WINTER 2005

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Insurance Observer

LOSS TRANSFER DENIED IN DERKSEN ACCIDENT

by Jay A. Stolberg

The *Derksen v. 539938 Ontario Ltd.* decision is well-known in the insurance industry. The concurrent causation principles which were defined in that case have significantly impacted commercial liability and automobile insurance coverage. The underlying fact situation has produced another insurance-related decision: *Royal Insurance Company v. Wawanesa Mutual Insurance Company*.[1]

The subject accident occurred when a metal base plate fell off a truck while it was travelling on a highway. The plate struck a school bus, killing one child and seriously injuring three others. Royal paid accident benefits to one of the injured students and sought a loss transfer claim against Wawanesa for reimbursement of the payments.

The issue in the case was whether Wawanesa's insured vehicle was a "heavy commercial vehicle." If so, a loss transfer claim would be available to Royal. The decision would also likely impact the other insurers who were responding to the various accident benefits claims.

A "heavy commercial vehicle" is defined in Ontario Regulation 664 as a commercial vehicle with a "gross vehicle weight" of 4,500 kg. or more. The offending vehicle had originally been manufactured as a mini-bus and weighted 4,536 kg. Wawanesa's insured, however, modified the vehicle and turned it into a parts supply truck. As modified, the vehicle when empty weighed 3,400 kg. At the time of the accident, the loaded weight of the vehicle was 4,170 kg.

The truck had been towing an air compressor at the time of the accident. The combined loaded weight of the vehicle and compressor was 5,430 kg.

The definition of a "heavy commercial vehicle" includes a "trailer". Royal argued that the compressor was a "trailer" and that it was the actual, loaded weight of the vehicle together with the trailer, which were to be considered in determining whether the threshold weight for a loss transfer was met.

The first issue in the case was whether "gross vehicle weight" referred to the actual, loaded weight of the vehicle at the time of the accident or the vehicle's listed manufactured weight. The term was undefined in the loss transfer provisions. Relying on the definition of "gross vehicle weight" in the *Highway Traffic Act*, the arbitrator agreed with Royal that it was the actual, loaded weight of the vehicle which mattered for the purpose of a loss transfer. On appeal, Justice Stach agreed.

The arbitrator held, however, that the air compressor was not a "trailer" (also an undefined term) and was therefore not to be included in the overall weight of the vehicle. Justice Stach upheld this finding on appeal as well. In his reasons, Justice Stach noted that the air compressor was a piece of equipment which was used at a construction site. It was not designed to carry a load. It was not considered a "trailer" under the *Highway Traffic Act* and it was not considered a "trailer" in the ordinary sense of that word.

Royal's loss transfer claim was therefore denied. The decision, however, highlights the fact that a loss transfer may not only be available in situations involving large transport vehicles. A loss transfer may be available in cases involving smaller commercial vehicles, depending on their loaded weight at the time of the accident.

From the perspective of the first-party insurer, a loss transfer may be available in a situation where intuitively it might not otherwise have been thought to have been available.

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From an underwriting perspective, the risk underwritten may be greater than otherwise contemplated. The decision in *Royal v. Wawanesa*, therefore, underscores the importance of appropriate inquiries (such as the use to which the vehicle will be made and its usual cargo) at the underwriting stage in the case of commercial automobile policies. ■

1 Unreported (June 23, 2004) Docket No. 03-0762 (Ont. S.C.).

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LOST & FOUND: DISPUTED COVERAGE IN MISSING POLICIES - PART II

by Marcus B. Snowden

Policy: What Policy?

What evidence is sufficient to prove the existence and contents of a missing policy? Consider the situation of a typical so-called "long tail" liability claim. The incident, accident or occurrence either began or in any event was continuing during a timeframe when the policyholder is unable to find the actual policy. In multi-year exposures, where the policyholder is unable to find and prove the existence as well as the content of the policy, there will be a self-insured time on risk.

This was the case, for example, in *Surrey (District) v. General Accident Assurance Co. of Canada*, where the municipality was unable to prove coverage for a certain number of years in the context of deterioration damage. The court concluded that the policyholder was self-insured for the timeframe when it could not prove coverage. Allocation was calculated on a pro-rated formula based on the years on risk with the policyholder assuming the risk for those years when no coverage was proven.

But what efforts of the policyholder's are sufficient to at least prove the existence of a policy?

The Policy's Existence: Using Secondary Evidence

In the case of *Catholic Children's Aid Society of Hamilton-Wentworth v. Dominion of Canada General Insurance Co.*, Justice Crane stated:

> There is secondary evidence. The authorities including Sopinka and Lederman, *The Law of Evidence in Canada* 1992 at pages 933 and 934 accept that secondary evidence is admissible in circumstances of loss or destruction of documents where it is established that original documents did exist, that they have been lost or destroyed and that a diligent and appropriate search has been made.

Justice Crane went on to elaborate briefly on the quality of the evidence before the court:

> There is evidence for most of the years of 1962 through 1973 through minutes of the Society and budgets of the Society to indicate that there were policies of insurance. There is evidence of dealings between Canadian Indemnity (the predecessor to the respondent) commencing in 1961. Thirdly, there is evidence of an actual policy of insurance between the Society and Canadian Indemnity for the three year period commencing in 1966. The Society has produced an insurance policy number accepted by the respondent as a valid Canadian Indemnity policy number providing for a policy of insurance "Comprehensive Business Liability". Fourthly, the respondent has produced standard policies issued by Canadian Indemnity in the subject period of its "Comprehensive Business Liability" policy. It is to be noted that the sample policy wording is essentially unchanged in the period 1948 through 1977.

The court was invited to impose an onus of proof at higher than the civil standard based upon certain U.S. authority. Justice Crane specifically rejected this submission, finding that under Ontario law the policyholder need only prove the existence of the coverage on a balance of probabilities.

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In the case of *Navy League of Canada v. Citadel General Assurance Co.*, Justice Wilton-Siegel adequately summarized the law as follows:

> In this motion, the onus of proof to prove the existence of the contract and its terms lies with the applicant. The standard of proof in Canada in respect of lost insurance policies is a balance of probabilities: *Catholic Children's Aid Society of Hamilton-Wentworth v. Dominion of Canada General Insurance Co.* (1998), 7 C.C.L.I. (3d) 11 (Ont. Gen. Div.). In considering whether a policy exists, secondary evidence may be used if the actual policy cannot be located: *Catholic Children's Aid Society of Hamilton-Wentworth (supra).*

After considering what evidence had been offered in the *Navy League* case, Justice Wilton-Siegel continued:

> …I am satisfied on a balance of probabilities that a policy existed. This is supported by the insurance advice sheet of Reed Shaw Osler Limited, the applicant's insurance broker in 1970, which refers to a policy in effect for a three-year term expiring January 1, 1971, as well as an affidavit of the former account manager at Reed Shaw Osler. Mr. Millar's affidavit confirms that the applicant was insured under a policy for a period expiring in January, 1971 and adds his re-collection that the applicant paid the premium on the policy.

So, at a minimum, it appears a policyholder must establish that a policy was issued and was paid for during the term claimed for. Where the evidence suggests a form of policy was used and where the insurer or policyholder can produce that form, this will be sufficient proof of not only the existence but also the content of the policy.

However, not every case will benefit from discovery of a sample or company "standard" policy which gives content to the contract, as happened in the *Catholic Children's Aid* case.

Where there is no such sample policy, proof of existence does not end the inquiry.

The Policy's Contents: Proof or Consequences

What if there is no evidence of the policy's contents? This is answered in part in the case of *W.(T.) v. W.(K.R.J.).* There, Justice Reilly concluded:

> Though the Insurer concedes the existence of a policy, it expressly denies liability or coverage for the claim in this case, (see para 5 of the Statement of Defence and Crossclaim of the third party, Halwell). Counsel for M. is effectively unable to reply to this pleading as, quite simply, there is no contract of insurance in evidence. None can be produced, apparently. Counsel for M. submitted that "most" insurance contracts include comprehensive liability for bodily injury and the court should "presume" such coverage. I disagree. Absent evidence of coverage, the court cannot "write" a contract for the parties, nor presume either the duty to indemnify or the duty to defend.

On the other hand, as noted above in the *Catholic Children's Aid* case, where there is such evidence, or as in the *W.(T.) v. W.(K.R.J.)* case, where a subsequent year's policy was conceded on this sample form basis, the question is whether and to what extent the court can or should accept the sample form as sufficient.

Here, it is evident from the cases that, absent proof of an ongoing relationship in concert with proof of consistent use of the type of policy offered in the sample, the policyholder's case will fail.

Consider the different results in the *W.(T.) v. W.(K.R.J.)* case for years one and two insured by Halwell. In the first year, although there was some evidence of insurance, there was insufficient evidence to prove the type and form of wording. As Justice Reilly noted in the quoted

passage above, court's will not engage in writing the policy wording for the parties.

In the second year, Halwell's position was quite different. In that year, there was sufficient evidence of the form of wording as Justice Reilly relates:

> On April 16th, 1976, the defendants…entered into a new contract of insurance with Halwell …The policy itself was not produced by either party. However, Halwell concedes for purposes of the motion, the applicability of the general "Comprehensive Farm Liability" policy used by the insurer during that period and found in the motion record at tabs 2(c) and 2(d).

Insurers might react by saying, in effect, "we should never concede that a particular form of wording was ever used". This, with respect, is neither particularly honest, nor particularly helpful. Apart from raising issues of good faith and fair dealing, such a position is open to fairly easy attack. If put to the task, resourceful policyholder's counsel would and could easily prove the lie by enlisting the assistance of a knowledgeable broker or other insurance professional. The point here is, of course, that standard wording was and continues to be the mainstay of the industry. It is simply unrealistic to suggest that underwriters would consider and write an individual manuscript for each risk.

So, where the evidence is sufficient to prove that the company's standard form of the day was used (as in year two of the Halwell era in the W.(T.) case) the proper concession should be made to avoid embarrassment and the risk of a punitive damages award. ■

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Part 3 of "Lost & Found" will appear in our next issue.

ANNOUNCING OUR NEWEST MEMBER

We are pleased to announce that **Eric J. Schjerning** will be joining the firm's insurance litigation group on March 1, 2005.

Eric was called to the Bar of Ontario in 1986 and has spent his entire career at the Canada Life Assurance Company where he was head of Canada Life's litigation group. He has wide litigation experience handling life, disability and critical illness claims from the group, individual and creditor claims areas, and in addition, spent 2 years as Director of Group Claims at Canada Life. Eric is a Fellow of the Life Management Institute, a frequent speaker at various insurance industry meetings including the Canadian Life and Health Insurance Association, Life Insurance Institute of Canada, Toronto Claims Association, and the Canadian Institute of Underwriters.

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Insurance Observer is a publication of the Insurance Law Group of Blaney McMurtry LLP. The information contained in this newsletter is intended to provide information and comment, in a general fashion, about recent cases and related practice points of interest. The information and views expressed are not intended to provide legal advice. For specific legal advice, please contact us.
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We welcome your comments. Address changes, mailing instructions or requests for additional copies should be directed to Chris Jones at 416 593.7221 ext. 3030 or by email to cjones@blaney.com. Legal questions should be addressed to the specified author.

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