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FSRA SUBMITS UNFAIR OR DECEPTIVE ACTS OR PRACTICES (UDAP) RULE FOR APPROVAL

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On December 21, 2021, the Financial Services Regulatory Authority of Ontario ("FSRA") submitted its Unfair or Deceptive Acts or Practices ("UDAP") Rule ("Rule") to the Minister of Finance for final approval, after making revisions and receiving positive feedback during two public consultations conducted throughout 2021.

The Rule will replace the current UDAP Regulation¹ and will prescribe prohibited UDAPs for purposes of Part XVIII of Ontario's *Insurance Act* (the "Act").²

The intent of the Rule is to strengthen the supervision of insurance industry conduct and better protect consumers by clearly defining the outcomes that are unfair or otherwise harmful to consumers. The Rule, if adopted, will provide FSRA with discretion to determine whether a UDAP has occurred based on clear legal tests and a consideration of the circumstances.

The Rule will apply to acts or omissions of insurance agents, brokers, adjusters, and insurers, and to any person who provides goods or services that are fully or partially expected to be paid for through the proceeds of insurance including, for example, automotive repair, towing, or storage services.

While the current UDAP Regulation defines UDAPs by virtue of a list of prohibited conduct (which has been criticized as being too prescriptive), the proposed Rule provides for an outcomes-based approach. A UDAP is "conduct, including inaction or omission, which results in, or could reasonably be expected to result in the outcomes, events or circumstances set out" under the following categories:

- non-compliance with law
 - for example, the commission of any act prohibited under the Act, or under any regulation or FSRA rule.
- unfair discrimination
 - for example, any unlawful or unfair discrimination in any rate or schedule of rates between risks in Ontario of essentially the same physical hazards in the same territorial classification.
- unfair claims practices
 - for example, any adjuster or insurer not providing a claimant with timely, clear, comprehensive and accurate information about the status of a claim, the process for settling a claim or reasons for a decision made respecting a claim.
- fraudulent or abusive conduct related to goods and services provided to a claimant

- for example, a referral fee being solicited, demanded, paid or accepted in connection with goods or services provided to a claimant.
- incentives
 - for example, the payment, rebate, consideration, allowance, gift or thing of value being offered or provided, directly or indirectly, to an insured or person applying for insurance in relation to auto insurance which is based, in whole or in part, on, or is calculated by reference to, prohibited factors.
- misrepresentation
 - for example, a person being charged for any premium or fee other than as stipulated in a contract of insurance.
- prohibited conduct in automobile insurance quotations, applications or renewals
 - for example, credit information about a person being collected, used or disclosed in any manner in connection with automobile insurance, other than in accordance with the consent obtained in compliance with applicable privacy laws.
- affiliated insurers
 - for example, an agent, broker or insurer providing a quote or renewal for automobile insurance from an insurer, and not offering the lowest rate available from amongst that insurer and its affiliated insurers.

An outcome, event or circumstance will be reasonably expected if a reasonable person in the person's business or profession with full knowledge of the facts and circumstances that were known or ought to have been known, would have expected it. For an insurer, the reasonable person will be deemed to have a level of knowledge and expertise comparable to the insurer's nature, size, complexity, operations, and risk profile.

Of particular note, the Rule adds that any contravention of the Ontario Human Rights Code³ in the provision or administration of insurance, or goods or services related to insurance, is an unfair act, thereby expanding the scope of unfair acts currently prescribed by the UDAP Regulation.

The UDAP Rule also purports to remove barriers to innovative consumer incentives and encourage competition. Generally, innovative incentives may be offered if they do not involve unlawful acts, unfair discrimination, or anti-competitive practices, and adhere to additional requirements set out under the Rule including, for example, clear and transparent communication.

The Rule reflects FSRA's ongoing commitment to strengthening consumer protections and adapting to the evolving market through a principles-based approach. If approved, the Rule will take effect once other consequential amendments are proclaimed into force. Stakeholders who will be subject to the new Rule should review it closely to ensure that their current practices would not constitute UDAPs and to update their processes and procedures, as needed.

¹ *Unfair or Deceptive Acts or Practices*, O Reg 7/00.

² *Insurance Act*, RSO 1990, c 18.

³ *Human Rights Code*, RSO 1990, c H 19.

QUANTUM OF DAMAGES

Injury	Non-Pecuniary	Total	Paragraph
Neck pain	\$120,000	\$354,226	[2022] I.L.R. ¶M-3367

RECENT CASES

Insurance Decisions

Umpire Did Not Have Jurisdiction to Adjudicate Issue of Coverage Under Policy

Alberta Court of Appeal, July 26, 2021

The respondents were the owners of a tenanted residential property that was destroyed by a fire in November 2014. The respondents submitted a claim for coverage to the appellant property insurer on the same day. On the next day, the adjuster sent a letter with a blank proof of loss form and under the heading "Proof of Loss Form", advised of the two-year limitation period. The insurer took the position that it would not pay for any damage to the kitchen cabinets or additional lost rent and utilities after November 2015. After the parties participated in two umpire processes under section 519 of the *Insurance Act* (the "Act"), the umpires assessed the amounts payable for kitchen cabinet repairs, rental income to November 2015, rental income for December 2015 to January 2017, additional rental income based on the assumption that the property would be repaired sufficiently in a further three months, utility costs to November 2015, and utility costs to January 2017. The insurer did not pay the amounts awarded by the umpires, taking the position that the umpire proceedings related only to quantum and not coverage issues, while the kitchen cabinet repair, rental income, and cost of utilities post-November 2015 were questions of coverage.

In December 2017, the respondents applied for summary judgment, seeking compensation for their losses and an extension of the two-year limitation period, under section 5.3 of the *Fair Practices Regulation* (the "Regulation"). The Master allowed the application, awarding \$127,241 for the remaining repairs; judgment for the amounts determined in the umpire proceedings; and judgment for lost rental income and utility costs, from the date of the umpire proceedings to the date of his decision. A chambers judge upheld the order and also awarded additional lost rent and utilities from the date of the Master's decision to the date of her decision, but imposed a negative contingency to some of the lost rent amounts.

The insurer appealed and the respondents cross-appealed the application of the negative contingency.

The appeal was allowed in part and the cross-appeal was allowed. Paragraph 5.3(2)(a) of the Regulation states that an insurer must give written notice to the insured of the applicable limitation period "if the claim has not been satisfactorily settled, within 60 days from the date the claimant notifies the insurer of the claim". Interpreting the provision in accordance with its consumer protection purpose, the Court found that the duty to provide notice did not crystallize until the 61st day after the insurer became aware of the claim. The Court found that the Master and the chambers judge had correctly found that the notice was not sufficient. While the notice referred to the *Insurance Act*, it did not link it to discussion of the limitation period, and including the notice under the heading "Proof of Loss Form" was confusing, making it unclear what was to be done within two years. The notice lacked the quality of being written in plain language in understandable terms. There was no error in extending the limitation period.

Statutory Condition 11, under section 540 of the Act, supported the insurer's position as to jurisdiction. The provision was clear that decisions about value or quantum were to be decided by the dispute resolution process. There was contradictory evidence regarding what caused the damage to the kitchen cabinets. The loss of rental income and the cost of utilities issue was dependent upon a determination of the period for which the losses were covered, and there was contradictory evidence on this issue. The umpire had made an adjudication on who was responsible for the delay and the length of time that the loss of rental income and utilities were covered by the policy. A valuation umpire was not an adjudicator. As there was a genuine issue for trial, the chambers judge erred in granting summary judgment.

As there had been no request by either party for the application of a negative contingency in the calculation of lost rental income, the chambers judge erred in applying it.

Statt v. SGI Insurance Services Ltd., [2022] I.L.R. ¶11-6309

Insurer Breached Duty of Good Faith in Disclosing Insured's Statements to Police

Alberta Court of Queen's Bench, May 28, 2021

The plaintiff and her husband were in her vehicle when it struck and injured a party that subsequently died from his injuries. The plaintiff and her husband left the scene before the police and ambulance arrived. Later that day, the police arrested the plaintiff's husband on the assumption that he had been the driver. He was charged with impaired driving causing death and other criminal offences. The plaintiff's vehicle was insured with the defendant insurer. The insurer assigned the co-defendant employee to investigate. The plaintiff informed the employee that it was she who was driving the vehicle and the employee volunteered this information to the RCMP. The police later charged the plaintiff with failing to stop, provide her name and address, and offer assistance to the victim. The plaintiff and her husband were tried and were acquitted.

The plaintiff brought an action for damages, taking the position that the defendants breached duties of good faith and confidentiality owed to her when they disclosed the contents of their investigation and conversation to the RCMP.

The action was dismissed. The Court did not find that there was a duty on an automobile insurer to keep confidential the information an insured provided the insurer under their obligations to provide all available particulars of an accident under statutory condition 3, under section 556 of the *Insurance Act*. There was no support for the plaintiff's submission that every obligation imposed on an insurer or insured by legislation created or implied a reciprocal duty on the other party.

There was an implied obligation in every insurance contract that an insurer would deal with claims in good faith. The Court found that the duty of good faith encompassed what the insurer did with information obtained during an investigation. Whether an insurer's disclosure to the police of the insured's compelled statements was reasonably justified depended on the facts of each case. The Court found that the insurer's employee's disclosure of information to the RCMP served no purpose in the insurance investigation. The employee was "trying to help the police with their investigation" and provided gratuitous information to them. As a result, the sharing of information was not reasonably justifiable as being part of an insurance investigation and was a breach of the duty of utmost good faith owed by the defendants to the plaintiff. The disclosure, further, was not authorized under paragraphs 20(f) and (m) of the *Personal Information Protection Act*.

While there was a breach of good faith, the plaintiff did not establish that the criminal charge or prosecution resulted from the insurer's disclosure to the RCMP or caused her damages. Four months passed between the disclosure and the charge, and in the meantime, the plaintiff's husband informed the RCMP that the plaintiff had been driving. The Court also found no evidence of bad faith by the insurer to such a degree that it would warrant punitive damages.

Barata v. Intact Insurance Company, [2022] I.L.R. ¶11-6310

No Error in Finding No Direct Physical Damage to Store Stock to Trigger Coverage

British Columbia Court of Appeal, June 10, 2021

The appellant operated a business that sold electrical equipment. In 2018, the property adjacent to the appellant's premises suffered a fire. The fire did not spread to the appellant's premises but there were smoke and soot deposits in and about the premises. The appellant made a claim to the respondent insurer under its commercial business insurance policy, which provided coverage for "direct physical loss of or damage" to insured property. The claim sought coverage for damage to the stock in the storage room. An electrical engineer retained by the insurer tested samples of the stock, namely, certain lighting fixtures, and found that there was some chloride contamination, but it was free of hazardous levels of contamination and was very likely fully functional. The insurer took the position that the stock did not sustain "direct physical loss or damage" and was therefore not covered.

The plaintiff brought a summary trial application seeking full indemnity for the storage room stock, alleging that it could not be sold, displayed, or otherwise disposed of by the business. The trial judge found that the lighting fixtures had not been damaged and dismissed the claim (see *Prosperity Electric v. Aviva Insurance Co. of Canada*, 2020 BCSC 1171, [2021] I.L.R. ¶11-6259). The appellant appealed.

The appeal was dismissed. Both parties relied on *Acciona Infrastructure Canada Inc. v. Allianz Global Risks US Insurance Company*, 2015 BCCA 347, [2015] I.L.R. ¶11-5778 ("*Acciona*") where "physical loss" and "damage" were described as

“denot[ing] an alteration in appearance, shape, colour or other material dimension of the property insured”. The appellant’s position was that an increase in the surface concentration of chloride anions was “an alteration in a material dimension”. The Court stated that it was prepared to proceed on the assumption that in referring to “material dimension” in *Acciona*, the Court only meant an alteration to a “physical parameter”, not a “pertinent dimension”. *Acciona*, however, did not abandon the well-established principle that “damage” referred to a harmful alteration to the insured property.

The evidence was clear that the deposition of a small amount of chloride anions on the lighting fixtures did not affect their appearance or their function. The appellant did not provide evidence indicating that the fixtures’ value was diminished. The Court therefore found no error in the trial judge’s holding that the appellant failed to show there was any “physical loss of or damage” to the property.

Prosperity Electric v. Aviva Insurance Company of Canada, [2022] I.L.R. ¶I-6311

Insurer Did Not Have Duty to Defend Where Intentional Act Was Alleged

British Columbia Supreme Court, September 21, 2021

The petitioner was the sole owner and proprietor of a daycare. The respondent insurer issued a commercial general liability policy to the petitioner. In 2019, an infant commenced an action alleging that the petitioner was negligent in shaking the infant to such a degree that a brain injury resulted. In the alternative, the infant alleged that the petitioner’s actions constituted an assault. The insurer denied a duty to defend or indemnify under the policy, relying on its exclusion for expected or intended bodily injury from the standpoint of the insured (the “bodily injury exclusion”). The insurer also relied on the exclusion for bodily injury arising out of or resulting from abuse (the “abuse exclusion”), with “abuse” defined in the policy as “any act or threat involving molestation, harassment, corporal punishment or any other form of physical sexual or mental abuse”.

The petitioner applied to the Court seeking declarations that the insurer had a duty to indemnify and defend her with regarding to the infant’s action. The petitioner’s position was that there was a distinction between “intent to injure” and “intent to act”, with the latter not being excluded under the policy. The petitioner argued that the alleged injury, which arose out of her negligence, was covered, whereas bodily injury intended while handling the infant was not covered. The insurer argued that this was a case of an intentional tort that had been “dressed up as a negligence claim”.

The application was dismissed. It was premature to determine the issue of the duty to indemnify and the Court considered the issue of duty to defend only. The infant’s notice of civil claim pleaded claims in both negligence and in assault, which was an intentional tort. The Court agreed with the Court of Appeal for Ontario that *Non-Marine Underwriters, Lloyd’s of London v. Scalera*, 2000 SCC 24 (“*Scalera*”), affirmed the decision in *Co-operative Fire & Casualty Company v. Saindon*, [1976] 1 SCR 735. In *Scalera*, the Court had held that the relevant distinction was between injuries caused by an intentional tort and those that arose from negligence, and found no effective distinction between an exclusion clause for “intentional acts” and one for “intentional injuries”. The Court considered whether the allegations of negligence in the underlying action were subsumed within the allegations of assault. Pursuant to *Scalera*, if the negligence and intentional tort claims both arose from the same actions and caused the same harm, the negligence claim was derivative and would be subsumed into the intentional tort when determining exclusion clauses. The Court found that the underlying elements of the claims in negligence and of the intentional tort of assault were not sufficiently disparate to render the two claims unrelated, as they arose from the same actions and caused the same harm. As a result, the Court concluded that the negligence claim was derivative and subsumed into the intentional tort assault, therefore falling under the bodily injury exclusion. The insurer did not have a duty to defend.

Henderson v. Northbridge General Insurance Corporation, [2022] I.L.R. ¶I-6314

Judge Erred in Devising Test for Determining if Insured’s New Vehicle Was “Newly Acquired Automobile”

Nova Scotia Court of Appeal, September 9, 2021

The respondent construction company held a commercial fleet automobile policy with the appellant insurer. One of the insured vehicles was an 18-person 1994 Ford E350 Van. The respondent used the van to transport employees and tools

to job sites and as a location for meetings and for employees to eat lunch. In 2016, the owner of the construction company purchased a 1997 Bluebird school bus (the "bus"). The bus had been modified to accommodate a vehicle at the back and had bench seating inside, and was intended to be used in the same way as the Ford van. On the day the bus was purchased, the company was unable to notify the insurance broker of the purchase, as it was after-hours on a Saturday. On the following day, the bus was involved in a single-vehicle accident. The company did not ask to add the bus to the policy, as it was now undriveable.

Three of the passengers advanced claims against the company owner and company. The company took the position that the bus was automatically covered during the 14-day period an insured had to notify its insurer of a "newly acquired automobile" under Nova Scotia's Standard Automobile Policy ("SAP"). The insurer declined to defend or indemnify the claims, taking the position that the bus was not a "newly acquired vehicle" and that if there had been a request to add it to the policy, the insurer would have refused to do so, as the bus was of a different nature and character, and constituted a material change in risk.

The motion judge found that this was not a rare and exceptional case for exclusion of the additional vehicle, as the bus was similar in function to the Ford van and its purpose was rationally connected to the business (see *PK Construction Limited v. Aviva Insurance*, 2020 NSSC 209, [2021] I.L.R. ¶¶6-257). The bus therefore met the definition of "newly insured vehicle" under the policy and was covered. The insurer appealed.

The appeal was dismissed. The Court found that the motions judge had incorrectly focussed on the reasonable expectation of the parties. The SAP was a contract and the interpretation of its terms was to be guided by, first, giving effect to the clear language of the provision. The Court found no ambiguity in the terms of the SAP. Under the policy, the insurer had agreed to offer fleet insurance for a "newly acquired automobile". While the SAP did not define "automobile", the *Insurance Act* defined "automobile" in a broad manner that included buses. As the bus was a self-propelled vehicle, it was an automobile, the Court found, and was therefore covered automatically for 14 days. Once notified of the new automobile during the 14-day period, the insurer had the opportunity to assess the additional risk, if any, and require an additional premium.

The Court did not endorse the motion judge's holding that coverage could be denied in "rare and exceptional circumstances" where the nature of the new automobile was so different as to sever any reasonable expectation of coverage. The Court found that this approach introduced an exclusion in the standard form policy that could not be implied from its terms or on any other basis. The question whether the bus was a newly acquired automobile under the policy was a question of interpretation of the policy and therefore a question of law. There was no need to devise a test, the Court stated. While the Court did not endorse the motion judge's test, the motion judge had ultimately arrived at the correct result in finding that the bus was covered under the policy.

Aviva Insurance v. PK Construction Ltd., [2022] I.L.R. ¶¶6-315

Judge Erred in Interpretation of Corrosion Exclusion in All-Risks Policy

Ontario Court of Appeal, September 3, 2021

The respondents were a global health science company. The respondents purchased radioisotopes produced at a Nuclear Research Universal Reactor ("NRU") located in Chalk River, Ontario, and processed them for sale worldwide. In 2009, a leak of heavy water containing tritium occurred at the NRU, resulting in the need to shut it down for 15 months. The leak was caused by corrosion. The closure of the NRU resulted in revenue losses for the respondents. The appellant insurer had issued an all-risks property policy to the respondents. The policy included coverage for "time element losses" including loss of profits to the insured flowing from physical damage to a supplier "directly resulting from physical loss or damage of the type insured by this Policy", subject to exclusions. The respondents submitted a claim for loss of profits and the insurer denied the claim, relying on the policy's "corrosion" exclusion. The term "corrosion" was not defined in the policy.

The respondents brought an action seeking coverage under the policy. They argued that the corrosion that caused the leak was unexpected and therefore not captured by the exclusion. The trial judge found that the term "corrosion" in the policy was ambiguous and that the exclusion applied only to non-fortuitous, anticipated corrosion, and therefore did not apply to the respondents' claim (see *MDS Inc. v. Factory Mutual Insurance*, 2020 ONSC 1924, [2020] I.L.R. ¶¶6-243).

The judge also found that the exception to the exclusion for “physical damage” caused by corrosion was ambiguous and should be interpreted to include economic loss, not just physical damage. The insurer appealed.

The appeal was allowed. The Court stated that all-risk policies were, by their grant, limited to cover only fortuitous or unanticipated losses. “Corrosion” had a plain and ordinary meaning that included any kind of wearing away. It was therefore clear and unambiguous that physical loss or damage caused by corrosion was a loss specifically excluded from coverage, and the trial judge erred in finding otherwise. The trial judge had modified this term based on her interpretation of subjective remarks made by two of the insurer’s representatives regarding the possibility of coverage for corrosion, which were misconstrued, the Court found. Defining “corrosion” to include both anticipated and unanticipated corrosion was consistent with commercial reality, the clear terms of the policy, and the need to interpret standard form policies consistently and objectively.

The exception provided that “[t]his Policy excludes [corrosion], but, if physical damage not excluded by this Policy results, then only that resulting damage is insured”. The Court found that the exception did not include coverage for economic loss. The exception to the exclusion for corrosion was restricted to “resulting physical damage” to the insured property, and the plain meaning of physical damage did not include economic loss. The Court found that a contextual analysis of the policy did not lead to a finding of a broader interpretation of “resulting physical damage”. The Court noted that the preponderance of case law in Canada, the United States, and the United Kingdom did not interpret resulting physical damage to extend beyond physical repairs to include loss of use. In the instant case, the only resulting physical damage was the leak in the calandria wall that was caused by corrosion. While economic loss could result from physical damage, it was not physical damage. The judge erred in her interpretation of the corrosion exclusion and the exception to the exclusion.

MDS Inc. v. Factory Mutual Insurance Company, [2022] I.L.R. ¶11-6316

Estoppel Did Not Apply Where Insurer Did Not Know of Policy Breach at Time of Providing Defence

Supreme Court of Canada, November 18, 2021

Steven Devecseri was involved in and died as a result of a motor vehicle accident in 2016. Mr. Devecseri’s motorcycle had collided with a vehicle driven by Jeremy Caton. Both Mr. Caton and Jeffrey Bradfield were injured in the accident and commenced claims against Mr. Devecseri’s estate. Mr. Devecseri’s insurer, the respondent, defended his estate in the two lawsuits. Three years post-accident, and over a year into the litigation, the insurer learned that Mr. Devecseri had consumed alcohol pre-accident, which meant he had breached his insurance policy, resulting in coverage being limited to the statutory minimum of \$200,000. Subsequently, the insurer ceased defending the estate. After one of the actions proceeded to trial, a judgment was issued against Mr. Devecseri’s estate and Mr. Bradfield and a judgment was issued for Mr. Bradfield on his cross-claim against Mr. Devecseri’s estate. Mr. Bradfield sought to enforce the judgement against the estate, rejecting the insurer’s position that its exposure on behalf of the estate was limited to \$200,000. Mr. Bradfield relied on waiver by conduct and promissory estoppel.

The trial judge found that waiver by conduct applied, and the insurer had waived its right to deny full coverage by providing a defence. The Court of Appeal allowed the insurer’s appeal. It found that the waiver by conduct was precluded under the *Insurance Act* (the “Act”) at the time, and that estoppel did not apply, as, due to the insurer’s lack of knowledge of the policy breach, the insurer’s conduct could not have amounted to a promise that was intended to affect the parties’ legal relationship. Mr. Bradfield appealed and subsequently reached an agreement with the insurer. The appellant Trial Lawyers Association of British Columbia was permitted to be substituted as the appellant.

The appeal was dismissed. The Court found, and the appellant conceded, that waiver by conduct was precluded under the Act. The Court found that the estoppel argument failed, as the insurer had not given a promise or assurance that intended to affect its legal relationship with Mr. Bradfield. At the time it provided a defence, the insurer lacked knowledge that Mr. Devecseri had breached the policy. As a result, the appellant could not establish the elements necessary for estoppel, which were that the other party had made a promise or assurance by words or conduct, the parties were in a legal relationship at the time of the promise or assurance, the promise or assurance was intended to affect that relationship and to be acted on, and the party actually relied on the promise or assurance.

The Court noted that the insurer was under a duty to Mr. Devecseri to investigate the claim against Mr. Devecseri fairly and in a balanced and reasonable manner. The insurer did not have an additional duty to Mr. Bradfield to investigate fairly and in a balanced and reasonable manner, as this duty was only owed to the insured. The Court upheld the Court of Appeal decision.

Trial Lawyers Association of British Columbia v. Royal & Sun Alliance Insurance Company of Canada, [2022] I.L.R. ¶I-6321

Other Insurance Decisions

Insured Failed to Notify of Material Change in Risk, Avoiding Policy Prior to Fire Loss — *Drechsler v. Canadian Northern Shield Insurance Company*, [2022] I.L.R. ¶I-6312, British Columbia Supreme Court (August 25, 2021)

Professional Liability Insurer Had Duty to Contribute Equally to Defence — *Northbridge General Insurance Corporation v. XL Specialty Insurance Company*, [2022] I.L.R. ¶I-6313, British Columbia Supreme Court (August 26, 2021)

Plaintiff Did Not Meet Coverage Criteria of Residing in Same Dwelling as Named Insured — *Verhoef v. Intact Insurance Company*, [2022] I.L.R. ¶I-6317, Ontario Superior Court of Justice (June 15, 2021)

Public Entity General Liability Insurer Had Duty to Defend in Negligence Action Against Municipality — *AIG Insurance Company v. Lloyd's Underwriters*, [2022] I.L.R. ¶I-6318, Ontario Superior Court of Justice (August 4, 2021)

Insurer Required to Defend Additional Insured for Covered Claims Only — *Oshawa v. MEARIE*, [2022] I.L.R. ¶I-6319, Ontario Superior Court of Justice (June 7, 2021)

"Other Insurance" Clauses in Policies Were Irreconcilable — *Northbridge General Insurance Company v. Aviva Insurance Company*, [2022] I.L.R. ¶I-6320, Ontario Superior Court of Justice (October 13, 2021)

Torts — Motor Vehicle

Trial Judge Erred in Application of "Pallos Approach" To Determine Future Earnings Loss

British Columbia Court of Appeal, September 24, 2021

In April 2017, the respondent was involved in a motor vehicle accident. The appellant admitted liability. At the time of the accident, the respondent was 57 years old. She had worked for Bell Canada until 2002 or 2003. She subsequently worked as an independent consultant, earning \$200,000 to \$300,000 in her prime years. In 2010, she started an ATM business. In 2012, she started a venture trying to develop a perfume and to sell exotic meats abroad. The respondent brought an action seeking damages in relation to her personal injuries. At trial, the judge found that the respondent suffered an aggravation to her underlying neck and back pain, had increased migraines, and her energy levels were reduced, though she was still able to work on her businesses for at least a few hours per day. The judge found that by 2012, the respondent had been struggling to retain her high-income positions and, by 2017, was several years past her top income year as a consultant. Applying the "Pallos approach", the trial judge awarded loss of future earning capacity of \$150,000, having applied a discount of 50 per cent to the respondent's suggested award of \$300,000, based on one year's income. The trial judge also awarded \$100,000 for costs of future care.

The appellant appealed, taking the position that the judge failed to properly analyse whether there was a real and substantial possibility of the respondent suffering a future loss of earnings.

The appeal was allowed. Having reviewed the case law, the Court stated that a three-step process emerged for considering claims for loss of future earning capacity, in particular where the evidence indicated no loss of income at the time of trial: (1) whether the evidence disclosed a potential future event that could lead to a loss of capacity; (2) whether, on the evidence, there was a real and substantial possibility that the future event would cause a pecuniary loss, and, if yes; (3) what was the value of that possible future loss, which included assessing the relative likelihood of the possibility occurring. The Court found that while the trial judge applied the first step, and found that the respondent suffered symptoms that made her less "less valuable to [her]self as a person capable of earning income in a competitive labour market", the judge erred in failing to perform an analysis of the second and third steps.

Having regard to the context of the respondent's work history, her intention to keep working in her new ventures, and her inability to devote the same amount of energy and hours to work, it was open to the judge to find that there was a

real and substantial possibility that this lack of capacity would lead to a future income loss. Accordingly, the second step was satisfied. Turning to the third step, the Court found that the trial judge erred in the application of the "Pallos approach" of using one or two years' income. The judge resorted to the highest annual income ever earned by the respondent, \$300,000, without giving a reason for accepting this figure. The Court instead considered the range of the respondent's income from her ATM business, which had a low of negative \$3,000 and a high of \$31,000 that occurred post-accident. Following the "Pallos approach", the Court valued the potential loss at \$100,000, being an average income of approximately \$25,000 per annum per venture over two years. The Court reduced this by 60 per cent to take into account the relative likelihood of the possibility of loss occurring, resulting in an award of \$40,000 for loss of future earning capacity.

In determining future care costs, the judge erred in accepting that trigger point injections would be delisted from the Medical Services Plan, without assessing whether there was a real and substantial possibility of this and the relative likelihood of that possibility occurring. The Court assessed the likelihood at 50 per cent and reduced the award by \$6,385, to \$93,614.

Rab v. Prescott, [2022] I.L.R. ¶M-3366

Other Motor Vehicle Tort Decisions

Plaintiff with Chronic Neck Pain Awarded \$120,000 in Non-Pecuniary Damages — *Martin v. Frederickson*, [2022] I.L.R. ¶M-3367, British Columbia Supreme Court (July 21, 2021)

Torts — General

City Did Not Establish Snow Plowing Decision Was "Core Policy" Immune from Negligence

Supreme Court of Canada, October 21, 2021

The appellant, City of Nelson (the "city"), experienced a heavy snowfall in January 2015 and city employees began plowing and sanding streets in response. The tasks included clearing snow in angled parking stalls in the downtown core. The employees plowed snow to the top of the parking spaces, creating a snowbank along the curb, separating the sidewalk from the parking stalls. The employees did not clear an access route between the stalls and the sidewalk. The respondent parked her vehicle in one of the stalls and as she attempted to cross the snowbank to the sidewalk, she injured her leg. The respondent brought an action in negligence against the city. The trial judge found that the city did not owe the respondent a duty of care, as its snow removal decisions were core policy decisions, which were immune from negligence. The trial judge found that, in the alternative, there was no breach of the standard of care and, if there was a breach, the respondent was the proximate cause of her injuries (see *Marchi v. Nelson (City of)*, 2019 BCSC 308, [2019] I.L.R. ¶G-2843). The Court of Appeal held that the trial judge erred and ordered a new trial (see *Marchi v. Nelson (City)*, 2020 BCCA 1, [2020] I.L.R. ¶G-2860). The city appealed.

The appeal was dismissed. The Court found that the city failed to establish that the respondent was seeking to challenge a core policy decision that was immune from liability for negligence. In determining whether a decision was a core policy decision, the focus lay on the nature of the decision, being: (1) the level and responsibilities of the decision-maker; (2) the process by which the decision was made; (3) the nature and extent of budgetary considerations; and (4) the extent to which the decision was based on objective criteria. The Court stated that the assessment was to be made not with regard to the overall winter maintenance policy of the city but with regard to the city's decision on how to treat the specific parking area. Even if the city's winter maintenance policy qualified as a core policy, this did not mean that the creation of the snowbank without a pathway for pedestrians was a matter of core policy. In clearing the parking stalls, the city invited persons to park in the stalls, but it did not create an access route to the sidewalk. There was no evidence that this decision was a choice that involved weighing of competing economic, social, and political factors, and conducting contextualized analyses of information. The city's evidence was that it was a matter of custom. The Court concluded that the city did not establish that the method of plowing the parking stalls was a core policy. The Court remitted the matter for a new trial on the standard of care and on causation.

Nelson (City) v. Marchi, [2022] I.L.R. ¶G-2887

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