Advocates' Quarterly

Volume 27, Number 3 October 2003

WHITEN'S WORLD: THE SUPREME COURT OF CANADA'S INSURANCE LAW DECISIONS SINCE WHITEN V. PILOT INSURANCE COMPANY

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1. Introduction

In the annals of Canadian insurance law, February 22, 2002, is a red letter day. On that date, the Supreme Court of Canada issued its decision in *Whiten v. Pilot Insurance Co.*,[1] upholding the trial jury's award of $1,000,000 in punitive damages against the insurer. The case was an unprecedented and unquestionable victory for the insured.

Since *Whiten*, the Supreme Court of Canada has continued to be active in advancing the rights of insureds who are in conflict with their insurance companies. In fact, between February 22, 2002, and June 30, 2003, the Supreme Court of Canada issued eight insurance law rulings.[2] This means that in the 16 months immediately follow-

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1. [2002] 1 S.C.R. 595, 209 D.L.R. (4th) 257, 156 O.A.C. 201.

2. By "insurance law rulings", I mean decisions regarding the substantive rights of an insured or an insurer under an insurance contract, including the right to pursue legal action to enforce a contractual right.

   In chronological order, the eight cases decided since *Whiten* (hereafter collectively the "Post-*Whiten* Cases") are: *Oldfield v. Transamerica Life Insurance Co. of Canada*, [2002] 1 S.C.R. 742, 210 D.L.R. (4th) 1, 156 O.A.C. 310 (issued March 8, 2002); *Goulet v. Transamerica Life Insurance Co. of Canada*, [2002] 1 S.C.R. 719, 210 D.L.R. (4th) 22, 35 C.C.L.I. (3d) 204 *sub nom. Goulet v.*

ing *Whiten*, the Supreme Court issued more insurance law rulings than in the five years preceding *Whiten*.[3] Further, seven of the eight Post-*Whiten* Cases dealt with issues arising from coverage contests directly between insured and insurer.[4] In each of these seven cases the Supreme Court found in favour of the insured. This record again

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Transamerica Canada, cie d'assurance-vie (issued March 8, 2002); *Smith v. Co-operators General Insurance Co.*, [2002] S.C.J. No. 34 (QL), [2002] 2 S.C.R. 129, 210 D.L.R. (4th) 443 (issued March 28, 2002); *Family Insurance Corp. v. Lombard Canada Ltd.*, [2002] S.C.J. No. 49 (QL), 212 D.L.R. (4th) 193, 38 C.C.L.I. (3d) 165 (issued May 23, 2002); *Somersall v. Friedman*, [2002] S.C.J. No. 60 (QL), 215 D.L.R. (4th) 577, 163 O.A.C. 201 (issued August 8, 2002); *Martin v. American International Assurance Life Co.*, [2003] S.C.J. No. 14 (QL), 223 D.L.R. (4th) 1, [2003] 6 W.W.R. 1 (issued March 21, 2003); *KP Pacific Holdings Ltd. v. Guardian Insurance Co. of Canada*, [2003] S.C.J. No. 24 (QL), 225 D.L.R. (4th) 193, 14 B.C.L.R. (4th) 1 (issued May 1, 2003); *Churchland v. Gore Mutual Insurance Co.*, [2003] S.C.J. No. 25 (QL), 225 D.L.R. (4th) 202, [2003] I.L.R. ¶1-4190 (issued May 1, 2003).

Two other insurance law cases have been heard by the Supreme Court of Canada since *Whiten* but were not decided before the June 30, 2003 cut-off point of this article's analysis: *Unifund Assurance Co. of Canada v. Insurance Corp. of British Columbia*, [2003] S.C.J. No. 39 (QL), 227 D.L.R. (4th) 402 (issued July 17, 2003) and *Gurniak v. Nordquist* (leave to appeal granted [2001] SCCA 544 (QL); heard March 12, 2003, judgment reserved). Both of these cases deal with the rights of an out-of-province insurer. Two additional insurance law cases were granted leave to appeal since *Whiten* and prior to June 30, 2003, but these appeals were discontinued: *McCunn Estate v. Canadian Imperial Bank of Commerce* (leave to appeal granted [2001] SCCA 203 (QL), 157 O.A.C. 398*n*) and *Fellowes, McNeil v. Kansa General International Insurance Co.* (leave to appeal granted [2000] SCCA 543 (QL), 151 O.A.C. 200*n*).

3. Excluding *Whiten*, the Supreme Court of Canada issued seven insurance law rulings between January 1, 1997, and February 22, 2002. In chronological order, these decisions are: *Lawlor v. Royal*, [1998] 3 S.C.R. 260, 167 D.L.R. (4th) 1, [1999] I.L.R. ¶1-3649 (issued November 13, 1998); *Fraser River Pile & Dredge Ltd. v. Can-Dive Services Ltd.*, [1999] 2 S.C.R. 108, 176 D.L.R. (4th) 257, [1999] 9 W.W.R. 380 (issued September 10, 1999); *Guarantee Co. of North America v. Gordon Capital Corp.*, [1999] 3 S.C.R. 423, 178 D.L.R. (4th) 1, 126 O.A.C. 1 (issued October 15, 1999); *Lloyds, London, Non-Marine Underwriters v. Scalera*, [2000] 1 S.C.R. 551, 185 D.L.R. (4th) 1 *sub nom. Non-Marine Underwriters, Lloyds of London v. Scalera*, [2000] 5 W.W.R. 465 *sub nom. Sansalone v. Wawanesa Mutual Insurance Co.* (issued May 3, 2000); *Sansalone v. Wawanesa Mutual Insurance Co.*, [2000] 1 S.C.R. 627, 185 D.L.R. (4th) 57, [2000] 5 W.W.R. 21 (issued May 3, 2000); *Monenco Ltd. v. Commonwealth Insurance Co.*, [2001] 2 S.C.R. 699, 204 D.L.R. (4th) 14, [2002] 2 W.W.R. 438 (issued September 13, 2001); and *Derksen v. 539938 Ontario Ltd.*, [2001] 3 S.C.R. 398, 205 D.L.R. (4th) 1, 153 O.A.C. 310 (issued October 19, 2001).

4. The one case that does not fall into this category is *Family Insurance Corp. v. Lombard*, *supra*, footnote 2, which involved a contest between two insurers regarding how much each insurer should pay toward a single loss.

stands in contrast to the court's insurance law rulings in the five years preceding *Whiten* when the Supreme Court favoured the insured in only three out of seven cases.[5]

My main purpose in this article is to determine what, if anything, the Post-*Whiten* Cases reveal about the current state of Canadian insurance law and, more specifically, about the Supreme Court's present view of the legal obligations undertaken by the parties to an insurance contract. To this end, I begin with a review of the collective outcomes of the Post-*Whiten* Cases followed by a precis of each case. Based on my review of the Post-*Whiten* Cases, I conclude that the Supreme Court is strongly committed to protecting the interests of insureds who are in conflict with their insurance companies and that the Supreme Court's objective apparently is to see Canadian insurance law reformed to clarify the respective rights of insurers and insureds.

2. A Collective Review of the Post-Whiten Cases[6]

Overall, the Post-*Whiten* Cases reveal very little dissention in the court. Most of the cases were decided by a full court, with a seven-member panel sitting on only two of the eight cases. In six of the eight decisions, the court arrived at a unanimously agreed-upon result and, in five of those six cases, only a single judgment was written. In the two cases where the ruling was not unanimous, the dissenting element of the court was small, involving only one or two judges. Moreover, the identity of the dissenting judges in each of these two cases was different, suggesting that the Supreme Court was not divided by any fundamental philosophical differences regarding insurance law. The author of the majority judgments also varies considerably among the Post-*Whiten* Cases, although Chief Justice McLachlin wrote the four most recent decisions. In short, the findings of the court do not appear to have been consistently driven or challenged by any one judge or faction of the court. Further, as noted above, the finding in each case favoured the insured regardless of whether the court's decision turned on the interpretation of an insurance contract, a statutory provision or a common law principle and irrespective of the type of insurance policy at issue.

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5. The Supreme Court ruled in favour of the insured in *Lawlor v. Royal, supra*, footnote 3; *Fraser River Pile & Dredge Ltd. v. Can-Dive Services Ltd., supra*, footnote 3; and *Derksen v. 539938 Ontario Ltd., supra*, footnote 3.

6. See Appendix A.

3. A Substantive Review of the Post-Whiten Cases

(1) Oldfield v. Transamerica Life Insurance Co. of Canada[7]

Paul Oldfield was insured under a life insurance policy issued by Transamerica Life, which named Maria Oldfield as the beneficiary. On April 27, 1996, Mr. Oldfield died when one of 30 condoms full of cocaine he was carrying in his stomach broke open, causing him to have a heart attack. Transamerica refused payment to Mrs. Oldfield, arguing that public policy prohibited payment for a loss caused by the insured's criminal act.

While the parties agreed that Mr. Oldfield's death resulted from a criminal act,[8] the insurance policy was silent as to whether insurance proceeds were payable in such a circumstance. Accordingly, the parties submitted a special case to the court asking whether a public policy rule exists which precludes recovery by an innocent beneficiary when the death of the life insured was caused by his own criminal act. Both the trial and appeal courts of Ontario held that no such public policy rule exists. This finding was unanimously upheld by the Supreme Court of Canada.

Writing on behalf of eight of the nine members of the court, Justice Major confirmed the existence of a public policy rule which, "independently of the rules of contract",[9] prohibits a criminal from profiting from crime. Justice Major also held that this rule "extends to those who claim through the criminal's estate".[10] As a named beneficiary of the policy, however, Mrs. Oldfield was not claiming through her husband's estate and, accordingly, Justice Major held that the public policy rule was inapplicable to the case at bar.

Justice Major also discussed the public policy prohibition against providing payment to a beneficiary claiming through a criminal's estate. He concluded that barring payment to a beneficiary under a will while allowing payment to a beneficiary under a life insurance policy results in an arbitrary distinction. While advocating for a relaxation of the public policy rule so as to allow payment to beneficiaries under a will, Justice Major ultimately left the issue to be resolved "either by the legislature or in another case where the issue arises".[11]

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7. *Supra*, footnote 2.
8. A violation of s. 3(1) and (2) of the *Narcotic Control Act*, R.S.C. 1985, c. N-1.
9. *Oldfield, supra*, footnote 2, at para. 11.
10. *Ibid.*, at para. 15.
11. *Ibid.*, at para. 67.

Writing for herself, Justice L'Heureux-Dubé agreed with Justice Major in the result, both with respect to the main question before the court and with respect to Justice Major's statement that public policy should not prevent payment to an innocent beneficiary claiming from the wrongdoer's estate. Justice L'Heureux-Dubé devoted her comments to explaining why the rule that prevents a criminal from benefiting from his or her criminal act cannot rationally be applied to prevent payment to a beneficiary of the wrongdoer's estate. Moreover, Justice L'Heureux-Dubé pointed out that the public policy rule must be applied strictly and narrowly because the rule excuses an insurance company from payment. She noted that the rule balances two competing interests: "although a wrongdoer cannot profit from his or her crime, neither should an insurance company be allowed to abrogate its responsibilities under a contract by invoking a rule of public policy".[12]

Although Justice Major did not describe the rationale behind the public policy rule in the same terms as Justice L'Heureux-Dubé,[13] he too recognized that the effect of the rule is to allow an insurance company to escape its contractual obligations. He stated:[14]

> Generally, though, an insurer seeks the shelter of public policy rules because they have failed to specifically provide for the contingency that gives rise to the dispute. In the present appeal, the insurance policy did not provide for the result that would occur if the insured died while committing a criminal act. If the policy specifically excluded coverage, there would be no need to resort to public policy.

Thus, both justices were critical of the insurance company for attempting to avoid payment on the basis of an unwritten public policy rule rather than including an appropriate exclusion in the insurance contract.

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12. *Ibid.*, at para. 74, quoting from *Brissette Estate v. Westbury Life Insurance Co.*, [1992] 3 S.C.R. 87 at p. 107, 96 D.L.R. (4th) 609, 58 O.A.C. 10.
13. The difference between the analysis of Justice Major and that of Justice L'Heureux-Dubé appears to be of little substantive significance. Justice Major suggested that the requirements of the public policy rule ought to be "loosened", meaning that coverage should be granted in circumstances where the beneficiary is not guilty of a criminal act. Justice L'Heureux-Dubé argued that the public policy rule should be applied "more strictly", such that insurance companies would be able to rely on the rule to avoid payment only in very limited circumstances. Taking either approach, the result is the same.
14. *Oldfield, supra*, footnote 2, at para. 12.

(2) Goulet v. Transamerica Life Insurance Co. of Canada[15]

Roger Arbic was insured under a life insurance policy issued by Transamerica Life Insurance Company of Canada naming Danielle Goulet (Mr. Arbic's wife) as beneficiary. On January 22, 1994, Mr. Arbic was killed by a bomb explosion. At the time of his death, Mr. Arbic was in the process of attempting to plant a car bomb. As in the *Oldfield* case, Transamerica refused payment to Ms Goulet on the grounds that public policy[16] prohibited payment when death occurred during the commission of a crime. Both the trial and the appeal courts of Quebec concluded that the public policy rule was not applicable. In a unanimous decision written by Justice LeBel, the Supreme Court again upheld the lower court rulings.

The first issue considered by Justice LeBel was whether Mr. Arbic's death was intentionally caused so as to fall within the policy's suicide exclusion. In this regard, Justice LeBel held that the exclusion of coverage for an intentional act applies only to situations where the insured intended to bring about the resultant loss. Based on the evidence at trial, Justice LeBel concluded that Mr. Arbic intended to commit a crime at the time of his death but that Mr. Arbic did not intend to die. The possibility that his death might occur was a contingency and therefore did not fall within the intentional act exclusion.

The second question addressed by Justice LeBel was whether public policy barred Ms Goulet from recovery. Justice LeBel found that the Civil Code of Quebec does not bar or nullify judicially established public policy rules, that "Quebec courts have expressly recognized the principle of public order holding that no one may profit from his or her own crime",[17] and that this principle has not been changed by provincial legislation. Finally, referring to Justice Major's comments in *Oldfield*, Justice LeBel concluded that the public policy rule did not bar payment to Ms Goulet as the innocent beneficiary of a life insurance policy. According to Justice LeBel, interpreting the public policy rule so as to exclude payment to Ms Goulet "would not be of any value to society" because it would "punish an innocent beneficiary who is in the position of a third

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15. *Supra*, footnote 2.
16. This case arose in Quebec and is based on Quebec civil law. Accordingly the case refers to "public order" instead of "public policy". For the purposes of this article, the meaning is the same.
17. *Goulet, supra*, footnote 2, at para. 45.

party in relation to the insured".[18] Further, echoing Justice Major's comments in *Oldfield*, Justice LeBel noted that the insurance company could have relieved itself of its obligation to pay Ms Goulet by providing an appropriate and express exclusion in the policy for loss caused by a criminal act:[19]

> Thus, to prevent Ms. Goulet from claiming the indemnity, the insurance contract should have contained a clause specifically providing that the insurer was not required to pay the indemnity if the insured died in the commission of an indictable offence.

Justice LeBel also noted that "the trend in insurance law is toward limiting the effect of causes of nullity or forfeiture as against innocent third parties who have personal interests under the insurance contract".[20]

(3) Smith v. Co-operators General Insurance Co.[21]

On April 14, 1994, Ms Smith was involved in a motor vehicle accident in which she suffered physical injury. She applied for and received statutory benefit payments from Co-operators General Insurance Co. On May 8, 1996, Co-operators terminated the benefit payments and provided Ms Smith with written notice of the termination. The written notice provided Ms Smith with the insurer's calculation of benefits and advised her as follows:[22]

> If you disagree with our assessment, please contact us immediately.
> If we cannot settle the application to your satisfaction, you have the right to ask for mediation through the Ontario Insurance Commission.

At Ms Smith's request, a mediation was held on April 11, 1997, but the mediation was unsuccessful in resolving the claim. Accordingly, on September 8, 1998, Ms Smith filed a statement of claim seeking ongoing benefit payments.

Co-operators brought a summary judgment application, arguing that Ms Smith's claim was barred by s. 281(5) of Ontario's *Insurance Act*,[23] which required a court action for statutory accident benefits to be commenced within two years of the insurer's refusal

18. *Ibid.*, at para. 57.
19. *Ibid.*, at para. 56.
20. *Ibid.*, at para. 53.
21. *Supra*, footnote 2.
22. *Ibid.*, at para. 2.
23. R.S.O. 1990, c. I.8.

to pay. Both the trial and the appeal courts accepted the insurer's argument and struck out Ms Smith's claim. By contrast, in a decision written by Justice Gonthier, a majority of the Supreme Court allowed Ms Smith's appeal. Justice Bastarache was the sole dissenting judge on the seven-member panel.

Justice Gonthier's finding in favour of the insured turned on his interpretation of s. 71 of the *Statutory Accident Benefits Schedule* ("SABS"), which provides as follows:[24]

> If an insurer refuses to pay a benefit that a person has applied for under this Regulation or reduces the amount of a benefit that a person received under this Regulation, the insurer shall inform the person in writing of the procedure for resolving disputes relating to benefits under sections 279 to 283 of the Insurance Act.

Justice Gonthier concluded that this provision clearly requires an insurer to advise its insured of the entire dispute resolution process described in ss. 279 to 283 of the *Insurance Act*. According to Justice Gonthier, this obligation was not fulfilled by Co-operators advising Ms Smith of only the first step in pursuing mediation. Co-operators had an obligation to advise Ms Smith of the entire mediation process, including the fact that the statutory limitation period was not suspended by mediation. Further, Justice Gonthier concluded that the fact the insurer had advised Ms Smith of the benefits termination via a form approved by the Commissioner of Insurance did not relieve the insurer of its obligations under s. 71 of the SABS.

Justice Gonthier also emphasized the need to interpret the *Insurance Act* and the SABS purposefully. In this regard, he identified "consumer protection"[25] as a central purpose of insurance law and interpreted s. 71 of the SABS as imposing an obligation on an insurer to advise an insured of the benefits refusal "in straightforward and clear language, directed towards an unsophisticated person".[26] According to Justice Gonthier, such a clear description of the dispute resolution process set out in ss. 279-283 of the *Insurance Act* would at least "include a description of the most important points of the process, such as the right to seek mediation, the right

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24. O. Reg. 776/93. This regulation is referred to in s. 5(5) of Ontario's *Insurance Act, ibid.*, which requires an insured to commence legal action against an insurer "within two years after the insurer's refusal to pay the benefit claimed or within such longer period as may be provided in the Statutory Accident Benefits Schedule".
25. *Smith, supra*, footnote 2, at para. 11.
26. *Ibid.*, at para. 14.

to arbitrate or litigate if mediation fails, that mediation must be attempted before resorting to arbitration or litigation and the relevant time limits that govern the entire process".[27]

In dissent, Justice Bastarache agreed with Justice Gonthier's conclusion that the insurer had failed to advise Ms Smith of the full mediation process as required by s. 71 of the SABS. However, Justice Bastarache found that the obligation imposed by s. 71 is separate from the insurer's obligation to advise its insured of the refusal or termination of benefit payments:[28]

> While I accept that the limitation period cannot begin to run until the claimant has been properly notified of the refusal of benefits, I disagree with my colleague that this notification is incomplete until the claimant is informed of his or her right to dispute pursuant to s. 71 of the SABS. In my view, the legislation establishes no clear link between the notification of the right to dispute and the notification of the refusal to pay benefits . . .
> . . . Section 71 reinforces the claimant's right to dispute a refusal of benefits and obligates the insurer to inform the claimant of this right. The appropriate sanction for the insurer's non-performance of its duty to inform the claimant of the right to dispute is to bar the insurer from resisting a request for mediation, which is the first step in the dispute resolution process.

Justice Bastarache also pointed out that his interpretation of the legislation did not prejudice the insured as s. 72(2) of the SABS allows an insured to commence legal action within 90 days after the report of a mediator is issued. In the case at bar, Ms Smith was given written notice of the termination of her benefits, and, having proceeded to mediation, she was advised by the mediator that she had 90 days in which to commence a legal action against the insurer.

(4) Family Insurance Corp. v. Lombard Canada Ltd.[29]

Lesley Young, the owner of a riding stable, was sued by Michelle Patterson for injuries that Ms Patterson sustained in March 1996 while riding a horse at Ms Young's stable. The claim was settled, with $500,000 in damages determined to be payable by Ms Young's two liability insurers, Family Insurance Corporation ("Family") and Lombard Canada Ltd. ("Lombard"). The Family policy was homeowner/residential insurance with limits of $1,000,000, while the Lombard policy was a commercial general liability policy with lim-

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27. *Ibid.*
28. *Ibid.*, at paras. 26-27.
29. *Supra*, footnote 2.

its of $5,000,000. Both insurers admitted that their policies applied to the loss but a dispute arose as to which policy provided primary coverage. Both policies contained an "other insurance" clause stating that the policy was excess to any other applicable insurance.[30]

The British Columbia trial court held that the two "other insurance" clauses were mutually repugnant and that each insurer therefore had to contribute equally to the loss. The British Columbia Court of Appeal overturned this finding and held that the Family policy provided primary coverage and the Lombard policy provided excess coverage. The Court of Appeal based its ruling on the different nature of the insurance policies involved: the Family policy being a homeowner policy issued personally to the insured and the Lombard policy being a general policy provided to the insured by virtue of her membership with the Horse Council of British Columbia. According to the Court of Appeal, the essential difference between the policies was reflected in the higher coverage provided by the Lombard policy and in the divergent underwriting concerns behind each policy. On the basis of this analysis, the Court of Appeal concluded that the Family policy was intended to be in the nature of primary insurance while the Lombard policy was designed to operate as excess coverage. In a unanimous ruling written by Justice Bastarache on behalf of a seven-member panel, the Supreme Court of Canada overturned the Court of Appeal's ruling.

Justice Bastarache's conclusion was based on his finding that the two "other insurance" clauses were indeed mutually repugnant, each expressing the same intention to serve as excess coverage if another applicable policy existed. Justice Bastarache further held that, in

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30. As indicated in the case, *ibid*, at para. 4, the "other insurance" clause in the Family Insurance Corporation policy stated:

> If other insurance exists which applies to a loss or claim or would have applied if this policy did not exist, this policy will be considered excess insurance and the Insurer is not liable for any loss or claim until the amount of such other insurance is used up.

The "other insurance" clause in the Lombard Canada Ltd. policy stated:

> If other valid and collective insurance is available to the Insured for a loss we cover under Coverages A, B or D of this form, our obligations are limited as follows:
>
> . . . . .
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> This insurance is excess over other existing insurance if any, whether such other insurance be primary, excess, contingent or on any other basis, that is liability insurance such as, but not limited to comprehensive personal liability, comprehensive general liability coverages or similar coverage for liability arising out of the activities of any insured.

such a circumstance, "principles of equitable contribution demand that parties under a coordinate obligation to make good the loss must share that burden equally".[31] In reaching this conclusion, Justice Bastarache considered and rejected the Court of Appeal's approach of reviewing the circumstances surrounding the issuance of the competing policies and broadly analyzing the intent of the policies. According to Justice Bastarache, this approach unfairly places the interests of one insurer over another: "This result does not accord with the principles of equitable contribution nor does it respect the intentions of both insurers."[32]

Justice Bastarache was clear about the court's intention to use this case as a means of clarifying Canadian insurance law regarding overlapping insurance coverage. He stated:[33]

> . . . the reconciliation of competing and apparently irreconcilable insurance policy provisions has plagued the courts and given rise to much academic comment in Canada as well as in American jurisdictions. This is a good opportunity for this court to clarify the law in this area.

Accordingly, Justice Bastarache reviewed the legal principles concerning an insurer's right to contribution from another insurer[34] and the rationale behind the notion of equitable contribution among insurers.[35] With respect to the court's role in applying the contribution doctrine, Justice Bastarche repeatedly emphasized that the

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31. *Ibid.*, at para. 28.
32. *Ibid.*, at para. 27.
33. *Ibid.*, at para. 1.
34. *Ibid*, at para. 15, where Justice Bastarache quoted the following basic principles of contribution in insurance law from Ivamy's *General Principles of Insurance Law*, 6th ed. (1993):
    1. All the policies concerned must comprise the same subject-matter.
    2. All the policies must be effected against the same peril.
    3. All the policies must be effected by or on behalf of the same assured.
    4. All the policies must be in force at the time of the loss.
    5. All the policies must be legal contracts of insurance.
    6. No policy must contain any stipulation by which it is excluded from contribution.
35. *Ibid.*, at para. 14, where Justice Bastarache stated:
    > It is a well-established principle of insurance law that where an insured holds more than one policy of insurance that covers the same risk, the insured may never recover more than the amount of the full loss but is entitled to select the policy under which to claim indemnity, subject to any conditions to the contrary. The selected insurer, in turn, is entitled to contribution from all other insurers who have covered the same risk. This doctrine of equitable contribution among insurers is founded on the general principle that parties under a coordinate liability to make good a loss must share that burden *pro rata*.

court's inquiry must focus only on the insurer's intentions vis à vis the insured. He stated:[36]

> . . . while it remains true that the intentions of the insurers prevail, the inquiry is of necessity limited to the insurers' intentions *vis-à-vis* the insured. In the case of an insurance contract, the entire agreement between the insurer and the insured is contained within the policy itself and evidence of the parties' intentions must be sought in the words they chose. *Were the dispute between the insurer and the insured, reference to surrounding circumstances may be appropriate if provisions of the policy are ambiguous. Once the interest of the insured is no longer at stake, that is, where the contest is only between the insurers, there is simply no basis for looking outside the policy.* In the absence of privity of contract between the parties, the unilateral and subjective intentions of the insurers, unaware of one another at the time the contracts were made, are simply irrelevant.

(5) Somersall v. Friedman[37]

On January 28, 1991, Pearl and Gwendolyn Somersall (the "Somersalls") commenced a lawsuit against Jerry Friedman, claiming that Mr. Friedman was responsible for causing the January 29, 1989 motor vehicle accident in which the Somersalls were injured. The claim exceeded the $200,000 limit of Mr. Friedman's motor vehicle liability insurance. On December 13, 1991, the Somersalls and Friedman entered into an agreement (the "Limits Agreement"), which provided that, while continuing to pursue their liability claim against Friedman, the Somersalls would not seek to recover any damages from Friedman in excess of his insurance limits. On July 4, 1994, the Somersalls added their automobile insurer, the Scottish & York Insurance Company ("S&Y") as a defendant in the action against Friedman. Relying on a Standard Endorsement Form 44 Family Protection Endorsement (the "SEF 44") issued by S&Y, the Somersalls claimed payment from S&Y for the amount by which their claim exceeded Friedman's insurance limits. S&Y commenced a subrogated claim against Friedman. Friedman argued that the subrogation action was barred by the Limits Agreement.

A chambers application was brought to determine the effect of the

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36. *Ibid.*, at para. 19 (emphasis added).
37. *Supra*, footnote 2. For a detailed critique of this case, particularly with respect to the subrogation issue, see B. Billingsley, "Somersall, Subrogation and the Supreme Court: How the Top Court's Ruling in Somersall v. Friedman Undermines Insurance Law Theory and Practice" (2003), 40 Alta. L. Rev. 917. Much of the present description of the case is borrowed from the *Alberta Law Review* article.

Limits Agreement on the SEF 44. The first issue was whether the Limits Agreement barred the Somersall's claim on the SEF 44 because the Somersalls were no longer "legally entitled to recover" compensation in excess of Friedman's policy limits. Assuming that the Somersalls were legally entitled to claim under the SEF 44, the second issue was whether the Somersalls were disentitled to payment because they had breached their duty to cooperate with S&Y by entering into a Limits Agreement which prejudiced S&Y's subrogation rights against Friedman.

The Ontario Court (General Division) ruled only on the first issue, finding that the Limits Agreement placed the Somersalls outside of the coverage provisions of the SEF 44. The Ontario Court of Appeal overturned the lower court ruling and held in favour of the Somersalls on both issues, finding that the Somersalls were still entitled to coverage under the SEF 44 notwithstanding the terms of the Limits Agreement. In a 5-2 ruling written by Justice Iacobucci, a majority of the Supreme Court of Canada upheld the Court of Appeal ruling with respect to both issues. In a strongly worded dissent supported by Justice Major, Justice Binnie held against the Somersalls on both questions.

With respect to the first issue, Justice Iacobucci held that the Somersalls were covered by the SEF 44 if, on the date of loss, Friedman would have been legally liable to the Somersalls for damages suffered.[38] Not having been in existence on the date of loss, the Limits Agreement did not impact on this analysis. With respect to the second issue, Justice Iacobucci reviewed many of the basic principles underlying the interpretation of insurance contracts and the right of subrogation (which was expressly included in the SEF 44). Of particular relevance, he emphasized the doctrine of *contra proferentum*, which requires any ambiguity in the SEF 44 subrogation clause to be interpreted in favour of the insured. He stated that *contra proferentum* means that "only a clear and unambiguous obligation upon the insured to maintain a claim in tort and not waive it in exchange for a payment" would result in a ruling favouring S&Y. He noted that, because Friedman was impecunious, the Limits Agreement in the case at bar did not undermine the main goal of subrogation, which is to ensure that an insured does not receive

38. Whether Friedman was liable would be determined at trial.

more than full indemnity and to ensure that the burden of the loss falls on the party who caused it:[39]

> . . . if there is no danger of the insured's being overcompensated and the tortfeasor has exhausted his or her capacity to compensate the insured there is no reason to invoke subrogation. Similarly, if the insured enters into a limits agreement or otherwise abandons his or her claim against an impecunious tortfeasor the insurer has lost nothing by the inability to be subrogated.

Justice Iacobucci also considered the cooperation duty owed by the Somersalls with respect to S&Y's subrogation ability and concluded that the duty was a limited one which required the Somersalls to pass to the insurer "whatever cause of action the insured may have in respect of the accident",[40] but which did not require the Somersalls to preserve a possible subrogated claim before receiving any payment by S&Y. He stated that "so long as the [Somersalls] genuinely believed that entering into the Limits Agreement was a wise and prudent thing to have done they must be regarded as having acted in good faith".[41]

Finally, Justice Iacobucci noted that his conclusions would not impose any undue harm on the insurance industry because the tortfeasor against whom such rights would be exercised is frequently impecunious:[42]

> The fact of the matter is, however, that subrogation rights against underinsured or uninsured drivers are rarely very valuable at all . . . Leaving the rules of interpretation aside, there is no good policy reason for this Court to read into the contract a provision that will so gravely prejudice the insured when the insurer will likely gain little but an exemption from the very payment for which the insured has faithfully paid her monthly premiums to ensure entitlement.

Iacobucci concluded that his decision reflected sound public policy given the "relative value of a subrogation right to an insurer and of an indemnity payment to an insured person".[43]

In dissent, Justice Binnie held that the Somersalls were not entitled to pursue their claim against S&Y. While Justice Binnie agreed with Justice Iacobucci's description of the doctrine of *contra proferentum* and the general goals behind the right of subrogation, he disagreed with all of Justice Iacobucci's conclusions regarding the

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39. *Somersall, supra*, footnote 2, at para. 50.
40. *Ibid.*, at para. 60.
41. *Ibid.*, at para. 54.
42. *Ibid.*, at para. 71.
43. *Ibid.*, at para. 74.

application of the doctrines of *contra proferentum* and subrogation in the present case. In particular, Justice Binnie found that the "relevant date to establish the cause of action against [S&Y] is the date the action is instituted against the insurer, not . . . at the earlier date when the accident occurred".[44] Justice Binnie also found that the subrogation clause in the SEF 44 was unambiguous in its intent to provide S&Y with the right to subrogate against a tortfeasor like Friedman and in its intent to impose a positive obligation on the Somersalls not to interfere with that right. Justice Binnie concluded that S&Y's right of subrogation arose upon the claim being made under the SEF 44, thereby simultaneously imposing a duty on the insured not to interfere with this right. Finally, Justice Binnie criticized at length Justice Iacobucci's findings regarding the value of the right of subrogation. He pointed out that the court had no evidence of Friedman's financial status, that the amount to be recovered in a subrogated claim is irrelevant to the insured's duty to preserve that claim, and that subrogation rights are of real value to insurers. On the latter point, Justice Binnie stated:[45]

> The insurance industry does not, I think, spend millions of dollars a year pursuing subrogated claims out of an academic interest in avoidance of overcompensation of insureds or a morality crusade against wrongdoers. They do so in the expectation of recovering a significant portion of their losses from wrongdoers to reduce their overall loss experience on which the calculation of premiums is ultimately based . . . A risk with recourse against the wrongdoer is different from a risk without such recourse.

Accordingly, Justice Binnie concluded that the Somersalls should not be entitled to claim under the SEF 44, having entered into the Limits Agreement which prevented S&Y from recovering from Friedman.

(6) Martin v. American International Assurance Life. Co.[46]

Dr. Edward Easingwood was insured under a life insurance policy that was issued by American International Assurance Life Co. and that provided benefits for death caused by "accidental means". Dr. Easingwood was addicted to opiate medications and he died from a demerol overdose. Evidence indicated that, just days prior to his death, Dr. Easingwood was happy and planning for his future,

44. *Ibid.*, at para. 125.
45. *Ibid.*, at para. 117.
46. *Supra*, footnote 2.

that the level of demerol in his blood at the time of death was barely at a lethal level and that phenobarbital, which has an additive effect upon demerol, was also in his sytem at the time of death. American International refused payment under the policy on the grounds that Dr. Easingwood's death was not accidental, having been instigated by the doctor's own deliberate act of injecting a particular dosage of demerol. The British Columbia trial court concluded that the cause of Dr. Easingwood's death did not qualify as "accidental means", but this finding was reversed on appeal. The Supreme Court of Canada unanimously held that Dr. Easingwood's death was accidental and that the insurer therefore was obliged to provide payment under the policy.

In a judgment written on behalf of the full court, Chief Justice McLachlin held that defining "accidental means" as excluding "accidental deaths that are the natural effects of deliberate actions"[47] would be "problematic"[48] because doing so would effectively deny an insured coverage in most cases and thereby frustrate the understanding and intention of the insured entering a life insurance contract:[49]

> Almost all accidents have some deliberate actions among their immediate causes. To insist that these actions, too, must be accidental would result in the insured rarely, if ever, obtaining coverage. Consequently, this cannot be the meaning of the phrase "accidental means" in the policy. Insurance policies must be interpreted in a way that gives effect to the reasonable expectations of the parties . . . A policy that seldom applied to what reasonable people would consider an accidental death would violate this principle.

Justice McLachlin defined "accidental means" as meaning that "the consequences of the actions and events that produced death were unexpected".[50] She then held that "to determine whether death occurred by accidental means, we must look to the chain of events as a whole, and we must consider whether the insured expected death to be a consequence of his actions and circumstances".[51]

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47. *Ibid.*, at para. 10.
48. *Ibid.*, at para. 12.
49. *Ibid.*
50. *Ibid.*, at para. 13.
51. *Ibid.*, at para. 14. With respect to the standard by which an insured's intentions or expectations are to be assessed, Justice McLachlin held that the subjective intention of the insured should be determined if possible. If such a determination is not possible, an objective standard may be used (para. 21):

    > The pivotal question is whether the insured expected to die. The circumstances of the death — what the insured said, or did, or did not do — may point to the

Based on the available evidence, Justice McLachlin concluded that Dr. Easingwood intended to inject himself with demerol but that he did not intend or expect to die from the injection.

Justice McLachlin's decision focused heavily on the notion that the court's role in interpreting an insurance contract is, "as far as is possible", to give effect "to the reasonable expectations of the parties".[52] She pointed out that, if an insurer wishes to exclude coverage for death caused by recklessness or risky activities, the insured could do so by writing a clear exclusion into the policy:[53]

> . . . coverage under an accidental death benefit policy depends not only on the circumstances but on what the insurance contract stipulates. It remains open to the insurer, as the party that drafts the insurance contract, to narrow coverage by means of explicit exclusion clauses. If an insurer wishes not to offer coverage for deaths that occur in certain circumstances — or, for that matter, for any death that results from a deliberate or voluntary action — then an explicit exclusion clause to this effect can simply be added to the contract. Insurers remain free to limit accidental death coverage in any way they wish, provided they do so clearly, explicitly, and in a manner that does not unfairly leave the insured uncertain or unaware of the extent of the coverage.

(7) KP Pacific Holdings Ltd. v. Guardian Insurance Co. of Canada[54]

KP Pacific Holdings Ltd. ("KP") was the owner of a hotel which was damaged by fire on June 6, 1997. KP brought a claim for the loss under an all-risks policy which had been issued by Guardian Insurance Co. of Canada ("Guardian"). Guardian refused to pay on the grounds that the claim had not been brought within one year from the date of loss as required by Statutory Conditions 14 and 15 of the Fire Insurance Part of the *British Columbia Insurance Act*.[55] KP argued that the applicable limitation period was found in Part 2, rather than Part 5 of the *Insurance Act*, and was one year from the filing of the proof of loss. KP's claim was within the deadline set by Part 2. Both the trial and appeal courts of British Columbia held that the insured's claim was limitation barred under Part 5 of the BC

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answer. However, to the extent that the answer is unclear when the matter is viewed solely from the perspective of the insured, the court may consider whether a reasonable person in the position of the insured would have expected to die.

52. *Ibid.*, at para. 16.
53. *Ibid.*, at para. 29.
54. *Supra*, footnote 2.
55. R.S.B.C. 1996, c. 226 (hereafter the "BC *Insurance Act*").

Insurance Act. In a unanimous ruling written by Chief Justice McLachlin, the Supreme Court of Canada accepted KP's argument.

The Supreme Court of Canada concluded that the BC *Insurance Act* was "unclear"[56] with respect to which limitation period properly applied to an all-risks policy. Justice McLachlin noted that the *Insurance Act* was set up to reflect "old classes of insurance" and that "newer comprehensive policies are difficult if not impossible to fit into the old categories".[57] Given the existing provisions, Part 5 of the BC *Insurance Act* must be read as not applying to multi-peril policies:[58]

> The comprehensive policy at issue on this appeal cannot be shoehorned into the Part 5 fire insurance section without contrived reconstruction and anomalous consequences. It simply does not fit. Consequently, it cannot be said that the Legislature intended the Fire Insurance provisions to govern. It follows that comprehensive policies are governed by Part 2, which is of general application.

Justice McLachlin recommended that legislators modernize the statute so as to make clear their intentions with respect to limitation periods in multi-peril policies:[59]

> In an insurance era dominated by comprehensive policies, it is imperative that Canada's Insurance Acts specifically and unambiguously address how these statutes are to operate and the rules by which comprehensive policies are to be governed.

(8) Churchland v. Gore Mutual Insurance Co.[60]

On December 16, 1991, the Churchlands suffered a theft at their home. The house and contents were insured under a homeowner's insurance policy issued by Gore Mutual Insurance Co. ("Gore"). More than one year after the date of loss, but within one year from filing an amended proof of loss, the Churchlands commenced a claim against Gore for coverage under the policy. Gore argued that the claim was barred by the fire insurance section of the British Columbia *Insurance Act*.[61] The Churchlands argued that the applicable limitation period was found in the general part of the *Insurance*

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56. *KP Pacific, supra*, footnote 2, at para. 2.
57. *Ibid.*, at para. 4.
58. *Ibid.*, at para. 6.
59. *Ibid.*, at para. 20.
60. *Supra*, footnote 2.
61. R.S.B.C. 1979, c. 200. At the time the case was started, Part 6 of the *Insurance Act* contained the fire insurance provisions. At the time of the Supreme Court's ruling, the relevant provisions were contained in Part 5 of the BC *Insurance Act*.

Act, which provided that a claim on the policy must be brought within one year from the filing of the proof of loss. The British Columbia trial court held that the claim was statute barred but the Court of Appeal set aside the decision. Adopting the analysis from *KP Pacific*, a unanimous Supreme Court of Canada held that the Churchlands' claim was not limitation barred. Again writing for the full court, Chief Justice McLachlin emphasized the obligation of the legislature to clarify its intent to relieve the court from having to engage in the "interpretive gymnastics required to analyse a multi-peril policy" under the fire insurance provisions and to avoid the "impractical consequences" of applying fire insurance provisions to comprehensive policies.[62]

4. Analysis: The Message of the Post-Whiten Cases[63]

Clearly, the trend exhibited by the Supreme Court of Canada in the Post-*Whiten* Cases is to protect the contractual interests of insureds over those of insurance companies. This trend is obviously illustrated by the simple fact that, with only minimal and sporadic dissension among court members, the Supreme Court ruled in favour of the insured in all of the Post-*Whiten* Cases involving a direct conflict between an insurer and an insured. This trend is also apparent in the substantive comments made by the court in the Post-*Whiten* Cases, the most revealing examples including the court's explicit statement in *Smith* that the main purpose of insurance law is consumer protection[64] and the court's comment in *Goulet* that insurance law is moving towards limiting forfeiture of insurance against innocent parties.[65]

Beyond simply illustrating the Supreme Court's commitment to protecting insureds, the Post-*Whiten* Cases also demonstrate that the court is prepared to develop, alter or expand insurance law principles as necessary to fulfil this commitment. For example, while the court emphasized the need to stick to the four corners of the insurance policy when determining the competing rights of insurers in

62. *Churchland*, *supra*, footnote 2, at para. 4.
63. As noted at the outset, the purpose of this discussion is to analyze the impact of the Post-*Whiten* Cases on Canadian insurance law in general. Accordingly, my remarks are intended to serve as observations about the Post-*Whiten* Cases rather than as critiques of the court's reasoning or resolution in any of the individual cases.
64. See footnote 25 and accompanying text.
65. See footnote 20 and accompanying text.

Lombard,[66] the Supreme Court's conclusion on the subrogation question in *Somersall* was explicitly influenced by the majority's perception of the limited practical value of an insurer's subrogation right.[67] Similarly, in *Churchland*, the court's decision was based in part on the court's desire to avoid the perceived "impractical consequences"[68] of applying fire insurance statutory provisions to all risk policies. Along the same lines, while the court refused to interpret creatively the statutory limitation provisions at issue in *KP Pacific* and *Churchland*, in *Smith* the court was willing to read the statutory notice obligation of an insurer as implicitly requiring the insurer to use "straightforward and clear language, directed towards an unsophisticated person".[69]

More generally, the Post-*Whiten* Cases suggest that the Supreme Court of Canada is dissatisfied with the state of insurance law in Canada and, in particular, would like to see more clarity in this area of law, especially with respect to the rights and obligations of insureds and insurers. In *Lombard*, for example, the Supreme Court expressly identified a need to clarify the principles of contribution.[70] In *KP Pacific*, the court explicitly called the relevant insurance legislation "outmoded" and characterized court decisions based on the legislation as "judicial lotteries".[71] In *Oldfield*, *Goulet*, and *Martin*, the court emphasized that insurers intending to rely on coverage exclusions to avoid payment must explicitly set out the terms of such exclusions so as to make the extent of coverage absolutely clear to the insured.[72] Overall, the Supreme Court's recurrent message in the Post-*Whiten* Cases appears to be that, in order to be successfully relied upon, an insurer's contractual rights must be explicitly and unequivocally set out in the insurance contract or in the applicable legislation. In the Post-*Whiten* Cases, the court consistently applied a very high standard in assessing whether an insurer's right to deny coverage is clearly set out in the contract or in the legislation, and the court repeatedly gave the insured the benefit of any doubt in this regard.

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66. See footnote 36 and accompanying text.
67. See footnote 42 and accompanying text.
68. See footnote 62 and accompanying text.
69. See footnote 26 and accompanying text.
70. See footnote 33 and accompanying text.
71. *Supra*, footnote 2, at para. 4. These comments were generally adopted by the court in *Churchland*, *supra*, footnote 2.
72. See footnotes 14, 19 and 53 and accompanying text.

5. Conclusion

In *Whiten*, the Supreme Court of Canada issued a ruling which unequivocally demonstrated the court's willingness to protect insureds from loss and suffering caused by the high-handed, egregious behaviour of their insurers. In the Post-*Whiten* Cases, the Supreme Court has demonstrated that its concern for the rights of insureds goes beyond circumstances where an insurer has acted improperly and extends to protecting insureds more generally from the power imbalance inherent in the insured/insurer relationship. Unless and until insurers and legislators heed the Supreme Court's warnings to more explicitly and unequivocally set out the rights of insurers in insurance contracts and in legislation, the Supreme Court will likely continue to actively protect the interests of insureds, altering and expanding insurance law principles as necessary in order to do so.

Appendix A: A Factual Breakdown of the Rulings in the Post-Whiten Cases[73]

Case Name	*Date*	*Court Members Present*	*Writers*	*Originating Jurisdiction*
Oldfield v. Transamerica Life Insurance Co. of Canada	Mar. 8, 2002	9	Major J. for 8 members. L'Heureux-Dubé J, for herself, concurring in the result.	Quebec
Goulet v. Transamerica Life Insurance Co. of Canada	Mar. 8, 2002	9 McLachlin C.J.C., L'Heureux-Dubé, Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour, LeBel JJ.	LeBel J. (for a unanimous court)	Ontario
Smith v. Co-operators General Insurance Co.	Mar. 28, 2002	7 McLachlin C.J.C., Gonthier, Iacobucci, Bastarache, Binnie, Arbour; LeBel JJ.	Gonthier J. (for the majority) Bastarache J. (dissenting alone)	Ontario

73. See footnote 2 for case citations.

Case Name	*Date*	*Court Members Present*	*Writers*	*Originating Jurisdiction*
Family Ins. Corp. v. Lombard	May 23, 2002	7 McLachlin C.J.C., Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour JJ.	Bastarache J. (for a unanimous court)	B.C.
Somersall v. Friedman 2002	Aug. 8,	7 McLachlin C.J.C., L'Heureux-Dubé, Gonthier, Iacobucci, Major, Binnie, LeBel JJ.	McLachlin C.J.C. (for the majority), Binnie J. (writing in dissent for himself and Major J.)	Ontario
Martin v. American Inter'l Assurance Life Co.	Mar. 21 2003	9	McLachlin C.J.C. (for a unanimous court)	B.C.
KP Pacific Holdings Ltd. v. Guardian Ins. Co. of Canada	May 1, 2003	9	McLachlin C.J.C. (for a unanimous court)	B.C.
Churchland v. Gore Mutual Ins. Co.	May 1, 2003	9 McLachlin C.J.C., Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour, LeBel, Deschamps JJ.	McLachlin C.J.C. (for a unanimous court)	B.C.