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AN INSURER'S APPROACH TO DEFENDING PUNITIVE DAMAGES

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INTRODUCTION

General Duty of Good Faith:

The duty to act in good faith in the context of insurance litigation originally applied only to insured's given their monopoly over information relevant to the risk at issue. However, more recently that duty has been expanded such that it now applies to insurers as well. The underlying purpose of this duty is to ensure that there is no imbalance of bargaining power between the insured and the insurer.

Generally, the duty of good faith requires that the insurer pay a claim in a timely fashion if there is no reason to do otherwise and to treat the customer properly while investigating, assessing and deciding whether or not to pay a claim. Moreover, the duty of good faith applies regardless of coverage (the existence, or lack thereof). The duty of good faith is viewed as independent from the loss for which the insured is claiming compensation. It is possible, therefore, for an insurer to be found to have acted in bad faith even where it has been determined that no coverage exists, for whatever reason. If the insurer's conduct amounts to bad faith and such conduct caused harm to the insured, that is likely sufficient to establish a claim of bad faith against an insurer.

As a result of the unique nature of the insurer-insured relationship, in that the insurer can control the litigation on behalf of the insured, there is an additional requirement placed upon the insurer's conduct in relation to settlement(s). When determining whether or not to make or accept a settlement offer, the insurer must give equal consideration to the interests of the insured as it gives to its own interests.

What is the Threshold for Bad Faith?

There is no threshold test set out to indicate when an insurer should be found to have acted in bad faith. The courts look at the facts of each case and decide accordingly. The types of conduct by an insurer that have failed to meet the standard of good faith include ignoring and/or manipulating evidence, denying or terminating benefits without proper attention to objective evidence, requesting information from an insured to which the insurer is not entitled and high handed treatment of an insured. It appears that the courts

ultimately determine the existence of bad faith based on the reasonableness of the insurer's conduct.[1]

Where a determination of bad faith on the part of the insurer has been made, punitive damages will usually be awarded against the insurer.

However, It is clear that a finding of bad faith conduct on the part of the insurer does not automatically result in an award of punitive damages. The case law sets out various factors to be considered in determining whether punitive damages should be awarded. The SCC in ***Whiton v. Pilot Insurance Co.*** held that a breach of an insurer's duty of good faith is an independent actionable wrong from the breach of the substantive terms of the insurance contract. It follows that a breach of the insurance contract (ie. denial of payment of benefits) will not automatically result in a finding of a breach of the duty of good faith. Furthermore, the determination of bad faith is independent of coverage.

Until the ***Whiten v. Pilot*** decision was rendered by the Supreme Court of Canada in February of 2002, punitive damages did not play a significant role in governing the conduct of insurer's in the handling of claims. Prior to ***Whiten v. Pilot***, the largest punitive damage award against an insurer was $15,000.00. In the ***Whiten*** case, one of the concerns for the Supreme Court of Canada was whether the award of $1,000,000.00 for punitive damages was so extreme as to be unconscionable in relation to existing legal precedent.

Punitive damages by their nature are not compensatory, they are designed to address the purposes of retribution, deterrence and denunciation. In the Waddams text on contracts, the author states "problems arise for the common law wherever the concept of punitive damages is posed. The award of punitive damages requires that a civil court impose what is in effect a fine for conduct it finds worthy of punishment and then to remit the fine, not to the State Treasury, but to the individual plaintiff who will by definition, be overcompensated".

What is interesting of course is that this punishment will be accomplished in the absence of the procedural protections for the defendant which are always present in criminal prosecutions such as proof beyond a reasonable doubt and stricter evidentiary considerations. The courts in Canada have always been willing to award punitive damages, even in a situation where the defendant may have already been convicted of a criminal or quasi-criminal offence. The courts have indicated that the conviction is only one factor to be taken into account, although it is deemed to be a very important factor. In situations where the fine or punishment that was imposed pursuant to the criminal justice standard does not appear to be sufficient deterrence either by way of specific deterrence

[1] 2 Craig Brown, Julio Henezes, *Insurance Law in Canada,* § 10.4 (1999)

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or general deterrence, then the civil court can proffer their condemnation of the defendant's actions with an award of punitive damages.

In the ***Vorvis v. Insurance Corporation of British Columbia*** case, a 1989 decision of the Supreme Court of Canada dealing with wrongful dismissal, the court stated that punitive damages are not recoverable for a breach of contract unless the conduct constituting the breach is also an actionable wrong for which punitive damages are recoverable. The court stated that in an action based on a breach of contract, the only link to the parties for the purposes of defining their rights and obligations is the contract. Where the defendant has breached the contract, the remedies open to the plaintiff must arise from that contractual relationship which the parties agreed to accept at its inception. When a breach of the contract occurs, the injured plaintiff is not entitled to be made whole, he is entitled to have that which the contract was created to do for him or compensation for its loss.

The court concluded that punitive damages may only be awarded in respect of conduct which is of such a nature as to be deserving of punishment because of its harsh, vindictive, reprehensible and malicious nature.

In ***Whiten v. Pilot***, Mr. Justice Laskin of the Ontario Court of Appeal in a minority opinion which was adopted by the Supreme Court of Canada, argued that the duty to act in good faith is separate from the insurer's obligation to compensate its insured for a loss covered by the policy. As a result, the breach of utmost good faith is a separate and actionable wrong. The Supreme Court of Canada agreed that a breach of the contractual duty of good faith is independent of any additional breach of a contractual duty to pay the loss. The court stated that the breach of the contractual duty of good faith constitutes an actionable wrong within the Vorvis rule.

RECENT CASE LAW DEALING WITH BAD FAITH ALLEGATIONS

The issue of bad faith was recently canvassed by the SCC in ***Fidler v. Sun Life Assurance***[2] *("**Fidler**")*. The Supreme Court in ***Fidler*** upheld the trial judge's decision that the insurer did NOT act in bad faith despite its denial of disability benefits (after paying such benefits for two years) in the face of strong medical evidence that the insured continued to be disabled. The trial judge concluded that it would not characterize the denial of benefits as bad faith given that the nature of the insured's disability was not observable (via X-rays or MRI's). While the SCC admitted that the insurer's actions were "troubling", it held that there was no error in law on the part of the trial judge sufficient to overturn the decision to refuse punitive damages.

[2] [2006] S.C.J. No.30

The Court said,

> *...we appreciate that the facts in this case represent conduct that is extremely troubling – the five year denial by Sun Life of disability benefits without medical support for the denial is, to say the least, inappropriate. But an insurer will not necessarily be in breach of the duty of good faith by incorrectly denying a claim that is eventually conceded, or judicially determined, to be legitimate.* (Emphasis added)

The British Columbia Court of Appeal had determined in a two-to-one decision that punitive damages should be awarded as a result of three factors:

1. The absence of medical evidence to justify denial of Ms. Fidler's claim;
2. Sun Life's internal memoranda exaggerating the surveillance results and indicating an intention to avoid looking bad in the conduct of litigation; and
3. Sun Life's failure to disclose to Ms. Fidler the surveillance video on which it relied in denying her claim.

As indicated, the Supreme Court of Canada found Sun Life's decision to terminate benefits "troubling" but the court emphasized that the question is whether the denial was the result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claim's process. The Supreme Court of Canada found that although Sun Life's Medical Consultants Report revealed "bald factual misstatements" and "Ms. Fidler's behaviour in the course of the surveillance seemed to demonstrate an ability to engage in some activities", the failure to disclose the surveillance was tempered by the fact that Sun Life set out in a letter to Ms. Fidler, the specific activities observed in the surveillance and the conclusion Sun Life drew as a consequence.

The court also confirmed the decision in ***Whiten v. Pilot Insurance Company*** [3] in which they said that the breach of an insurer's duty to act in good faith is a punishable wrong separate and apart from the breach of the insurance contract. In that case, the court determined that the threshold for an award of punitive damages is whether the insurer breached not only its contractual obligation to pay the claim, but also the independent contractual obligation to deal with the claim in good faith.

[3] [2002] S.C.J. No.19

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The court further cited the 2002 Ontario Court of Appeal decision of ***702535 Ontario Inc. v. Lloyd's London, Non-Marine Underwriters*** [4] *("702535 Ontario")* which discussed the legal standard to which insurer's are held in relation to bad faith conduct.

> *The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy. This duty of fairness, however, does not require that an insurer necessarily be correct in making a decision to dispute its obligation to pay a claim. Mere denial of a claim that ultimately succeeds is not, in itself, an act of bad faith.*

As has been pointed out in a number of cases, an insurer will not necessarily be liable for punitive damages by incorrectly denying a claim that is eventually conceded or judicially determined to be legitimate. The question in each case is whether the denial was the result of the overwhelmingly inadequate handling of the claim or the introduction of improper considerations into the claim process. In the ***Lloyd's*** case the court advised that ultimately each case revolves around its own facts and what constitutes bad faith will depend on the circumstances in each case. A court considering whether the duty has been breached will look at the conduct of the insurer throughout the claim process to determine whether in light of the circumstances as they then existed, the insurer acted fairly and promptly in responding to the insured's claim.

In the ***Sun Life*** case, the Supreme Court of Canada stated that by their very nature, contract breaches will sometimes give rise to censure. However, to attract punitive damages, the impugned conduct must depart markedly from ordinary standards of decency. This will be the exceptional case that can be described as malicious, oppressive or high-handed and that offends the courts sense of decency. Misconduct must be of a nature as to take it beyond the usual circumstances that surround the breaking of a contract. The court in the ***Sun Life*** decision made it clear that it is important that punitive damages be resorted to only in exceptional cases and then with restraint.

Recently, the Ontario Court of Appeal, in ***Pereira v. Hamilton Township Farmers' Mutual Fire Insurance Company*** [5], suggested that actions such as prejudging the merits of a claim, conducting a biased investigation of a claim and advancing baseless defences

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[4] 184 D.L.R. (4th) 687, leave to appeal refused
[5] [2006] I.L.R. I-4499

are all actions by an insurer that support an award of punitive damages. Such actions were viewed by the court as evidence of conduct that is "reprehensible, high-handed or malicious, such that it departs to a marked degree from ordinary standards of decent behaviour"[6]. The court also stated that the award of $2.5 million in punitive damages was excessive since "the appellant did not go quite so far as to shop for an expert willing to report that the fire was incendiary...nor did the insurer ignore conclusions drawn by independent third parties...there is no suggestion that evidence was concocted...". Since the threshold for an award of punitive damages is higher than for a finding of bad faith conduct, the court is suggesting that the specific behaviour identified is connotative of bad faith on the part of an insurer.

In ***Plester v. Wawanesa Mutual Insurance Company***[7], the Ontario Court of Appeal found that a seven month delay in informing the insureds that their claim was denied was not in itself evidence of bad faith as the insurance company was entitled to conduct an investigation as a result of the information it received that the fire was incendiary. However, the court did find bad faith in the insurer's ultimate denial of payment and defence of arson. The insurers reliance on its follow up investigation, which was found to be not conclusive in respect of the financial motive of the insureds, was not strong or credible evidence that the insureds started the fire. Moreover, it was appropriate for the trial jury to take the fact that the insurance company sent out its letter of denial one day after it requested a written opinion from a forensic accountant as evidence of bad faith conduct.

Interestingly, the court decided that an award of punitive damages for the bad faith conduct of an insurer could be made to the estate of a deceased plaintiff. An expansive interpretation of S.38 of the Trustee Act was used to conclude that the estate of a deceased person should be put in the same position as the deceased person would have been in if he/she were alive. In making this decision, the court came to a different conclusion than that arrived at by the British Columbia Court of Appeal.

The Court said that,

> *...the fact that some provincial legislatures have seen fit to exclude claims for punitive damages by an estate invites the suggestion that if the Ontario legislature had intended to exclude such claims, it would have expressly done so.*

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[6] This is the test set out in *Whiten v. Pilot Insurance Company* to an award for punitive damages.

[7] [2006] O.J. No. 2139

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The court of appeal in British Columbia recently discussed, in some depth, the issue of an insurers duty of good faith in ***Insurance Corp of British Columbia v. Hosseini*** [8]. It stated,

> *The duty of an insurer to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its insureds applies equally to the investigating, assessing and resolving of claims made against its insureds.*

Thus, the duty of good faith applies equally to both first party claims and third party claims.

The court overturned the trial judge's decision and held that the insurer acted in bad faith by not promptly informing its insured that it had considered him as uninsured since 1992. Instead, the insurer only notified the insured of its position approximately eight years after the accident. Throughout the duration of this case, the insurer held the position that the insured was an 'insured in breach of the contract, *or in the alternative*, an uninsured motorist'. The trial judge felt that there was nothing inherently wrong with this position. The appeal court confirmed that an insurer is required to (promptly) inform the insured of all material information relating to the insured's position in the litigation.

The above case also involved a settlement between the insurer and the passenger in the vehicle driven by the insured. After the settlement was reached, the insurer pursued the insured for the full amount of the settlement, even though the settlement amount also settled any personal injury claims that the passenger may have had as a result of five other motor vehicle accidents in which he was involved. The court held that the insurer acted in bad faith in pursuing the insured for the full amount, for which he was not entirely liable.

Lastly, the insurer in the above case was found to have acted in bad faith in taking steps that resulted in the denial of a driver's licence to the insured. While the trial judge found that this was nothing more than a "clerical mix-up", the appeal court found that in light of the bad faith conduct by the insurer mentioned above, that this action further substantiated the bad faith conduct of the insurer.

In Alberta, in the recent case of ***Baudisch v. Co operators General Insurance Co.***[9]**,** the court determined only certain actions of the insurer to be bad faith conduct. For example, it held that the insurer acted in bad faith in requiring the insured to accept the insurer's evaluation of the vehicle as a condition of payment. Yet it found that giving the insured

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[8] [2006] B.C.J. No.6

[9] [2004] A.J. No 1456

the impression that the insurer would pay for any appraisal he obtained and then not doing so was not found to be bad faith. It also appears that the court did not find bad faith on the part of the insurer where the insured was found to have no economic interest in that portion of the claim. This case also stands for the proposition that an insurer can be deemed to have acted in bad faith even though it paid the insurance coverages under the policy.

The specific facts of each case are very relevant in determining whether or not an insurer acted in bad faith.

THE IMPLEMENTATION OF RULE 49 (OFFER TO SETTLE) IN THE CONTEXT OF AN INSURER'S DUTY OF GOOD FAITH

The only case I was able to find in relation to bad faith and offers to settle was the case of ***Kavanaugh v. ING Insurance Company of Canada***[10], where the court found that the insurer did NOT act in bad faith since

> *There is no evidence whatsoever that the plaintiff did not enter into this settlement willingly, that she was pressured or unduly influenced.*

From this it can be inferred that bad faith may be found where there is evidence that the insurer has placed undue influence or pressure on the insured for the purposes of entering into a settlement (of a first party claim).

In order to avoid a bad faith allegation when entering into a settlement of a third party claim**,** on behalf of the insured, the insurer should place equal value on the interests of the insured as it does its own interests.

RECOGNITION FACTORS THAT INSURERS SHOULD BE AWARE OF IN REGARD TO BAD FAITH CLAIMS

No one court decision sets out the exact factors that the courts look at when determining whether the insurers actions constitute bad faith. Rather, the courts appear to follow the general guideline set out by the Ontario Court of Appeal in ***702535 Ontario v. Lloyds***, which states that the determination of the existence of bad faith conduct will depend on the circumstances of each particular case. More specifically, it held that

[10] [2005] O.J. 5290

> *A court considering whether the duty has been breached will look at the conduct of the insurer throughout the claims process to determine whether in light of the circumstances, as they then existed, the insurer acted fairly and promptly in responding to the claim.*

Based on the reasoning used in the cases outlined above, the courts place significant weight on the reasonableness of the insurer's actions in determining whether or not a valid claim for bad faith exists. The court also looks at whether or not any economic or other harm/prejudice was caused to the insured as a result of the questionable conduct.

In ***Whiton v. Pilot***, the Supreme Court of Canada indicated that there were a number of factors that the court should consider in assessing whether it was necessary to assess punitive damages:

a. whether the misconduct was planned and deliberate;

b. the intent and motive of the defendant;

c. whether the defendant persisted in the outrageous conduct over a lengthy period of time;

d. whether the defendant concealed or attempted to cover up its misconduct;

e. the defendant's awareness that what he or she was doing was wrong;

f. whether the defendant profited from its misconduct;

g. whether the interest violated by the misconduct was known to be personal to the plaintiff (professional reputation – Hill case) or a thing that was irreplaceable – trees.

BEST PRACTICES FOR INSURERS SEEKING TO PROTECT THEMSELVES FROM BAD FAITH CLAIMS

The case law is clear in setting out some general practice tips for insurers to follow in protecting themselves from claims of bad faith. Most importantly, insurers should act promptly, fairly and reasonably throughout all stages of answering a claim, including the investigation, assessment and resolution stages.

[11]The facts of each case will give rise to particular actions that insurers should take in avoiding bad faith claims. For example, when assessing claims, insurers should take into consideration all of the objective evidence available. Insurers should not deny a claim unless they can substantiate such a denial with objective evidence. Insurers should inform their insured of their position in the litigation. Insurers should balance their own interests with the interests of their insured. Insurers are not expected to be correct in their assessment of every claim, rather it is the manner in which they handle the claim that is relevant. Insurers should also be aware that the Ontario Court of Appeal recently stated that it is NOT the obligation of an insurer to investigate the representations made by an applicant for insurance.[12]

How Should an Insurer Approach a Potential Bad Faith Claim?

There are a number of claims practices that need to be part of any claims handling but particularly when the insurer is considering a denial of a claim based on a defence of arson or fraud. It is important to remember that in raising such a defence you are alleging that the insured has committed a criminal offence. This is not a step to be taken lightly as these are allegations that may very well have a detrimental effect on the name and good character of the insured for the rest of their life. The information and rumours in regard to the arson defence does not have to be spread by the insurer to be known to the public at large. When people see a property destroyed by fire and not rebuilt, or an insured is asked by someone why their property has not been rebuilt, most people will quickly conclude that the insured must have done something wrong. As Shakespeare wrote in Othello:

> *"Good name in men and women... is the immediate jewel of their souls,*
> *who steals my purse steals trash*
> *but he who filches from me my good name*
> *robs me of that which not enriches him*
> *it makes me poor indeed"*

It is important to remember that a person's good name or reputation has a dignitary value and it also has an economic worth since a person would encounter difficulty finding and keeping a job if he had a bad name. It is therefore imperative that if an insurer is to make these allegations as against an insured, that they must have completed a thorough investigation and must also make sure that their claims file has been properly handled. I might suggest that the following are some of the elements that should be included in a

[11] Supra Note 4
[12] Supra Note 5 at para 70

claims file where there is concern that the claim may have to be denied on the basis of arson or fraud.

1. Investigate immediately. If there is a Claim's Manual or a Claim's Protocol in place, ensure that the claim is investigated and adjusted according to the standards set out in the Claims Manual.

2. Ensure that the scene is protected immediately with the use of a professional security company. If you are going to have professional fire investigators or other experts view the scene, you need to be able to account for everyone who entered onto the property.

3. Immediately board-up and secure the premises for the insured. The property needs to be protected from further damage and from further contamination of the scene.

You should always look after the insured's immediate needs. It is always important to keep in mind that if a fire loss occurs and the policy is in force, you have a covered loss until such time as the insurer can prove that the loss was not fortuitous. Therefore, it is important to deal fairly with the insured. The money spent to insure the comfort of your insured for a couple of months will provide enough time to investigate and make a decision. Payments for additional living expenses and a minimal clothing allowance can be made on a without prejudice basis and the reservation of rights can be communicated in writing to the insured.

It is extremely important at all stages of the claims investigation to communicate with the insured. When concerns arise during the course of the investigation, the insured should be advised of these concerns and should be given an opportunity to explain these concerns. In most instances, the insurer is the only one who is investigating the loss and the result of those investigations must be communicated preferably in writing to the insured. The insured requires an opportunity to decide if he or she should also be conducting an investigation of the loss.

It is extremely important to interview all potential witnesses. If you are investigating a fire loss, then you should be interviewing firefighters, police officers, the insured, any other residents of the building, the person who discovered the fire and any neighbours who may have made observations of the property up to the time the fire occurred. It is important that the insurer carries out their own investigation independent of any investigation carried out by the police or the fire marshal's office. The insurer must decided on the basis of their own investigation and all of the evidence gathered whether they believe that a defence of arson can be made out.

It is important to make a decision in regard to the denial of the claim promptly but certainly not before you have all of the facts. Again, if you are investigating a fire loss, it is important to remember that you will have to prove to a court on the balance of probabilities that the fire was incendiary in nature, the insured had opportunity and the insured had motive. Generally in order to prove that a fire was incendiary, you are going to require the opinion of an expert, usually a forensic engineer specializing in fire origin. At the very least you will require a preliminary opinion from the engineer advising that in his or her opinion, the fire is incendiary. In reviewing this you will need to ensure that your expert has ruled out all other possible causes of loss. Your expert will have to be able to say that the only plausible explanation for the fire is that it was incendiary.

In regard to motive, it is always important to determine if there is a real motive to destroy the property. Compensable Fire losses do occur to people who are suffering financial hardship but would not dream of burning down their property. In fact, most people who are suffering real financial hardship have very little equity in their property and have little or nothing to gain by the property's destruction. If you have a house with three mortgages on it and no equity, there may be little incentive to the insured to cause the destruction of the house. Also in relation to a stock loss, there may be little incentive for the insured in the absence of obsolescence to arrange for stock to go missing if the stock was heavily financed. It is important to not just determine if the insured was suffering financial difficulties but also to determine if the insured's financial difficulties would be improved or alleviated with the destruction of the property or stock.

When the decision is made to deny the claim it is imperative that you explain to the insured both orally and in writing why the claim is being denied. Sending the insured a letter simply saying "our investigation into this loss has caused us to deny your claim", is no longer sufficient. The insured has purchased a contract of insurance to provide them with peace of mind when just such a loss occurs. Certainly if there is a good defence, then it is incumbent on the insurer to refuse to pay the claim. However, it is equally important to provide the insured with a detailed explanation as to why the loss is being denied. By the time the decision has been made to deny the claim there should be no hesitation in explaining the basis upon which that decision was arrived at.

Make sure you always send out a Proof of Loss to the insured. You must have the insured complete and have notarized the Proof of Loss and have it submitted to the insurer. Under the *Insurance Act*, the insurer is allowed 60 days to consider the claim as presented on the Proof of Loss. This will allow additional time to complete the investigation and if the insurer is not in a position to make a decision on the claim as presented on the Proof of Loss, then again the insurer should explain in detail why they are not in a position to make a decision. The insurer should advise the insured as to what documentation or information it requires before it will be in a position to make a final decision. There must

be communication between the insurer and the insured throughout the entire claims process.

If you require further information from the insured such as financial documents or accounting records, explain to the insured why you need this information and ask that they obtain the information as soon as possible from their accountant or seek authorization to deal directly with their accountant. In a situation where the insured does not have proper financial records, you can offer to have your professional accountants organize the documents and reports.

During the course of the investigation and even subsequent to the decision to deny the claim, it is extremely important to keep an open mind. Explanations or evidence produced by the insured must be reviewed objectively. If the insured has produced an expert's report which has come to a different conclusion than your expert's report, then you should have your experts review the insured's report. You should review the insured's report carefully to determine if there is evidence they considered in forming their opinion that appears to have been missed by your expert. You should ask your expert to comment on whether or not the report produced by the plaintiff has caused them to reconsider any aspect of their opinion. When you have reconsidered this evidence you should communicate the findings of your expert to the insured or their solicitor.

If the matter is litigated it is important to review your defence in light of the evidence that was heard at the examinations for discovery of both the insured and the insurer's representative. Again, it is important to weigh the evidence and all of the circumstances surrounding the loss to make sure that it makes sense that this person would have taken the drastic step of destroying their own property.

At some point during the course of the defence of a first party lawsuit, you may wish to have a second solicitor give you an opinion on whether or not the defence of arson or fraud can succeed. This is often beneficial after the examinations for discovery when most if not all of the evidence is known. This again will provide a fresh set of eyes and hopefully an objective review of all of the evidence.

If the damages aspect of the case cannot be agreed upon then use the appraisal process provided for in Statutory Condition No. 11 of the Policy and Section 128 of the *Insurance Act*. This is an inexpensive, expedient way to have the damages fixed for trial. The appraisal process is available regardless of whether or not coverage is being denied.

If at any point during the investigation or litigation of the claim a determination is made that you cannot prove the arson or any other reason for denial of the claim, then the insurer has a positive duty to pay the claim. In ***Whiton v. Pilot*** the court was critical of the insurer's attempt to settle the claim cheaply by using their superior bargaining power

and threat of litigation to try and get a better settlement. Again, it is important to keep in mind that if the policy was in force at the time of the loss and the loss is one which would ordinarily be covered in the absence of a legitimate defence, the insurer has a duty to pay the claim. It is not a licence to negotiate the best deal possible.

Finally, make sure that management at all levels is involved in the decision to deny the claim and that they approve the direction of the file. The court in ***Whiton v. Pilot*** were critical of Pilot not only in regard to the original decision by the claim's supervisor to deny the claim but also the fact that the claim was being reported to mid and upper level management and no one seemed to be taking a proactive interest in regard to the denial of this claim.

CONCLUSION

Although the ***Whiton v. Pilot*** decision may have seemed like a death knell to some insurers, we are now five years passed that landmark decision and most insurers have not been affected. The court in the ***Whiton v. Pilot*** decision and the decisions which have followed in which punitive damages have been assessed have provided a guideline as to how insurers should conduct themselves in the making of a decision to deny a claim. The courts have consistently held that an insurer is entitled to conduct a thorough investigation and to even be wrong in the determination that a claim should be denied. However, the court has also made it clear that the insurer's investigation must be timely thorough and objectively carried out. In denying a claim an insurer is telling the insured and perhaps society at large that we believe you committed a criminal offence. The courts have advised that if this is the position taken by the insurer although it does not have to be a correct one, it had better be a reasonable one. The courts have allowed room for error but have not allowed room for malicious, vindictive or high-handed conduct.