pressure, it might be difficult to rationalize an investigation strategy that involved a forensic audit of all of the insured's bank accounts for several

years prior to the accident. Since such an investigation would seem extreme, the court would need to hear an explanation for why that type of investigation was being undertaken in the circumstances. It may be that there was a valid explanation, but if that was not properly documented in the claims file, plaintiff counsel could certainly argue at trial that the insurer's motive for pursuing that line of investigation at the time was not legitimate claims handling, but an effort to delay to the disadvantage of the insured.

The claims file should be well documented and reflect an ongoing process of evaluating the evidence available at the time and responding to such with a reasonable investigative plan. This process should continue from the start of the claim through trial. The claims file should not only document what is being done, but why. By documenting the claims file in this fashion the insurer should have no difficulty convincing a Judge or Jury at trial what the insurer was thinking as it implemented its litigation strategy. A well documented claims file is also essential in the event that the claims handler is not available at the time of trial or would otherwise be lacking in a clear memory of why the litigation strategy was adopted.

EXPERTS

Integral to most claims handling strategies is the necessity to consult with experts to assist the insurer in making a determination. The steps the insurer has taken, or not taken, in identifying the need to utilize and expert to assist in its claim decision as well as how the insurer has conducted itself in the use of the expert will certainly be a source of inquiry in bad faith litigation.

(a) Identifying the Need for Expert Assistance.

The first level of inquiry for the insurer should be an analysis of whether an expert is reasonably required to assist in the evaluation of the claim. Unnecessary use of experts could be characterized as unfair to the insured, particularly if this results in significant delay in processing of the claim. On the other hand, failing to utilize an expert where one is reasonably required to evaluate the issue may also be characterized as unfair to the insured. The claims decision may be seen as capricious wholly lacking a reasonable evidential foundation. The critical point is that **there should be evidence that the insurer has addressed its mind to whether experts are required or not.**

Since the duty of good faith requires the insurer to respond to a claim in a timely fashion, it is important that the insurer's file reflect that, if experts are reasonably required, there is no undue delay in retaining the experts. This is particularly important where the nature of the expert analysis will require a significant time to complete, i.e., forensic accounting issues, origin and cause issues and lengthy waiting times for medical examinations. In these situations **the insurer must be able to defend the timing for when the expert was retained.**

(b) Choice of Expert

Choice of experts can be an integral component to the insurer discharging its duty to assess the merits of the claim in a balanced and reasonable manner. Selection of an expert that is not appropriately qualified not only undermines the insurer's chance of succeeding on the merits of the contractual claim,

but also has potentially significant ramifications in the bad faith litigation. Retaining an expert that is known to have a particular bias will undoubtedly be characterized by plaintiff counsel as evidence that the insurer was not interested in an objective assessment of the claim, but only in developing evidence to deny the claim. The plaintiff's bar is now quite well organized and connected and they do track experts that seem to have a particular bias and are able to come to court well prepared to expose that bias. The situation becomes particularly acute if the insurer regularly uses the biased expert. The insurer must be able to justify its selection of expert. **The time for the insurer to address its mind to that issue is at the time of retaining the expert, rather than trying to come up with a justification months or years after the fact when the matter is in litigation.**

(c) Retaining and Communicating with the Expert

Assuming the expert retained is appropriate in the circumstances, then **it is critical that the expert be given access to all potentially relevant information.** As is seen from the case law, keeping evidence favourable to the insured from the expert can be very damaging to the insurer in bad faith litigation. There is simply no excuse for not making all relevant evidence available to the expert. This includes evidence that may be acquired after the expert has provided an initial report. It is quite common for an insured who is being served with an expert report to provide information why they believe the expert's report is flawed. The expert retained by the insurer should know about this information and be able to rationally explain it in the context of their opinion.

The expert's opinion must be seen as truly objective and not influenced by the insurer that is paying the expert's account. **Letters of instruction to the expert need to be neutral**, otherwise plaintiff counsel will be able to use the letter of instruction to suggest that the insurer's motive for retaining the expert was to develop evidence to support a denial. Letters of instruction which are capable of being interpreted as if the insurer has prejudged the case can be used as evidence of bad faith as was the case in *Whitten v. Pilot Insurance*. Phrases in letters of instruction such as "it is our position..." are suggestive that the insurer had prejudged the matter and is subtly trying to influence the expert into writing an opinion supportive of the insurer's theory.

Care must also be taken when summarizing facts in the letter of instruction. It is critical that any factual summary be absolutely accurate. Firstly, it should not be assumed the expert will independently verify these facts and if the summary provided by the insurer is inaccurate, then the expert's opinion may be worthless. Moreover, such inaccurate summaries will allow plaintiff counsel to suggest that the inaccuracy was no mistake, but a deliberate attempt to influence the expert's opinion. This is what occurred in the *Whitten v. Pilot* case. **It is preferable if the expert is provided with the actual evidence, i.e., statement transcripts, medical reports, etc., rather than a summary prepared by the insurer.** If there are specific factual issues that the insurer wishes to draw the expert's attention to, this can be done in a neutral manner, such as "in preparing your opinion can you please comment on what significance, if any, there is to fact...".

Another area where insurers are likely to be questioned about at trial with regard to their experts, is whether there have been any meetings or conferences between the insurer and the expert prior to preparation of final report. Where such meetings have occurred, plaintiff counsel will be attempting to suggest some form of collusion between the insurer and the expert. It should be recalled how the meetings between the expert and Pilot's counsel were characterized in a very negative manner in the *Whitten v. Pilot* decision. It is certainly troubling where the expert has cited in the preamble of their opinion that there has been a meeting between the insurer and the expert, yet there is no record of what was disclosed. Juries can be sceptical enough of insurers without having this scepticism fuelled

by meetings of this sort. If it is necessary for a meeting to take place, it should be for the sole purpose of providing evidence to the experts. In this case, the nature of the meeting should be logged and confirmation sent to the expert outlining what information was provided. **It is critical that the insurer not discuss any preliminary views or concerns that it might have with the expert.** These type of comments have a nasty way of finding their way into the expert's file. There is no such thing as an "off the record" discussion with the expert. The expert witness testifying under cross-examination will have to recount any such discussions. More innocently, the expert may paraphrase the discussions and record that somewhere in their file and when this is disclosed at trial months or years later, the comment may be potentially embarrassing to the insurer's position. For example, a statement made to the expert that "we think the claim might be fraudulent because..." might get paraphrased and recorded by the expert as "thinks the claim is fraudulent". **A prudent strategy to adopt when dealing with experts is to keep communications with the expert, prior to rendering their opinion, as transparent as possible, i.e., written communication and avoid disclosing to the expert either expressly or inferentially any opinion the insurer is hoping to obtain.**

It goes without saying that an insurer will bear the onus of proving that they acted in accordance with the advice given. For this reason, when all of the steps recommended above are taken, the insurer should diligently log each and every step so that a detailed recitation of what actually took place can be provided.

(d) Review of the Report

While the insurer is certainly not obligated to go into the expert's realm and second guess their own expert, there is a positive duty upon the insurer to evaluate and provide appropriate weight to their expert opinion. The insurer should carefully scrutinize their report to make sure the expert has not made any errors outside of the realm of their expertise. For example, has the expert misinterpreted the law or perhaps given an opinion in an area where they are not appropriately qualified? Is the experts analysis consistent with accepted scientific principles and methodology? Has the expert's theories been tested in court or the subject of peer review? Has the expert made an error in reciting the facts or failed to address significant facts in the report? These are all red flags which could potentially undermine the expert opinion and it is incumbent upon the insurer to deal with these red flags rather than blindly following the conclusion of the expert.

If there is an obvious error or inadequacy in the expert's report this should be drawn to the expert's attention for explanation or, if need be, correction. Under no circumstances should the original report be altered other than simply dealing with obvious typographical errors. If the original report is altered, the perception is that the insurer is dictating how the report is written rather than simply having the error corrected or the issue explained further. It is preferable if the original report is accepted in its entirety and supplemented with an addendum as need be. If the insurer addresses the above noted issues with its expert and does not receive an explanation that it is comfortable with then a second opinion should be sought.

(e) Failure to Re-evaluate

Even if the insurer has acted diligently in identifying, retaining and using an expert and has received an expert report which supports the denial of the claim, the insurer may still be exposed to a punitive damage claim if it fails to evaluate its position in the face of changing circumstance. This was clearly

the message delivered by the Court of Appeal in *Kahzzaka v. Commercial Union*. A distinction needs to be made between a situation where the factual premise of the case has changed to the point where the denial is no longer reasonably viable from a case where, notwithstanding the change in factual circumstances, the insurers position remains a viable albeit hotly contested. In the latter situation, the insurer is entitled to continue to contest the claim. In the former situation, however, the insurer's obligation would be to withdraw the denial and make prompt payment.

It is tempting, when the factual basis for the denial crumbles, not to withdraw the denial and embark upon a course of settlement negotiations with the insured in hopes of reaching a compromise position. Proceeding in this fashion is fraught with problems from the insurer's perspective. Courts have very clearly stated that it is bad faith for an insurer to deny a claim without a reasonable factual foundation for the purpose of leveraging an insured into a compromise settlement position. **The best strategy to adopt where the factual circumstances change and the denial is no longer viable is to first communicate to the insured that the denial is being withdrawn and then move promptly to resolve valuation issues in the usual course. This recommendation holds true irrespective of whether the change in circumstances occurs before or during litigation.**

The bottom line is that the more professional the insurer comes across in the evidence, the better the insurer's chance of avoiding a punitive damage award. Even where an insurer's actions constitute a breach of the duty of good faith, how the insurer has conducted itself may save it from an award of punitive damages. This is quite evident from the decision of *702535 Ontario Inc. v. Non Marine Underwriters, Lloyds of London and Laplante & Fils Ltée v. Grenville*. Unfortunately, the opposite is also true.

CONCLUSION

Perfect claims handling is rarely achievable in a complicated first party insurance claim. Claims handling decisions are largely subjective based upon the claims handlers' impression of the evidence at the time. Such decisions will inevitably come under close scrutiny in punitive damage litigation. It is vitally important that those decisions are not only actually made in good faith, but made in a manner which leaves no room for debate on that issue. Sloppy or inattentive claims handling, including the use of experts, significantly increases the insurer's exposure in punitive damage claims. The more opportunities a plaintiff has to suggest bad faith the more likely they are to strike a nerve with the Jury and have them conclude that the claims handling represented a course of conduct deserving of a punitive damage award. Limiting the number of opportunities a plaintiff has to make that suggestion is the key to minimizing the risk of a bad outcome in these types of cases.

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