



EXPECT THE BEST

Blaney  
McMurtry  
BARRISTERS & SOLICITORS LLP

# COVERAGE ANALYSIS OF SEXUAL ABUSE CLAIMS

**Colin Empke**

**Blaney McMurry LLP**

**416.593.2988**

**[cempke@blaney.com](mailto:cempke@blaney.com)**

**with Farah Zafar and Jason Mangano**

**Blaney McMurry LLP**

## TABLE OF CONTENTS

Introduction.....	1
I. Fundamentals .....	2
<b>A. General Liability Coverage</b> .....	2
(i) CGL Insuring Agreement.....	3
(ii) What is Bodily Injury? .....	5
(iii) Trigger of Coverage.....	9
<b>B. Errors &amp; Omissions Coverage</b> .....	13
(i) Professional Services .....	14
(ii) The Wrongful Act .....	16
II. Limits on coverage for abuse claims .....	19
<b>A. Intentional acts</b> .....	19
<b>B. Coverage for innocent co-insureds</b> .....	22
<b>C. Sublimits or retentions</b> .....	27
<b>D. Specific abuse exclusions</b> .....	31
<b>E. Evidentiary issues</b> .....	35
III. Issues Related to the Duty to Defend.....	38
<b>A. Extrinsic Evidence</b> .....	39
<b>B. Insurer/insured conflicts</b> .....	40
<b>C. Allocation</b> .....	45
(i) Allocation with the Insured .....	45
(ii) Equitable contribution .....	47
IV. Insured’s Post-Incident Obligations.....	50
V. Conclusion .....	56

## BLANEY McMURTRY'S INSURANCE LAW UPDATE 2007

### COVERAGE ANALYSIS OF SEXUAL ABUSE CLAIMS<sup>1</sup>

#### Introduction

Recent cases suggest a perpetrator of sexual abuse cannot obtain insurance coverage to defend or indemnify them for lawsuits brought by their victims. However, in certain circumstances innocent co-insureds, including the institutions employing the perpetrators, may seek and obtain insurance coverage for their vicarious and concurrent liability. This paper provides an overview of some of the significant insurance coverage issues arising in the context of claims alleging an insured person is responsible for acts of sexual abuse.

The paper will discuss the two most common types of policies which are asked to provide coverage for abuse claims: commercial general liability policies and errors and omissions policies. The standard insuring agreements and exclusions will be considered. The paper will also address issues related to the insurer's duty to defend; potential conflicts between insured and insurer; and the requirement for the insured, in certain cases, to contribute to its own defence by way of allocation rules.

---

<sup>1</sup> Colin Empke has revised this paper for Blaney McMurtry LLP's Insurance Update 2007 (June 6, 2007). The paper was originally authored by Colin and Farah Zafar for presentation to the Canadian Institute's 7<sup>th</sup> Annual National Summit on Institutional Liability for Sexual Assault and Abuse (February 20, 2007). Colin and Jason Mangano updated and further revised the paper for presentation to the Canadian Institute's 7<sup>th</sup> Annual Managing Legal Risks and Responsibilities in Mental Health Care (April 12, 2007). This work is copyrighted and all rights are reserved. No part of this work may be reproduced without the written permission of the authors, except in accordance with the provisions of the *Copyright Act*. Requests to reproduce this work should be directed to Colin, who may be reached at 416-593-2988.

## **I. Fundamentals**

Two principle types of liability insurance coverage are typically implicated in cases involving sexual abuse allegations against businesses or institutions: commercial general liability (CGL) policies and professional errors and omissions (E&O) policies.<sup>2</sup>

The CGL policy is intended to protect against liability arising out of the risks associated with operating a business. Property damage and bodily injury claims arising from such everyday risks (such as slip and fall accidents) will be covered by such policies.

Sexual abuse claims often involve professionals or professional institutions, who purchase E&O policies to cover the specialized risks associated with the provision of professional services. Both the CGL and E&O policies are potential sources of insurance coverage for claims involving alleged acts of abuse, neglect or sexual assault.

### ***A. General Liability Coverage***

CGL policies are designed to respond when the policyholder is sued by those who have suffered damage as a result of some event or course of action allegedly involving the policyholder.<sup>3</sup> Most claims for abuse against institutions will be submitted under such policies in circumstances where a

---

<sup>2</sup> Individuals may acquire liability coverage via homeowner's policies. Homeowner's policies will not be specifically addressed in this paper, however the interpretation of such policies is similar to CGL policies. Indeed, several of the leading cases involve homeowner's policies.

<sup>3</sup> Mark Lichty & Marcus Snowden, Annotated Commercial General Liability Policy (Aurora: Canada Law Book, 2006), 1:10.

professional is not involved. Abuse involving doctors, nurses, therapists and other regulated health professionals are more likely to also involve professional liability policies.<sup>4</sup>

*(i) CGL Insuring Agreement*

When seeking coverage under a liability policy the policyholder must be able to demonstrate the allegations against it satisfy the required elements of the insuring agreement. It is not necessary to reference exclusionary language unless the policyholder meets this first requirement.<sup>5</sup> The Insurance Bureau of Canada publishes standard form language which is similar to or forms the basis for most CGL policies in Canada. The IBC 2100 Commercial General Liability Policy form contains the following insuring agreement:

We will pay those sums that the insured becomes legally obligated to pay as compensatory damages because of "bodily injury" or "property damage" to which this insurance applies. No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS - COVERAGES A, B AND D. This insurance applies only to "bodily injury" and "property damage" which occurs during the policy period. The "bodily injury" or "property damage" must be caused by an "occurrence". The "occurrence" must take place in the "coverage territory".

Before a duty to defend or a right to indemnity is found to exist, this insuring agreement requires the insured to demonstrate:

---

<sup>4</sup> The case law is generally consistent on what constitutes a "professional service." A professional service requires intellectual activity within a recognized professional discipline, involving the use of special skills, knowledge or training. Every act by a "professional" does not constitute a "professional service." Actions of an everyday nature, capable of being performed by a non-professional, are not professional services. See *Chemetics International Ltd. v. Commercial Union Assurance Co. of Canada* (1984), 55 B.C.L.R. 60 (C.A.). Such "everyday" incidents may be covered by the CGL policy.

<sup>5</sup> Mark Lichty & Marcus Snowden, Annotated Commercial General Liability Policy (Aurora: Canada Law Book, 2006), 6:10.

- (a) the plaintiff seeks payment of compensatory damages;<sup>6</sup>
- (b) the plaintiff alleges (or proves) the happening of a bodily injury;
- (c) the bodily injury has taken place during the policy period;
- (d) the bodily injury is caused by an “occurrence” or accident which happens in the coverage territory.

Most claims for abuse will unambiguously seek compensatory damages, satisfying the first requirement. Most will involve conduct taking place within the coverage territory. Most CGL policies cover conduct taking place anywhere in Canada or the United States. Larger institutions will often purchase coverage for operations anywhere in the world. The fourth requirement is rarely at issue in a sexual abuse case.

The main areas of dispute in relation to abuse claims are whether a lawsuit alleges the happening of “bodily injury” and whether that injury has taken place during a particular policy period (the “trigger of coverage”). We will discuss these two issues.

---

<sup>6</sup> Claims for restitution or punitive damages are not generally covered.

(ii) What is Bodily Injury?

As noted above, one of the prerequisites for coverage under a CGL policy is that the lawsuit seek damages on account of the happening of a “bodily injury”. In physical abuse cases this is usually self-evident: an obvious bruise or a broken bone will satisfy this requirement.

The most common definition of “bodily injury” found in CGL policies states:

“Bodily injury” means bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.<sup>7</sup>

A claim involving sexual abuse may involve no allegation of lasting physical harm to the victim. There may be no observable bodily injury. The trauma of sexual abuse is often psychological in nature. Frequently, therefore, a claim may seek damages only for mental distress or emotional trauma and make no reference to lasting physical injury. There is some debate, particularly in the United States, as to whether or not mental distress and emotional trauma falls within the definition of “bodily injury”.<sup>8</sup>

The majority of jurisdictions in the United States have adopted a fairly narrow interpretation of the term “bodily injury”. These jurisdictions limit coverage to situations involving actual physical injury. Courts adopting this approach deny coverage for claims seeking only damages for pure emotional trauma or mental distress.<sup>9</sup> Most U.S. courts will find coverage if there is some form of physical

---

<sup>7</sup> This is the definition used in IBC Form 2100 and in the newer 2005 version.

<sup>8</sup> We note that some policies define “bodily injury” to include claims for mental distress, emotional trauma or psychological injury. Such policies do not engage the debate. Institutions at considerable risk for abuse claims are well served by insisting the expanded definition is used in their policies.

<sup>9</sup> See *Home Insurance Com. v. Hartford Fire Ins. Co.*, 379 F.Supp.2d 1282 (M.D. Ala. 2005). This U.S. position is exemplified by *Allstate Ins. Co. v. Diamant*, 518 N.E.2d 1154 (Mass. 1988) where the court held that “bodily injury

manifestation of abuse symptoms.<sup>10</sup> The debate then turns to what constitutes a physical manifestation. Physical symptoms such as headaches, nausea and other adverse health effects have been held to qualify as bodily injury.<sup>11</sup> Other courts have refused to extend the definition of bodily injury even this far.<sup>12</sup>

There is greater consensus in Canada and it appears to favour a finding that emotional trauma is a bodily injury for the purposes of satisfying the insuring agreement requirements, without regard for the necessity of a physical manifestation. The issue is not, however, entirely settled. One Ontario court reached a conclusion favouring the U.S. view. In *Dow v. Trumper*<sup>13</sup>, without referring to any authorities, the court concluded:

In my opinion, the “emotional upset and distress” alleged to have been suffered . . . are not encompassed within the definition of “bodily injury” contained in the policy. The alleged “injuries” are to the mind and not to the body. In coming to this conclusion, I acknowledge that there are well defined sicknesses and diseases of the mind, which may in turn cause, (or

---

is a narrow term and encompasses only physical injuries to the body and the consequences thereof.” See also *Galgano v. Metropolitan Property and Cas. Ins. Co.*, 838 A.2d 993 (Conn. 2004) where the court stated “emotional distress, by itself, is not a bodily injury”.

<sup>10</sup> *Coregis Ins. Co. v. City of Harrisburg*, 401 F.Supp.2d (M.D. Pa. 2005).

<sup>11</sup> “Regular loss of sleep” was a physical manifestation of a emotional distress because it reflects the inability of the body to restore itself and the continued activity of the nervous system: see *Peck v. Public Service Mut. Ins. Co.*, 363 F.Supp.2d 137 (D. Conn. 2005). See also *State Farm Fire & Cas. Co. v. Nikitow*, 924 P.2d 1084 (Colo. C.A. 1995).

<sup>12</sup> Crying and sleep difficulties were not considered physical manifestations in *Economy Preferred Ins. Co. v. Jia*, 92 P.3d 1280 (2004). See also *Dickens v. General Acc. Ins.*, 695 N.E.2d 1168 (1997) (court refused to classify headaches and other adverse health effects as bodily injury). See also *ERA Franchise Systems Inc. v. Northern Ins. Co. of New York*, 32 F.Supp.2d 1254 (D.Kan. 1998), aff’d 208 F.3d 225 (10<sup>th</sup> Cir. 2000) (insomnia was not considered a physical manifestation sufficient to be a bodily injury).

<sup>13</sup> *Dow v. Trumper*, [1995] O.J. No. 2261 (Ont. Gen. Div.). A subsequent decision of the Ontario General Division did not refer to this case, but preferred to rely on the broader interpretation advanced in other Canadian jurisdictions - see *L. (C) v. Dominion of Canada*, [1997] I.L.R. I-3456 (Ont. Gen. Div.).



manifest themselves in), a state of bodily sickness or disease. However, emotional upset and distress of the kind alleged in the case at bar have their origin in the mind and not in the body. In my opinion, the peril insured against is primary injury to the body of a third party, (or bodily sickness or disease, or death resulting from any of them), and not injury to his or her mind, whether primary, or, secondary to bodily injury.<sup>14</sup>

The Ontario court was prepared to insist upon a physical manifestation of symptoms arising from emotional distress. Several decisions in British Columbia, Nova Scotia and Manitoba have refused to adopt this narrow approach. In *Victoria General Hospital v. General Accident Assurance Co. of Canada*<sup>15</sup> the plaintiff alleged emotional trauma as a result of a sexual assault which took place in the hospital. The hospital sought insurance coverage under its general liability policy issued by General Accident.<sup>16</sup> The Manitoba court was asked to interpret the standard definition of “bodily injury”. The court expressly rejected the narrow American approach and relied on an apparent ambiguity in the definition to find that pure emotional trauma constitutes a bodily injury. The court held:

In my opinion, having regard to the sentence structure and the plain meaning of the words used, the wording is, at the very least, ambiguous. General Accident chose to define "bodily injury" as "bodily injury", followed by a comma, and then followed by the words, "sickness or disease". It is certainly open for a court to consider that in this policy "bodily injury" means three separate and distinct acts or events or occurrences, namely:

---

<sup>14</sup> *Dow v. Trumper* at paragraph 13.

<sup>15</sup> [1995] 8 W.W.R. 106 (Man. Q.B.).

<sup>16</sup> The hospital sought coverage under other liability policies, which were found to not apply due to their particular policy language which precluded coverage for claims arising out of occurrences taking place before the inception dates.

- (a) bodily injury, which taken alone might be restricted to those cases involving physical injury but, according to some of the American authorities, not necessarily so;
- (b) sickness, which is by definition something different from physical injury;
- (c) disease, which is by definition something different from physical injury.<sup>17</sup>

The court concluded that sickness included the impairment of mental health, and coverage was provided by the policy. Psychological abuse would similarly appear to meet this definition. In a later case, *Wellington Guarantee v. Evangelical Lutheran Church in Canada*<sup>18</sup>, the British Columbia Court of Appeal specifically rejected the reasoning in *Dow v. Trumper* and adopted a broader approach to the term “bodily injury” as it relates to allegations of emotional trauma. The court held:

Following the foregoing analysis of the dictionary meanings of the words "sickness" and "disease", the American authorities and the recent decision in *Victoria General Hospital*, I conclude that the injuries alleged in the statement of claim in the Underlying Action, that is to say, "nervous shock", "depression", "insomnia", "psychological injury" and "mental stress", are allegations which come within the meaning of "sickness", and possibly come within the meaning of the word "disease", as contained in the Policy.

The Court of Appeal also noted that the American authorities appear to place too much emphasis on the term “bodily” in the definition, at the risk of ignoring the terms “sickness” and “disease”.

---

<sup>17</sup> *Victoria General Hospital v. General Accident Assurance Co. of Canada*, [1995] 8 W.W.R. 106 at para. 27 (Man. Q.B.).

<sup>18</sup> (1996), 35 C.C.L.I. (2d) 164.

The narrow American approach has also been rejected by the Nova Scotia Supreme Court in *Children's Aid Society of Halifax v. Boreal Insurance Co.*<sup>19</sup>.

The Canadian trend is clearly in favour of permitting claims for pure emotional trauma, distress and psychological injuries to satisfy the definition of “bodily injury”.

### (iii) Trigger of Coverage

As noted, before the insuring agreement is engaged under an “occurrence” policy it is necessary for the policyholder to demonstrate the alleged bodily injury took place during the policy period. This is known as establishing the “trigger of coverage”. It is necessary to determine when the injury occurred and whether the lingering effects of an abuse injury are sufficient to trigger coverage. In circumstances where abuse took place over an extended period of time it is also necessary to determine which of several successive policies is required to respond, from a selection of those on risk from the time the abuse first took place until the time a lawsuit is commenced.<sup>20</sup> The importance of this question should not be overlooked. In many cases involving abuse the victim has been subjected to ongoing and repeated abuse over an extended period of time. If a policyholder can establish bodily injury was sustained over multiple policy periods, it may obtain coverage for each policy period and thus the benefit of multiple limits of liability to pay any resulting judgments.

A victim will not, in many cases, be able to allege, or even recall, exact dates on which abuse occurred. It is necessary, therefore, for courts to adopt an approach capable of making a determination of when the bodily injury has occurred, in order to determine which policies must

---

<sup>19</sup> (1996), 39 C.C.L.I. (2d) 296 (N.S. S.C.).

<sup>20</sup> The date the claim is commenced will almost always be considered the end point for triggering insurance coverage. After that date there is no possible way to consider the claim fortuitous and thus insurable. Insurance companies coming on risk after that date are not usually expected to respond, except claims made policies.

respond. This issue has not received detailed consideration in Canada. The American approach to sexual abuse claims is, however, instructive.

There are two widely adopted U.S. approaches.<sup>21</sup> The “first encounter” rule suggests that the only insurer which must respond is the one that was on risk at the time when the first incident of sexual abuse took place. Courts adopting this approach reason that all injuries arising from the sexual abuse, even if the abuse continues over multiple policy periods, are attributable to the first incident and there is a single bodily injury. No other insurer need respond. This approach clearly limits the amount of insurance available to respond to a particular claim.

The first encounter rule has its genesis in a common liability policy term which states “continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.” The argument goes that the first incident of sexual abuse is the “occurrence” causing the bodily injury and each subsequent incident is merely a repeated exposure.<sup>22</sup> This approach is distasteful as it seems to minimize the nature of a sexual assault and the resulting injury. The first encounter rule has, in large measure, been discredited. Indeed, the cases first proposing its use have subsequently been overturned.<sup>23</sup>

---

<sup>21</sup> There is also a “manifestation rule” which will not be discussed. The Ontario Court of Appeal in the *Alie v. Bertrand & Frere* (2002), 62 OR (3d) 345 (C.A.) decision forcefully rejected manifestation theories in the insurance coverage context. It is therefore our view this particular approach would not be adopted in Canada.

<sup>22</sup> See *May v. Maryland Cas. Corp.*, 792 F.Supp. 63 (E.D. Mo. 1992) for an articulation of this reasoning. We note, however, that the court only applied the first encounter rule upon assurances by all counsel that it was the applicable theory.

<sup>23</sup> The rule had its first articulation in the early 1990s in two cases: *Interstate Fire & Cas. Co. v. Portland Archdiocese*, 747 F.Supp 618 (D.Or 1990) and in *Society of Roman Catholic Church Diocese of Lafayette & Lake Charles v. Interstate Fire & Cas. Co.*, Civil No. 88-0289 (W.D.La. 1991). Both decisions’ use of the first encounter rule was rejected on appeal: see 35 F.3d 1325 (9<sup>th</sup> Cir. 1994) and 26 F.3d 1359 (5<sup>th</sup> Cir. 1994) for the appeal decisions.

The most common approach in the United States favours the triggering of each policy period during which a sexually abusive incident occurs. Underlying this approach is a recognition that, with acts of abuse, the happening of a bodily injury is, in essence, contemporaneous with the assault. It is recognized that the first encounter rule is contrary to the policy language in three principle ways:<sup>24</sup>

- (a) Future damages resulting from an act of abuse are entirely separate from those arising from a subsequent act of abuse. Liability policies cover consequential damages arising from an act of abuse. A subsequent act of abuse is not a consequential injury arising from a prior act.
- (b) Attributing all injury to the first encounter prevents insurers from limiting coverage to damages sustained during the policy period only.
- (c) The first encounter rule is inequitable by denying a victim compensation if the abuse commenced prior to the institution purchasing insurance coverage.

It is more appropriate to allocate responsibility for the injuries to each of the successive policy periods, to the extent abuse and consequential injury took place in that period. Since the actual extent of loss from each act of abuse is likely impossible to calculate, the most equitable allocation is to apportion the loss according to the insurers' time on risk.

This approach accepts that an act of sexual abuse results in an immediate bodily injury and that each act of abuse results in a new injury. This approach can be usefully extended to acts of physical or psychological abuse, provided sufficient evidence exists as to the happening of a bodily injury.

---

<sup>24</sup> This critique of the first encounter rule is derived from the thorough discussion of the issue, found in the case *Society of Roman Catholic Church Diocese of Lafayette & Lake Charles v. Interstate Fire & Cas.* 26 F.3d 1359 at 1366 (5<sup>th</sup> Cir. 1994).

It is beyond the scope of this paper to discuss the so-called “trigger theories” in any great detail, but we will note the Ontario Court of Appeal’s comments in *Alie v. Bertrand & Frere*. In discussing the appropriate approach to interpreting the insuring agreement, the Court noted that the policy language requires the triggering of coverage whenever the date of the injury can be determined with certainty.<sup>25</sup> In situations where the exact dates or the scope of injury cannot be determined the Court acknowledged the necessity and fairness of allocating the damages across all policy periods.

To the extent a lawsuit alleges acts of abuse and specifically identifies the date on which such acts took place, it may be possible for an insurer to argue that its policy is not required to respond if no acts of abuse occurred during its policy period. In effect, this would prevent the continuous trigger theory from applying - the trigger would “skip” those periods in which no abuse is alleged. This argument requires a court to accept that the bodily injury arising from an act of abuse is immediate and that any lingering effects are, in fact, merely sequelae to the original injury. One commentator has noted that such lingering effects should not trigger the insuring agreement:

This is to be distinguished from the situation in which the injury occurred at the time of the abuse but the effects of the injury continue through multiple policy periods. In the latter case the continuing effects are not treated as a new injury in each policy period, no more than an ongoing physical disability resulting from a motor vehicle accident triggers coverage in more than one policy period...the continuing effects of a previous injury (as distinct from

---

<sup>25</sup> The newer version of the standard CGL wording prepared by the IBC in 2005 contains extensive amendments to the insuring agreement and definitions in an effort to resolve these trigger of coverage issues by deeming when bodily injury has occurred.

a new injury) do not constitute an occurrence for the purposes of coverage under a liability insurance policy.<sup>26</sup>

Provided an injury arising from the abuse occurs in a policy period, coverage will be triggered. To the extent a claim does not provide particulars of when the abuse occurs, it is most likely a court will conclude, for the purposes of the duty to defend, that there is no rational way to exclude a policy which happens to be on risk from the date of first abuse to the time the claim is filed. In such cases each of the policies will be required to respond with a defence, although actual indemnity payments may be limited to those policies on risk at times the injuries are proven to have taken place.

### ***B. Errors & Omissions Coverage***

Errors and omissions insurance provides protection to individuals and institutions against liability arising from negligent or wrongful conduct. Errors and omissions policies are often issued to institutions and provide a broad and generalized protection against lawsuits alleging wrongful conduct by any of its employees. A specialized type of E&O coverage is the professional liability policy, which insures claims brought against a policyholder making allegations concerning the manner in which the insured professional services are provided or have not been provided.

E&O policies are most often “claims made”. These provide coverage for a claim first made against the insured during the policy period. It is not necessary for the act giving rise to the lawsuit to have occurred during the policy period, but the circumstances of the lawsuit must be unknown to the insured prior to policy inception. It is still necessary for the claim to be fortuitous, in the sense that the insured cannot have purchased the insurance while having actual knowledge that a claim was

---

<sup>26</sup> Gordon Hilliker, *Liability Insurance Law in Canada*, 4th ed. [Toronto: Butterworths, 2006] at page 325. Mr. Hilliker cites as support for this view the case *Synod of the Diocese of Edmonton v. Lombard General Ins. Co. of Canada* (2004), 20 C.C.L.I. (4<sup>th</sup>) 221 (Alta. Q.B.).

about to be commenced against it.<sup>27</sup> Newer policies will have a “retroactive date” which provides a date before which an event giving rise to the claim will not be afforded coverage. Thus, it is often the case that a sexual abuse claim arising from very old events may not be covered under such a policy.

The typical insuring agreement in a professional liability policy will be similar to the following:

We will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as compensatory damages because of injury arising out of the rendering of or the failure to render, during the policy period, professional services in the practice of the profession described in the declarations.<sup>28</sup>

To secure coverage, the policyholder must therefore demonstrate the claim contains allegations seeking compensatory damages in relation to the provision of “professional services”.

An errors and omissions policy is available to institutions which provide services other than those traditionally considered professional in nature. Such policies provide coverage to the insured for compensatory damages payable for injury arising out of “Wrongful Acts”.

(i) Professional Services

Insurers presented with abuse claims tendered under a professional liability policy must usually determine whether the alleged acts arose out of the insured professional service or how closely

---

<sup>27</sup> A discussion of the nature and quality of what constitutes a “claim” under a claims-made policy and the importance of the timing of notice to the insurer takes place in *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, [2006] 1 S.C.R. 744.

<sup>28</sup> This is the language of IBC 2018, used for physicians, surgeons and dentists.



related such act was to the professional service. Coverage is contingent on the wrongdoing having some connection or nexus with the professional service. Thus, in the context of a doctor's professional liability insurance, the alleged abusive activity would have to be in some way connected with the professional insured. The focus of the inquiry is on the nature of the action rather than the person performing it. Not every act occurring in a professional's office will constitute a "professional act". This "degree of connection" issue has not been litigated to a great extent in Canada. However, it is a hotly litigated subject in the United States.

The majority view in the United States is that alleged sexual misconduct is not connected with the insured's professional services. This position will likely be supported in Canada. However, there are cases which have held in favour of the insured by finding that a professional liability policy responds to allegations of sexual misconduct.<sup>29</sup> Such a connection might be found in circumstances where some degree of contact with sexual organs is required in the context of the professional service, such as a gynaecological examination, but these situations are very rare. The majority of cases state that acts of sexual abuse are outside the scope of any medical examination and therefore not related to professional services. This is particularly the case where the victims are children, where the courts have held in no uncertain terms that such conduct is beyond the pale of any professional act.

---

<sup>29</sup> Roxanne Barton Conlin & Gregory S. Cusimano, Editors-in-Chief, Insurance Coverage -- Professional Liability Policies, ATLA's Litigating Tort Cases § 54:16 citing the following cases at footnote 3: "See, e.g., *St. Paul Fire & Marine Ins. Co. v. Asbury*, 149 Ariz. 565, 566, 720 P.2d 540, 541 (Ct. App. Div. 2 1986) (clitoral stimulation occurring in the course of medical pelvic exam was "committed in the course of and as an inseparable part of the professional services rendered"); *St. Paul Fire & Marine Ins. Co. v. Shernow*, 1991 WL 40029 (Conn. Super. Ct. 1991), judgment aff'd, 222 Conn. 823, 610 A.2d 1281 (1992) (negligent administration of Nitrous Oxide by dentist was part of ongoing dental treatment; simultaneous sexual assault therefore covered). See also *St. Paul Fire and Marine Ins. Co. v. Engelmann*, 639 N.W.2d 192 (S.D. 2002); *T.M. ex rel. Cox v. Executive Risk Indem. Inc.*, 59 P.3d 721 (Wyo. 2002) (psychologist's negligent failure to protect foster children residing in her home from sexual abuse by her husband was potentially covered as "professional services" if she negligently performed or failed to perform psychological services for the children even though she was acting as a foster parent). For a discussion of the leading cases on both sides of this issue, see *R.W. v. Schrein*, 264 Neb. 652 N.W.2d 574 (2002); *Princeton Ins. Co. v. Chunmuang*, 698 A.2d 9 (1997).

Cases involving mental health care providers are more difficult to resolve, particularly when the victims are adult patients. The problem arises because sometimes a sexual relationship between therapist and patient is facilitated by transference and counter-transference situations. A therapist's inability to control transference issues is perceived as evidence of malpractice.

Claims are frequently framed as the negligent failure to handle the transference phenomenon. The insured therapist then characterizes the claim as being connected to the professional services provided and seeks insurance coverage. It is a matter of debate whether such claims can trigger insurance coverage. It has been held that such allegations will require the insurer to defend, until such time as expert evidence is able to determine if the alleged mishandling of the transference phenomenon amounted to medical malpractice or was intentional sexual assault.<sup>30</sup>

As noted elsewhere, when the victim is a child, almost all jurisdictions will find that the act of abuse is an intentional act which cannot be insured by any kind of policy. Such intentional conduct does not constitute an "error or omission" within the proper meaning of those words.<sup>31</sup> There remains the possibility that coverage can exist for innocent co-insureds or for related negligence, such as faulty supervision or hiring practices. Thus, institutional insureds may acquire coverage under such policies. This issue is discussed below.

#### (ii) The Wrongful Act

A non-professional errors and omissions insurance policy typically provides coverage for losses arising from a Wrongful Act. The term "Wrongful Act" is typically defined quite broadly and may

---

<sup>30</sup> *St. Paul Fire and Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126. See also *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698 (Minn. 1990).

<sup>31</sup> Thomas P. O'Leary, *The Duty to Defend in Sexual Tort Cases: Perpetrators, Innocent Co-Insureds and the Impact of Non-Marine Underwriters*, *Lloyd's of London v. Scalera*, 19 Can. J. Ins. L., (March 2001)

state “any actual or alleged negligent act, error or omission committed solely in the performance of or failure to perform insured services.” The insured services are those which are identified in the declarations or sometimes elsewhere in the policy. The issue is if abuse, whether physical, sexual or mental, can constitute such a Wrongful Act. The answer will be found by interpreting the exact words used in the insurance policy.

The Wrongful Act definition is often characterized by courts as being quite broad and encompassing of a wide range of conduct by the insured.<sup>32</sup> There is some dispute about whether an E&O policy providing coverage for Wrongful Acts will afford coverage for some kinds of intentional conduct. One line of U.S. authority holds that the word “negligent” modifies the word “act” as well as the words “error or omission”. In such circumstances only negligent conduct is covered by the policy.<sup>33</sup>

There is competing U.S. authority suggesting that some intentional conduct might be captured by the insuring agreement of an E&O policy. One case stated:

A professional indemnity policy does not necessarily cover only negligence. In my view I must give effect to the literal meaning of the primary insuring words and construe them so as to include any error or omission without negligence.

---

<sup>32</sup> *Peterborough (City) v. General Accident Assurance Co.*, 1998 CarswellOnt 1466 (C.A.); *British Columbia v. Surrey School District No. 36*, 2005 BCCA 106.

<sup>33</sup> See in particular the discussion of this issue in *Group Voyagers Inc. v. Employers Insurance of Wausau*, 2002 WL 356653 (U.S.D.C.: N.D. Cal.: 2002). In this case the Court noted that the policy employing the phrase “negligent act, error or omission” could not provide coverage for deliberate errors or omissions.

But not every loss caused by an omission or error is recoverable under the policy. In the first place, which is common ground, it must not be a deliberate error or omission.<sup>34</sup>

But note the second paragraph. There is no suggestion that deliberate error is recoverable. Thus, while non-negligent conduct might trigger coverage, fraudulent conduct should not. In most circumstances, courts have held that when actions are deliberate and the consequences are intentional in the sense of being the natural and probable consequence of those actions, no “error” or “omission” has occurred. Thus, intentional torts such as sexual assault and/or battery usually do not fall within the definition of Wrongful Act.

However, most lawsuits involving allegations of abuse are not restricted to claims of intentional conduct. An abuse lawsuit against a perpetrator and the institution where the abuse took place will likely allege both intentional and unintentional torts.<sup>35</sup> For example, a claim may allege sexual assault and battery committed by the perpetrator. There will also be allegations against the institution for negligent supervision, hiring, misrepresentation and failure to warn and also for vicarious liability for the actions of the employee. In certain circumstances, it is possible for the separate causes of action to be distinguished and therefore attract different results from the insurance coverage perspective. For example, in *Sommerfield v. Lombard Insurance Group*<sup>36</sup>, the court was examining the claims of professional negligence against four teachers. Each was responsible for committing their own acts of abuse and were sued for such acts. At the same time, each was accused of failing to report the

---

<sup>34</sup> *SEC v. Credit Bankcorp*, 147 F.Supp.2d 238 (S.D.N.Y. 2001); see also *Corporate Realty v. Gulf Ins.*, 2005 WL 236182 (E.D. La) and *Continental Cas. Co. v. Cole*, 809 F.2d 891 (D.C.Cir.1987).

<sup>35</sup> See for example, *S. (J.A.) v. Gross* 2002 ABCA 36 (Alta. C.A.).

<sup>36</sup> *Sommerfield v. Lombard Insurance Group*, (2005), 20 C.C.L.I. (4<sup>th</sup>) 301 (Ont. S.C.J.).

sexual abuse being committed by the other teachers. The court held that the failure to report allegations and the abuse allegations were distinct and separate. The professional negligence claims therefore attracted coverage.

Similarly, in another case the insurer argued that allegations of sexual assault, battery and personal injury could not be separated from the underlying allegations of negligence and failing to prevent the assault and battery brought against the institution<sup>37</sup>. The court concluded the complaint included allegations of negligence and the policy did not expressly exclude coverage for claims of negligent supervision, control or hiring. The court reasoned that there was “a legitimate prospect that negligence, rather than intentional assault or battery caused the injury.” As such, the insurer had a duty to defend its insured.

## **II. Limits on coverage for abuse claims**

### ***A. Intentional acts***

Insurance provides coverage for fortuitous events. As noted above, events which are not accidental in nature cannot satisfy the requirements of the insuring agreement. It has been noted:

Fortuity is an essential element shared by all different types of liability insurance policies consistent with the principles of indemnity. The concept of accident is dominant throughout these policies, appearing in the insuring agreement and in exclusions for bodily injury or property damage expected or intended from the standpoint of the insured.<sup>38</sup>

---

<sup>37</sup> *Kentucky School Boards Ins. Trust v. Board of Educ. of Woodford County* 2003 WL 22520018 (Ky.App.).

<sup>38</sup> Brown and Menezes, *Insurance Law in Canada*, (Carswell: 1999+) at p. 18-3. This passage was adopted by the Supreme Court of Canada in *Sansalone v. Wawanesa Mutual Insurance Co.*, [2000] 1 S.C.R. 551 and more recently by the Ontario Court of Appeal in *Liberty Mutual Insurance Co. v. Hollinger Inc.* (2004), 10 C.C.L.I. (4<sup>th</sup>) 200 (Ont. C.A.).

If an event for which insurance is sought is not fortuitous, there is no insurance coverage.<sup>39</sup> This is a matter which may be argued in the context of the insuring agreement. However, policies generally bar coverage for injuries that are expected or intended, i.e. not accidental, from the standpoint of the insured. The 2005 revision to the standard IBC CGL form contains language designed to explicitly bar coverage for events which are known to the insured prior to policy inception.

Traditionally, the prohibition against coverage for intentional acts was the main defence used by insurers in claims dealing with CGL policies. Most often these policies require an “occurrence”, which is in turn defined to require, or at least include an “accident”. While the term is not normally defined in the policy, Canadian courts have defined “accident” as something unintended or unexpected from the standpoint of the insured. Insurers might effectively argue that sexual assault should not be covered because it is not an “accident”, being both intentional and foreseeable by the insured perpetrator.<sup>40</sup> Most E&O policies will also include a specific exclusion for intentional or criminal acts.

It is difficult to underestimate the importance of the Supreme Court of Canada’s decision in *Non-Marine Underwriters, Lloyd’s of London v. Scalera*.<sup>41</sup> The influence of this case is widespread, but is directly relevant to the issue of coverage for claims of abuse and sexual abuse in particular.

The *Scalera* decision resolved the issue of whether an allegation of sexual abuse will trigger an intentional act exclusion to bar coverage sought by an insured who is alleged to have committed the abuse. The court ruled that it must be inferred that such an individual intended to cause harm, as a

---

<sup>39</sup> *Algonquin Power (Long Sault) Partnership v. Chubb Insurance Co.*, (2003), 50 C.C.L.I. (3d) 107 (Ont. S.C.J.).

<sup>40</sup> Some American courts have found that sexual abuse claims are not “occurrences” and therefore such claims cannot trigger coverage. See *T.M. v. Bremen Farmers’ Mutual Insurance Company*, 135 P.3d 774 (Kan., 2006)

<sup>41</sup> [2000] 1 S.C.R. 551.

matter of law. The insured who is the subject of these allegations will be unable to compel his or her insurer to defend the action on his or her behalf. Madam Justice McLachlin summarized the position as follows:

In other words, where there is an allegation of sexual battery, courts will conclude as a matter of legal inference that the defendant intended harm for the purpose of construing exemptions of insurance coverage for intentional injury.<sup>42</sup>

In reaching this conclusion, the Supreme Court was careful to note that an insurer will not be subjected to providing coverage where plaintiffs have engaged in “creative pleadings”. In the abuse context, it is common for allegations of abuse to be cast as negligence in an attempt to trigger coverage. This was the case before the court. However, the *Scalera* court put an end to such practices by finding that a party could not circumvent policy terms simply by manipulating the pleadings. The court will look beyond the mere words of the pleading in order to determine the “true nature and substance” of the allegations. Coverage is not triggered merely because a plaintiff uses the word “negligence”. The Supreme Court carefully analyzed the nature of a claim based on sexual abuse allegations.

In *Scalera*, a defence was sought by an alleged perpetrator of sexual assaults under his personal liability policy. The court established a three step analysis for determining whether a sexual abuse claim could trigger a duty to defend:

- 1) which of the plaintiffs legal allegations are properly pleaded?;
- 2) are any of the claims entirely derivative?;

---

<sup>42</sup> *Ibid.* at paragraph 38.

- 3) can any of the properly pleaded non-derivative claims potentially trigger the insurer's duty to defend?

The court went on to discuss the issue of intent in the context of sexual assault. The court was clear that a perpetrator's defence that he or she negligently believed there was consent is not relevant to the coverage issue. The court found that if lack of consent is alleged, then an intent to harm can be inferred.<sup>43</sup> The court said:

[T]he logic is simply that either the act must have been consensual or not consensual. If it was not consensual, the policy does not apply because neither the insured nor the insurer contemplated coverage for non-consensual sexual activities. If it was consensual, then there is no battery and no claim for recovery.<sup>44</sup>

Where sexual abuse is alleged, it is impossible for a sexual abuser to obtain indemnity by operation of the intentional act exclusion. The *Scalera* decision makes this position unassailable. It is less clear whether other forms of abuse invoke this principle, since physical and mental abuse is potentially caused by inadvertent or negligent conduct. In any event, it is possible the intentional act exclusion will not apply to others also insured by the policy. An analysis of the exact wording of the exclusion is required to determine this issue.

### ***B. Coverage for innocent co-insureds***

---

<sup>43</sup> American decisions have similarly found that an intent to harm can be inferred in sexual misconduct cases. See *Bender v. Glendenning*, 219 W.Va. 174 (W.Va., 2006); *K.M.R. v. Foremost Insurance Group*, 171 S.W.3d 751 (Kentucky, 2005) (acts of sexual molestation are intentional as a matter of law); *West Virginia Fire & Casualty Company v. Cass-Sandra Marko Gene Stanley*, 216 W.Va. 40, 51 (W.Va., 2004) (“our adoption of the inferred-intent rule in sexual abuse cases is based on the inherently injurious nature of the wrongful sexual act”).

<sup>44</sup> *Non-Marine Underwriters, Lloyd's of London v. Scalera*, [2000] 1 S.C.R. 551, para. 39



The *Scalera* decision has clearly stated that insurers are not obligated to provide a defence to policyholders who engage in acts of sexual abuse against children. However, the court did not address the issue of coverage for innocent co-insureds, an issue of great importance in the institutional liability context. Institutions which employ abusers are frequent targets of lawsuits seeking compensation for the abuse, and will often seek coverage from their liability carriers.<sup>45</sup> Such claims generally allege vicarious liability for the employee's action as well as independent causes of action involving negligent supervision or hiring practices. Insurers will generally seek to exclude coverage for such claims by applying the intentional act exclusion to the innocent co-insureds on the same basis as the perpetrator.

The Supreme Court of Canada has examined the issue of vicarious liability for employers in the context of abuse claims.<sup>46</sup> The court has found that to impose vicarious liability on an employer, the law requires “a strong connection between what the employer was asking the employee to do (the risk created by the employer's enterprise) and the wrongful act.”<sup>47</sup> Based upon this analysis, courts have found that there may be factual scenarios which will support a finding of vicarious liability against an employer. However, a finding of liability does not necessarily translate into a finding of coverage.

---

<sup>45</sup> See *Bazley v. Curry*, [1999] 2 S.C.R. 534 wherein the court notes:

It is tragic but true that people working with the vulnerable sometimes abuse their positions and commit wrongs against the very people they are engaged to help. The abused person may later seek to recover damages for the wrong. But judgment against the wrongdoer may prove a hollow remedy. This raises the question of whether the organization that employed the offender should be held liable for the wrong.

<sup>46</sup> See *E.B. v. Order of the Oblates of Mary Immaculate in the Province of British Columbia*, [2005] 2 S.C.R. 45; *Jacobi v. Griffiths*, [1999] 2 S.C.R. 570; *Bazley v. Curry*, [1999] 2 S.C.R. 534.

<sup>47</sup> *Bazley v. Curry*, [1999] 2 S.C.R. 534. See also *E.B. v. Order of the Oblates of Mary Immaculate in the Province of British Columbia*, [2005] 3 S.C.R. 45, para. 2 (quoting *Bazley*).

When conducting a coverage analysis to determine whether an innocent co-insured is covered for a sexual abuse allegation, courts tend to review the policy language strictly. Most policies will contain severability language which necessitates a separate coverage analysis for each insured.<sup>48</sup> Therefore a determination that an insured perpetrator is not covered by the policy does not in and of itself prevent an innocent co-insured from obtaining coverage. Instead, a finding of coverage for an innocent co-insured will depend upon the particular policy wordings. The most frequent debate in this context is whether the intentional act exclusion refers to acts committed by “an insured” or “the insured”.

In *W. -V(T) v. W.(K.R.J.)*<sup>49</sup> a daughter alleged that she had been sexually assaulted by her stepfather. The daughter also brought an action against her mother for not preventing the assaults. Over the years in which the alleged assaults took place the defendants were covered under various homeowners’ policies. While the first policy of insurance excluded “bodily injury caused intentionally by or at the direction of an insured”, the second policy excluded “bodily injury caused intentionally by or at the direction of the insured.”

There was no real debate that coverage was excluded for the stepfather. However, in determining whether there was coverage for the mother, the court found that under the first policy the mother was not owed a defence but under the second policy she was entitled to a defence. In reaching this

---

<sup>48</sup> See e.g. *Bluebird Cabs Ltd. v. Guardian Insurance Co. of Canada*, [1999] 173 D.L.R. (4<sup>th</sup>) 318 (B.C. C.A.) (The policy at issue contained a “separation of insureds” clause. The court found that the policy applied separately to each insured which meant that the application of the policy to the employer was to be considered entirely separately from the application of the policy to the employees.) But see *Sheppard v. Co-operators General Insurance Co.*, (1997) 33 O.R. (3d) 362 (C.A.) (court was reluctant to expand coverage even without a clause providing for separation of insurance).

<sup>49</sup> (1996) 39 C.C.L.I. (2d) 272 (Ont. Gen. Div.)

decision the court relied upon the distinction between “an” and “the”. The court’s discussion was as follows [citations omitted]:

I conclude that "an insured" must be given its ordinary, common-sense meaning. "An" is an indefinite article, and it means "any" insured. Therefore, intentional conduct by W., or any other insured, excludes the obligation to indemnify on the part of the insurer. There is abundant American jurisprudence to support this conclusion.

However, "the" is a definite article, and does not mean, nor can it be equated with the indefinite article "an", nor with the adjective "any", both of which are used to modify "insured" in other paragraphs of the exclusion clause in policy [no. omitted]. Reference to "the insured" in an exclusion clause has generally been held in the American jurisprudence to mean "the insured making the claim", or at the very least, to be ambiguous.

In Ontario the use of "the insured" in an exclusion clause has been held to mean the insured making the claim.

Similarly, in *Thompson v. Warriner*<sup>50</sup>, the Ontario Court of Appeal was presented with an exclusion clause which referred to “any” insured. The court distinguished the terminology from that in *Godonoaga v. Khatambakhsb*<sup>51</sup>, where the wording precluded coverage for “the” insured. Therefore, in *Thompson*, the court found that that the policy wording clearly excluded liability; whereas in *Godonoaga*, the court found there was coverage for an innocent co-insured.

---

<sup>50</sup> [2002] O.J. No. 1769 (Ont. C.A.). It must be noted that the consensus in Ontario is not yet complete, as there is one case from the Court of Appeal which challenges this principle: see *Snaak v. Dominion of Canada* (2002), 61 O.R. (3d) 230 (C.A.).

<sup>51</sup> [2000], 49 O.R. (3d) 22 (C.A.).

As a general rule, the effect a court will give to an intentional act exclusion will, in the context of claims against innocent co-insureds, turn on the language of the exclusion. An excellent summary of the applicability of the intentional act exclusion to innocent co-insureds can be found in a recent article in the *Canadian Journal of Insurance Law*:

[w]here the exclusion uses terms such as “you”, “your” or “the insured”, the exclusion will likely be interpreted to be confined to the particular insured asserting the claim for coverage, with the result that coverage will be extended provided that insured did not commit the excluded intentional act. Conversely, where the exclusion uses the terms “any insured” or “any person insured by this policy”, courts have generally found that an intentional act committed by any person insured under the policy will be sufficient to preclude coverage under this exclusion to any innocent co-insured.<sup>52</sup>

In an effort to bring home the insuring intention to exclude all harm arising from intentional acts, regardless of which insured commits the act, many insurers are incorporating even stronger language to this effect. For example, the following expanded exclusion can be found in some homeowners’ policies:

We do not insure claims arising from:

Bodily injury or property damage resulting directly or indirectly from any intentional or criminal acts or failure to act<sup>53</sup> by:

---

<sup>52</sup> Keith N. Batten, *A Review of Some Significant Insurance Issues in the Sexual Abuse Context*, 23 *Can. J. Ins. L.*, (November 2005). This is similar to the “best reasoned rule” adopted by many jurisdictions in the U.S. See *American Family Mutual Insurance Company v. Eastman*, 698 N.W.2d 337 (Iowa, 2005).

<sup>53</sup> The addition of the words “failure to act” are important as allegations of negligence for failure to prevent abuse will be captured by an exclusion using these words. See *G.(P.) v. Children’s Aid Society of Dufferin (County)*, [2001] I.L.R. I-3927 (Ont. S.C.J.).

- a) Any person insured by this policy; or
- b) Any other person at the direction of any person insured by this policy;

This exclusion applies to persons insured under this policy even though the intentional or criminal act or failure to act is by only one or more of any other person or persons insured under this policy.

Determination of coverage for the innocent co-insured will require careful analysis of the policy wordings.

### ***C. Sublimits or retentions***

Insurers are well aware that a court may find a particular exclusion ambiguous or unenforceable for some reason. In an attempt to deal with this concern, some carriers attempt to limit their exposure to liability for sexual abuse claims by creating sublimits or separate deductibles for such claims.

Canadian courts have not seen much litigation involving sublimits, but there is guidance available from cases in the United States.<sup>54</sup> American courts have disagreed on whether a sublimit for abuse claims is appropriate, usually for reasons of public policy.

In *American Home Assurance v. Cohen*<sup>55</sup> a psychologist was insured under a professional liability policy with a limit of \$1 million. A married couple being treated by the psychologist brought an action against him, alleging malpractice, unprofessional conduct, and inducing the wife to engage in sexual

---

<sup>54</sup> See *TIG Insurance Company v. San Antonio YMCA*, 172 S.W.3d 652 (Tex, 2005) (Court upholds a \$1million per claim limit for a sexual abuse occurrence.) See also *American Home Assurance Co. v. Stephens*, 943 F.Supp. 703 (Tex., 1996); *American Home Assurance Co. v. Smith*, 462 S.E.2d 441 (Ga.,1995).

<sup>55</sup> 881 P.2d 1001 (Wash., 1994)

relations with him. The policy contained a sublimit of \$25,000 under a provision relating to sexual misconduct, which stated:

The total limit of the Company's liability hereunder shall not exceed \$25,000 in the aggregate for all claims against any insured(s) involving any actual or alleged erotic physical contact, or attempt thereat or proposal thereof: (a) by any Insured... In the event any of the foregoing are alleged at any time... any and all causes of action alleged and arising out of the same or related courses of professional treatment and/or relationships shall be subject to the aforesaid \$25,000 aggregate limit of liability and to all other provisions of this clause... Furthermore, once sexual misconduct is alleged, and all claims arising out of the same or related course of treatment, whether involving sexual misconduct or not, are subject to the same \$25,000 sublimits.

The Washington Supreme Court was presented with two certified questions involving the proceeding. First, was it against public policy for an insurer to provide lesser coverage for a psychologist's sexual misconduct than it provides for the psychologist's nonsexual misconduct? Secondly, the court was asked to determine whether it was against public policy for an insurer to provide lesser coverage for a psychologist's nonsexual misconduct when it is alleged that sexual misconduct also occurred in the same or a related course of professional treatment.

In deciding the first question, the court found that it was not against public policy for an insurer to provide lesser coverage for sexual misconduct than nonsexual misconduct. The court found the sexual misconduct limit to be based on an identifiable risk to insurers and concluded that the limit did not offend the public good. In deciding the second question, the court found that limiting recovery to \$25,000 on a malpractice claim that included a claim of sexual misconduct was against

public policy, in that it would discourage clients from reporting unethical sexual conduct by therapists. The sublimit could not be applied in a case involving mixed allegations.

The issue of sublimits was again touched upon in *American Home Assurance Co. v. Stone*,<sup>56</sup> a case also involving allegations against a psychotherapist alleging that he had initiated a sexual relationship with the wife during the course of counselling. The therapist was insured under a professional liability policy for \$1 million per occurrence and \$3 million in the aggregate. The policy also contained a sublimit of \$25,000, applicable to sexual misconduct claims, which stated:

Sexual Misconduct- The total limit of the Company's liability hereunder shall not exceed \$25,000 in the aggregate for all damages with respect to the total of all claims against any Insured(s) involving any actual or alleged erotic physical contact, or attempt thereat or proposal thereof:

- a) by any Insured or by any other person for whom any Insured may be legally liable; and
- b) with or to any former or current patient or client of any Insured, or with or to any relative of or member of the same household as any said patient or client, or with or to any person with whom said patient or client or relative has a affectionate personal relationship.

In the event any of the foregoing are alleged at any time, either in a complaint, during discovery, at trial or otherwise, any and all causes of action alleged and arising out of the same or related courses of professional treatment and/or relationships shall be subject to the aforesaid \$25,000 aggregate limit of liability and to all other provisions of this clause. The aforesaid \$25,000 aggregate limit of liability shall be part of, and not in addition to, the limits of liability otherwise afforded by this policy.

---

<sup>56</sup> 61 F.3d 1321 (7<sup>th</sup> Cir., 1995)

The Company shall not be obligated to undertake to nor continue to defend any suit or proceeding subject to the aforesaid \$25,000 aggregate limit of liability after said \$25,000 aggregate limit of liability has been exhausted by payments for damages.

The insurer attempted to limit its liability to the sublimit amount of \$25,000. The couple argued the sublimit violated public policy in that it discouraged victims from reporting sexual abuse committed by therapists. The couple asserted that patients would be in a better position if they alleged malpractice, but withheld allegations of sexual abuse. The court rejected this argument and found that the provision could not be declared against public policy without a clear indication that insurance companies should be limited in the form or amount of insurance they provide to psychotherapists: The Court said: “public policy must be clearly defined and dominant, and should not be gleaned from general considerations of supposed public interests”. The appellate court agreed with the lower court decision, and went on to say that because the state has an interest in protecting the public from sexual exploitation by psychotherapists, it could not be said that a public policy reason existed to preclude insurers from limiting their coverage for liability arising out of the insured’s sexual misconduct.<sup>57</sup>

Higher deductibles or self-insured retentions for claims involving sexual abuse are also a frequent mechanism for insurers to limit their exposure to such claims. Another method involves making the insured a more involved party in the litigation by way of imposing a co-insurance requirement for such abuse cases. An example of such wording:

The Insurer will only pay ninety (90%) percent of compensatory damages that the Insured becomes legally obligated to pay because of “bodily injury” arising from “abuse”. The

---

<sup>57</sup> *American Home Assurance Co. v. Stone*, 61 F.3d 1321 (7<sup>th</sup> Cir., 1995)



Insured will be obligated to pay ten (10%) percent of compensatory damages that the Insured becomes legally obligated to pay because of “bodily injury” arising from “abuse”.

Other policies require the insured to participate in the payment of some measure of the defence costs in addition to indemnity. The purpose of limiting recovery for sexual abuse is twofold: to provide the insurer with limited exposure to a risk which is difficult to assess but can result in very high indemnity payments; and to make the insured a more interested party when assessing its own risk. When an insured is obliged to contribute a greater share of the costs of an abuse claim their motivation to seek out and prevent such risks is arguably stronger.

#### ***D. Specific abuse exclusions***

In recent years, many insurers have elected not to provide coverage for abuse claims at all. These insurers have included express abuse exclusions in their policy forms. This reduces reliance on the intentional act exclusion, but it should be noted both exclusions will be advanced in any coverage dispute.

Abuse exclusions are generally drafted in absolute terms. Such an exclusion was reviewed by the Ontario Court of Appeal in *Thompson v. Warriner*<sup>58</sup>. In this case, the plaintiff was an inmate in a young offender custodial facility. He brought an action against a facility employee and the facility itself, for sexual assault, negligent hiring and supervision. The facility submitted the claim to its carrier for coverage. The policy at issue contained an abuse exclusion which stated:

---

<sup>58</sup> [2002] O.J. No. 1769 (C.A.)

This insurance does not apply to claims arising out of molestation, harassment, corporal punishment or any other form of physical or mental abuse, committed or alleged to have been committed by:

- (i) any insured; or
- (ii) any employee, agent, servant, officer, director or member of any insured; or
- (iii) any person performing voluntary services for or on behalf of any insured.

The court found that the exclusion was clear and unambiguous. The pleading contained reference to a sexual assault, which clearly fit the category of “molestation” or “physical abuse.” Furthermore, it was the court’s view that the allegations of negligent supervision of the employee were subsumed into the intentional tort and could not be distinguished for the purpose of applying the exclusion clause. Both the intentional tort allegations and the negligent supervision claims were excluded.<sup>59</sup>

Another abuse exclusion was tested and upheld by the Nova Scotia Supreme Court in *Children’s Aid Society of Halifax v. Boreal Insurance Co.*<sup>60</sup> The plaintiff commenced an action alleging that the adult whose care she had been placed in had sexually abused her from the years 1968 through 1973. The plaintiff also alleged that the social worker, employed by the Children’s Aid Society of Halifax, who had placed her in that environment, was aware of the abuse and failed to take steps to prevent or stop it. The Children’s Aid Society sought coverage under a professional liability policy, issued by Boreal Insurance Company. Boreal denied the claim on the basis of an endorsement to the policy which provided:

---

<sup>59</sup> It is worth noting that the Court of Appeal in *Snaak v. Dominion of Canada* (2002), 61 O.R. (3d) 230 (C.A.) characterized the claims of negligent supervision as distinct from a claim sounding in an intentional battery. As noted above, however, the *Snaak* decision is controversial in several ways, including its findings on the intentional act exclusion, which run contrary to judicial trends.

<sup>60</sup> [1996] N.S.J. No. 508 (N.S.S.C.)

This insurance does not apply to any and all claims resulting from, connected with, or alleging sexual behaviour or physical, mental or emotional abuse.

The insured argued that applying the exclusion would render the insurance illusory. It was argued the purpose of the policy was to protect the Children's Aid Society and its employees against negligence claims arising from the performance of its professional duty, which was to protect children who have been abused and neglected. The court rejected this argument, noting the intent of the exclusion was clear, especially when the policy was read as a whole. Therefore, the court found that the exclusion properly excluded coverage for the claim.<sup>61</sup>

There was also an express "sexual molestation exclusion" discussed in *C.(D.) v. Royal & Sun-Alliance Insurance*.<sup>62</sup> The insureds, a married couple, and their son were insured under a homeowners' policy. The wife was responsible for babysitting two infants. The insureds were unaware their son, who was living in their home, had sexually assaulted the infants. The parents of the infants commenced a lawsuit against the insureds alleging that the babysitter had been negligent in failing to adequately supervise and protect the infants. The insureds sought coverage from their insurer, and the carrier denied the claim.

The policy at issue contained an "Intentional or Criminal Acts" exclusion, and a "Sexual Molestation Exclusion". The wordings of such exclusions were:

---

<sup>61</sup> An opposite conclusion was reached in *M.(R.) v. Children's Aid Society of London & Middlesex* (2001), 53 O.R. (3d) 631 (S.C.J.), where the court noted the policy included coverage for "assault and battery" but also excluded criminal acts. The court noted the CAS' "reasonable expectation was that there should be coverage for assault and battery when one takes into account the nature of the activity or business of the society. I conclude that the policy was drafted with the particular insurance needs of the Society and its employees in mind." The criminal act exclusion was not applied, because there could also be civil liability arising from such acts and the policy contemplated covering such claims.

<sup>62</sup> [2004] O.J. No. 4587 (S.C.J.)

## LOSS OR DAMAGE NOT INSURED

You are not insured for claims arising from:

--your business or any business use of your premises, except as specified in this policy;

--loss or damage resulting from the intentional or criminal acts of, or the failure to act by,

(a) any persons insured by this policy; or

(b) any other person at the direction of any insured by this policy.

--Actual or alleged sexual molestation, sexual harassment, corporal punishment or physical or mental abuse or harassment by any person insured by this policy.

The court found no ambiguity in these exclusions. When the exclusions were viewed together, the court noted they clearly applied to eliminate the possibility of coverage for all claims arising out of the son's sexual assaults. Even though the court found that the claims against the parents were properly plead in negligence, this did not alter the reality that the claims arose from an event for which coverage was expressly excluded. Therefore the court found that there was no coverage available to the plaintiffs, as "it would be an injustice to the insurer to suggest that this policy conceivably provides coverage for what is so obviously excluded."<sup>63</sup>

---

<sup>63</sup> *C.(D.) v. Royal & SunAlliance Insurance Co. of Canada* (2004), 73 O.R. (3d) 611 (Sup. Ct.). American courts have found that sexual molestation exclusions are applicable in minor-on-minor abuse cases as well. See *Concord General Mutual Insurance Company v. Madore*, 178 Vt. 281, 284 (Verm. 2005).

The IBC's 2005 revision of the standard CGL wording contains an abuse exclusion, intended to encompass claims involving any connection to abuse. It is to be noted the policy now defines the term "abuse", the absence of which has been troublesome in some cases. The new exclusion states:

This insurance does not apply to:

- o. Abuse
  - a. Claims or actions arising directly or indirectly from abuse committed or alleged to have been committed by an insured, including the transmission of disease arising out of any act of abuse.
  - b. Claims or actions based on your practices of employee hiring, acceptance of volunteer workers or supervision or retention of any person alleged to have committed abuse.
  - c. Claims or actions alleging knowledge by an insured of, or failure to report, the alleged abuse to the appropriate authorities.

The variety in the wording of abuse exclusions is broad. The new IBC form has not yet received wide acceptance and many insurers continue to rely upon versions prepared for their own use. Each case must be determined on its own facts. It is clear, however, that Canadian courts will give effect to appropriately worded exclusions to bar coverage for institutions, innocent co-insureds and perpetrators alike.

### ***E. Evidentiary issues***

One of the most thorny issues for policyholders and insurers alike arises when allegations of abuse span decades. It is often a difficult evidentiary issue to determine what, if any, insurance coverage

existed for individuals and institutions many years ago. Like individuals, it is not unknown for insurance companies to discard old papers. Accordingly, it is often the case that there is little evidence of insurance remaining. Policyholders seeking coverage for sexual abuse claims are therefore required to be creative in finding such evidence.

The primary onus of proving the existence of insurance coverage rests with the insured. The insured must first prove that a particular insurance company issued a policy and then must also prove its essential terms, including limits and the insuring agreement. The burden of proof is the balance of probabilities, not certainty.<sup>64</sup> Assuming an insured can provide satisfactory evidence and convinces a court that the policy exists, the onus then shifts to the insurer to establish any exclusion that may serve as a basis to limit or exclude coverage. This approach is akin to the usual burdens attributable to parties in a coverage dispute.

In *Synod of the Diocese of Edmonton v. Lombard General Insurance Co. of Canada*<sup>65</sup>, a parish member filed a statement of claim against a priest and the Synod for damages resulting from sexual abuse. The parish member alleged that he was abused by a Synod priest during a six year period from 1978 to 1984. The parish member also stated that he did not become aware of the abuse until 1998. The Synod sought coverage from its insurers Assitalia and Lombard.<sup>66</sup> The Synod asserted that Assitalia was its insurer from 1982 until 1984. Assitalia denied that it provided insurance to the Synod during this timeframe.

---

<sup>64</sup> See *Navy League of Canada v. Citadel General Assurance Co.*, 2003 CarswellOnt 308666, add'l reasons at 62 O.R. (3d) 460 (S.C.J.).

<sup>65</sup> (2004), A.B.Q.B. 803.

<sup>66</sup> It was acknowledged that Lombard's coverage did not come into effect until 1985. Since there was no liability inducing event after 1984, the court found that Lombard's policy, which was an occurrence policy, had no application to the claim.

The Synod could not locate a copy of the actual policy. It was therefore forced to rely upon secondary evidence to establish the existence and terms of the policy.<sup>67</sup> It relied upon the affidavit of its insurance broker, who indicated that he had placed the alleged insurance. The broker was able to provide some of its own documents suggesting the existence of insurance, but could not provide copies of any documents actually generated by Assitalia. The court found, however, that this limited evidence was sufficient to meet the Synod's burden to demonstrate the existence of liability coverage during the 1982-1984 time period.

The court then examined whether the Synod had met its burden of proving the terms of the insurance policy. The Synod relied upon the affidavit of its insurance broker, who stated that the Assitalia policy in effect during the relevant time was similar to the subsequent Lombard policy, of which a copy could be found. The court found that this constituted satisfactory proof of the terms of the Assitalia policy.

In *E.M. v. Reed*<sup>68</sup>, the court was also forced to grapple with the issue of a missing policy. A priest was accused of long term sexual abuse by a parishioner. The relevant policy, issued by Great American, and in force from 1963 to 1971, could not be found. The Diocese attempted to reconstruct the process of procuring insurance and the policy terms. The Diocese established that the policy was a manuscript form, drafted to meet the specific needs of the Diocese. The Diocese relied upon the testimony of an insurance broker, who was found to be knowledgeable of insurance practices in the industry at the relevant time. The broker testified that many of the standard clauses

---

<sup>67</sup> “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.” See *Catholic Children’s Aid Society of Hamilton-Wentworth v. Dominion of Canada* (1998), 7 C.C.L.I. (3d) 11 (Ont. Gen. Div.).

<sup>68</sup> (2000), 24 C.C.L.I. (3d) 229 (Ont. S.C.J.), aff’d (2003), 49 C.C.L.I. (3d) 57 (C.A.).

applicable to a manuscript policy would be contained in a policy “jacket”. The Diocese could not locate the actual jacket, however the court found that the evidence was sufficient to establish the existence of a jacket, and thereby adequate to establish the existence of a duty to defend clause, which would in all likelihood have been contained in such a jacket. The court stated its conclusion in these terms:

[I]t is the archaeological discovery of the presence of such a term in the contract at a level of proof sufficiently high to allow me to find as a fact that the duty to defend clause was present as part of the total contractual agreement between the parties.<sup>69</sup>

These cases establish that both the existence and terms of missing policies may be proven by secondary evidence, according to a simple balance of probabilities. Often the only evidence of insurance will be the policyholder’s copy of a declarations page. Hopefully that document will identify the form used by the insurer and the terms and conditions can be found from other sources, including standard forms published and maintained by the Insurance Bureau of Canada. Where the policy is known to be a manuscript form, however, proof of the terms can be much more difficult and the policyholder may fail in its efforts. Other sources of evidence include renewal letters from brokers, returned cheques, bank records, minutes of board meetings discussing the placement of insurance combined with the testimony of insurance brokers or other witnesses. If the whole of the evidence is sound and diligently pursued, a court may be satisfied it was more likely than not that a policy did exist, and extend coverage for the acts or omissions, loss and damage in question.<sup>70</sup>

### **III. Issues Related to the Duty to Defend**

---

<sup>69</sup> *E.M. v. Reed*, (2000), 24 C.C.L.I. (3d), 229 (Ont. S.C.J.)

<sup>70</sup> Neo J. Tuytel, *Who’s on the Risk*, 12 Can. J. Ins. L., (Nov-Dec 1994)



A policy of third party liability insurance contains two valuable obligations on the part of the insurer: a duty to defend covered claims and a duty to indemnify the policyholder for damages payable for such covered claims.<sup>71</sup> When sued, an insured's first concern is the arrangement and funding of its defence. Resolution of the defence obligation is also significant because indemnity will often follow the outcome of the defence obligation.<sup>72</sup>

In *Nichols v. American Home*<sup>73</sup>, the court found the existence of a duty to defend is premised on an analysis of the claims raised in the statement of claim and the wording of the insurance policy. As a general proposition, the duty to defend is to be determined solely by reference to the allegations in the pleadings. Though a simple enough proposition, much litigation in the coverage area is based upon determining whether a carrier has the obligation to defend a policyholder in a particular matter and the manner in which that defence will be provided.

#### ***A. Extrinsic Evidence***

The basic rule when assessing a claim and making a determination of the duty to defend is that the court should limit its analysis to the actual pleadings and policy wordings. Extrinsic evidence is not generally permitted in order to inform the analysis. As noted above, the *Scalera* decision makes it clear that the words contained in the claim will not be read at face value. The court will view the claim in its whole context and determine its true nature and substance. The plaintiff's choice to use certain words or plead a cause of action in a particular way is not determinative. The court will, if possible, avoid being manipulated by the pleadings.

---

<sup>71</sup> *Wilkinson-Valiente v. Wilkinson et al.*, [1996] I.L.R. I-3351(Ont. Gen. Div.)

<sup>72</sup> Keith N. Batten, *A Review of Some Significant Insurance Issues in the Sexual Abuse Context*, 23 Can. J. Ins. L., (November 2005)

<sup>73</sup> [1990] 1 S.C.R. 801.

The rule against admission of extrinsic evidence is an area of constant dispute. Insurers which have obtained information which clearly demonstrates to it that there should be no coverage for a particular claim are understandably upset when forced to defend because the statement of claim alleges something different or fails to plead the material fact which avoids coverage. The Supreme Court of Canada, in *Monenco v. Commonwealth Insurance Co.*<sup>74</sup>, has made it clear that the benefit of the doubt should always favour the policyholder seeking coverage. In most circumstances, the insurer will not be able to present such extrinsic evidence to support a coverage denial.

One exception which was clearly articulated by the Supreme Court is that documents specifically referred to in a claim may be reviewed by the court to add context to the analysis. An insurer may not, however, rely on or present evidence which goes to the very heart of the dispute between the plaintiff and the policyholder. To permit litigation of such facts at the duty to defend stage is to potentially prejudice the insured when defending the underlying litigation.

It is beyond the scope of this paper to conduct a detailed analysis of the duty to defend and review the various permutations of it, but we will present some issues of practical concern to the institution seeking coverage for sex abuse claims.

### ***B. Insurer/insured conflicts***

Typically, if an insurer has a duty to defend a claim it also has the right to appoint a lawyer of its choice to conduct the defence. Further, the insurer acquires the sole right to determine strategy and, if it desires, to settle the case. In situations involving allegations of sexual abuse, however, there are underlying insurance coverage issues which can create conflict between insurer and insured.

---

<sup>74</sup> [2001] 2 S.C.R. 699.

As noted above, most insurers will look to the intentional act exclusion to bar coverage for sex abuse for some or all of the insureds. The defence may be undertaken pursuant to a strict reservation of rights with respect to the indemnity obligation. In contrast, the policyholder is likely asserting that the claim is covered. In fear that a lawyer appointed by the insurer will not have the policyholder's best interests in mind, this conflict may result in a policyholder seeking the right to select counsel.

The problem arises because of the nature of the duty to defend and the relationship between the parties who must be involved in the defence of an insured claim: the defence lawyer; the insurer and the insured. The insurer has an interest in the outcome because it is both paying for the defence and may be required to pay any damages. The insured has an interest because its reputation is at stake and it too may be required to contribute to the costs.

Two theories have been developed to analyze the potential conflict of interest between an insurer and its policyholder. The first theory (the "one client" theory) holds that the defence counsel's only client is the policyholder and that all duties are owed directly to that person. The second theory (the "two client" theory) states that defence counsel represents both the insurer and the policyholder at the same time.<sup>75</sup>

In Canada, there is no consensus concerning which theory more accurately reflects the nature of the defence lawyer's retainer.<sup>76</sup> At least one judge has held in favour of the one client theory. In

---

<sup>75</sup> It should be noted that these theories are generally academic and do not alter the manner in which legal services are provided. They are used to determine when a conflict exists. They do not describe the manner in which a diligent defence lawyer conducts litigation, which is always for the best benefit of the policyholder.

<sup>76</sup> The English courts appear to recognize a two client situation by acknowledging a solicitor and client relationship with both the insured and the insurer: *Groom v. Crocker*, [1938] 2 All E.R. 394 (C.A.). The *Groom* case was cited favourably in *Abick v. Continental Insurance Co. of Canada* (2002), 157 O.A.C. 334 (Div. Ct.).

*Hopkins v. Wellington*<sup>77</sup> the court rejected a characterization of the retainer as being for the benefit of two clients, preferring instead to insist that the only true client is the policyholder. The Quebec Court of Appeal has recognized that defence counsel has obligations to both the insured and the insurer, but that in the event of conflict the duty to the insured is primary. Likewise, while not specifically addressing the issue, the court in *Brockton (Municipality) v. Frank Cowan Co.*<sup>78</sup> implicitly recognized that defence counsel is acting for both the insurer and the insured.

One possible outcome of a conflict between an insurer and a policyholder is that the insurer may lose the right to appoint and instruct counsel. This may be the only manner in which the conflict can be resolved. In *Brockton (Municipality) v. Frank Cowan Co.*<sup>79</sup> the Ontario Court of Appeal was asked to consider when a conflict of interest between an insurer and its policyholder will be sufficient to remove the insurer's right to appoint counsel. The insured in that case asserted the existence of an "appearance of impropriety", created by the insurer's assertion that there were limits and restrictions on the insurance coverage. The insurer had issued a reservation of rights letter. The Court of Appeal rejected the idea that this created a real conflict of interest, such that the insurer lost its right to control the conduct of the litigation.<sup>80</sup> The court recognized that not every potential dispute between an insured and insurer will create a conflict. The question is the extent to

---

<sup>77</sup> (1999), 68 B.C.L.R. (3d) 152 at paragraph 9 (S.C.). It should also be noted that the court in *Hopkins* appears not to have been advised of the British Columbia Court of Appeal decision in *Chersinoff v. Allstate Insurance Co.* (1968), 69 D.L.R. (2d) 653 (B.C. S.C.), rev'd in part (1969), 3 D.L.R. (3d) 560 (C.A.) which favoured the two client theory. That said, the *Hopkins* case was followed in *Walker v. Wilson*, 2000 BCSC 149 (B.C. S.C., 2000).

<sup>78</sup> (2002), 57 O.R. (3d) 447 at paragraph 41 (C.A.).

<sup>79</sup> (2002), 57 O.R. (3d) 447 (C.A.).

<sup>80</sup> In reaching this conclusion the Court of Appeal placed particular reliance on the decision of Justice LeBel in *Zurich du Canada c. Renaud & Jacob*, [1996] R.J.Q. 2160 (C.A.).

which their interests either coincide or diverge. This is a question of balance, to be determined in each case.

It seems clear that the insurer should retain the right to appoint and instruct counsel so long as there is no reasonable apprehension of conflict of interest. A straightforward reservation of rights respecting policy limits, policy interpretation issues or coverage for punitive damages will, in almost all cases, not create such a conflict. Sexual abuse claims are more problematic, because the application of an intentional act or sexual abuse exclusion could affect the indemnity obligation. In such a case the insurer and the insured may have very different interpretations of the evidence which affects that issue.

Where the insured's conduct may be directly in issue in the underlying litigation, a conflict may exist as the insurer might be motivated to adduce evidence detrimental to the insured in order to advance a coverage defence. This conclusion was reached in *Morrison v. Co-operators General Insurance Co.*<sup>81</sup> In that case the insured was sued for an assault and battery. The statement of claim was later amended to include an allegation of negligence. The insurer refused to provide a defence in light of the allegations of intentional conduct. The court ordered the insurer to defend and permitted the insured to appoint counsel of its choice. In reaching this decision the court accepted the approach set out in *Brockton*. It found that resolution of the coverage issue involved a determination of the insured's conduct. This was the very issue in dispute in the underlying litigation. In such circumstances, a conflict of interest was apparent.

---

<sup>81</sup> (2004), 12 C.C.L.I. (4<sup>th</sup>) 171 (N.B. C.A.). See also *Ladner v. American Home Assurance Co.*, 607 N.Y.S.2d 296 (N.Y., 1994).

In *Roman Catholic Episcopal Corp. of St. George's v. Insurance Corp. of Newfoundland*<sup>82</sup>, the underlying lawsuit involved allegations of sexual misconduct against a Catholic priest. The plaintiffs sought damages from the priest, the local Bishops and Archbishops, the local Episcopal Corporation and the Roman Catholic Church. The Episcopal Corporation was insured and was provided a defence by its insurer. A principal platform of the defence advanced on behalf of the Episcopal Corporation was an effort to transfer liability to the Roman Catholic Church. The preference of the Episcopal Corporation was, however, to support the interests of the Roman Catholic Church. Accordingly, it sought to remove appointed defence counsel by asserting the existence of a conflict of interest between the insurer and the Episcopal Corporation. In essence, it argued that the defence position might harm the interests of the Church.

The Newfoundland and Labrador Court of Appeal refused to limit the insurer's right to appoint defence counsel. The Church was not a party to the insurance policy and the insurer had no obligations to protect the interests of the Church. The Court held the appointed defence counsel's "only mandate is to firmly advance argument to exonerate the Episcopal Corporation from liability". The *Episcopal Corporation* case suggests that the insurer will, in most cases, be afforded the right to control the litigation. Indeed, this right is essential in order to protect the insurance company's financial interest in the outcome of the lawsuit. If the insurer is obliged to pay for the legal expenses, it should be afforded at least oversight of those expenditures.

Defence of the underlying litigation will, in most cases, be unrelated to that coverage dispute. The insurer's interest is always to adduce all necessary evidence to avoid liability. Once the decision is made (either by consent or via an application to determine the issue) to extend a duty to defend, the

---

<sup>82</sup> (2003), 6 C.C.L.I. (4<sup>th</sup>) 83 (Nfld. & Lab. C.A.).

issue of whether the policy provides indemnity can be determined and, if necessary, litigated after the underlying abuse claim has been resolved. The potential coverage conflict will not usually impact the ability of the insurer to conduct the defence and should not, in most circumstances, result in the policyholder appointing its own counsel. Of course, many large institutional insureds have negotiated the right to appoint counsel as part of their insurance package.

### ***C. Allocation***

Under Canadian law the duty to defend exists only with respect to claims which are potentially within coverage. If the claims advanced can have no possibility of indemnity the insurer has no obligation to defend. It is entirely possible for a claim to contain both covered and non-covered allegations. It is therefore open to insurers to argue that their policyholders must, in some circumstances, contribute to the costs of the defence in order to share the burden of defending those allegations for which no coverage is provided. This process is known as allocation of defence costs with the insured. A related issue is the obligation of successive insurers on risk to contribute to the costs in accordance with their respective burdens. This is known as equitable contribution between insurers. Both issues are very likely to arise in relation to sex abuse claims.

#### *(i) Allocation with the Insured*

It is the rare case in which the allegations are so well articulated that there is an obvious division between covered and non-covered claims. As noted, courts are loathe to order an insured to contribute to defence costs unless there are clear and compelling reasons to do so. Courts will not impose a burden to share defence costs without a logical basis to determine the respective burdens.<sup>83</sup>

---

<sup>83</sup> *St. Paul Fire & Marine Insurance Co. v. Durabla Canada* (1996), 29 O.R. (3d) 737 (C.A.) (“We do not find ourselves in a position to articulate an equitable formula for such proration at this stage of the proceedings.”)

There will, however, be circumstances where it is reasonable and possible to divide the defence burden.

A number of principles have been developed to guide the extent to which an insurer may obtain an allocation. These are:

1. The insurer must pay defence costs related to all items that are clearly within coverage. If the defence costs associated with defending a covered claim happen to benefit the non-covered items, the insurer is not entitled to a reduction.<sup>84</sup>
2. If the insurer accepts that at least one claim is covered, yet refuses to provide a defence for any of the claims, the insurer will be obliged to pay all of the costs of the defence.<sup>85</sup>
3. Where it is impractical to divide the defence costs in any rational way, the insurer must pay all of the costs.<sup>86</sup>

Quite recently the Ontario Superior Court did find it possible to allocate defence costs between the insurer and the policyholder. In *Sommerfield v. Lombard Insurance Group*<sup>87</sup> the court was asked to deal with the issue of allocation of defence costs in the sexual abuse context. The insureds were four teachers who were all employed at Upper Canada College between 1986 to 1990. The insureds were

---

<sup>84</sup> See *St. Andrew's Service Co. v. McCubbin*, (1987), 31 C.C.L.I. 166 (B.C. S.C.)

<sup>85</sup> See *Modern Livestock v. Kansa General Insurance Co.* (1993), 18 C. C. C. I. (2d) 266 (Alta. C.A.).

<sup>86</sup> See *McRae v. Kitching* (1997), 49 C.C.L.I. (2d) 93 (Ont. Gen. Div.).

<sup>87</sup> (2005), 75 O.R. (3d), 571 (Sup. Ct.).



all accused of having sexually abused the plaintiff while he was a student at Upper Canada College. The statement of claim alleged sexual battery and professional negligence for failure to report the sexual assaults of the other teachers. The teachers requested Lombard to provide a defence. Lombard denied the claim on the basis of an intentional acts exclusion contained in the policy. The court found that the sexual battery allegations were excluded but the professional negligence claims were covered. The court found that the professional negligence claims were independent of, and not derivative of, the sexual abuse allegations.

Upon finding coverage for portions of the claim, the court was forced to deal with the issue of apportionment of costs. The court acknowledged that the majority of the allegations involved the sexual battery, and hence it would be unfair to require the insurer to pay for the entire defence.<sup>88</sup> The court stated that in cases where some of the claims fall within coverage and some do not, it may be possible and proper to apportion the defence costs. The court found that Lombard was only responsible for twenty percent of the cost of the defence.

Allocation of defence costs to the insured is permitted and desirable in many circumstances. Litigation of such issues is complicated, however. Most often an insurer will seek to negotiate this particular issue at the commencement of the defence obligation.

*(ii) Equitable contribution*

A study of insurance decisions indicates the reconciliation of competing and often irreconcilable insurance policy provisions has plagued the courts and even given rise to much academic comment

---

<sup>88</sup> *Sommerfield v. Lombard*, (2005) 75 O.R. (3d), 571 (Sup. Ct.), para. 42.

in Canada.<sup>89</sup> However, given the variety of policies available that may potentially cover such claims, allocation is inevitably an issue that must be addressed. The doctrine of equitable contribution among insurers is well-established and is best summarized in the oft-quoted statement:

[i]f the insured is to receive but one satisfaction, natural justice says that the several insurers shall all of them contribute pro rata, to satisfy that loss against which they have all insured.<sup>90</sup>

Though this doctrine is well-established, its application can be difficult, especially in the face of clauses that are specifically designed to limit an insurer's exposure when there may potentially be other insurance available - the so-called "other insurance" provisions found in most liability policies.

The Supreme Court attempted to offer some guidance on the "other insurance" clause issue, a recurring problem in coverage cases, in *Family Insurance Corp. v. Lombard Canada*<sup>91</sup>. In this decision the court confirmed the general rule that where the "other insurance" provisions in the overlapping policies are identical or substantially similar, they will cancel each other out and both policies will be called on to respond, although there is no fixed rule as to how such defence costs should be shared.

The other most common forum for disputes involving equitable contribution are situations in which the sexual abuse occurred over an extended period of time and thus occurred in each of several successive policy periods, insured by a series of insurance companies. If the claim falls within the coverage of each of the policies, it is necessary to ensure that one insurer is not unfairly burdened with the costs of defending and indemnifying the claim

---

<sup>89</sup> *Family Insurance Corp. v. Lombard Canada*, [2002] 2 S.C.R. 695.

<sup>90</sup> *Family Insurance Corp. v. Lombard Canada*, [2002] 2 S.C.R. 695 (quoting Lord Mansfield C.J. in *Godin v. London Assurance Co.* (1758), 1 Burr. 489, 97 E.R. 419 (K.B.)).

<sup>91</sup> [2002] 2 S.C.R. 695.

In *E.M. v. Reed*<sup>92</sup> the plaintiff brought an action against defendants Reed, the Diocese, and Leibl, alleging negligence, assault, battery, breach of fiduciary duty and vicarious liability. The plaintiff alleged the defendant Reed was her parish priest and was in a position of significant authority considering her strict Catholic upbringing. In addition, Reed began counselling her at the age of 17. Over time the relationship between the plaintiff and Reed became physical. This relationship lasted for years and even through periods during which she was hospitalized for psychiatric care. During plaintiff's time in a psychiatric facility she encountered Leibl, who conducted regular psychotherapy sessions with her. Such psychotherapy sessions eventually led to an improper relationship between plaintiff and Leibl. After six weeks at trial, the parties arrived at a settlement agreement. This settlement addressed plaintiff's claims against the defendants, however the issue of defendants' claims against their insurers remained unresolved.

Reed and the Diocese sought coverage from their carriers for defence fees and for monies paid to the plaintiff. The alleged sexual abuse constituted an ongoing and continuing injury over an extended period of time, during which the Diocese had been covered by insurance policies issued by three different insurance companies. Two of the three insurers agreed to contribute to defence costs and indemnity. However the third insurer, Great American, refused to contribute to the settlement or defence costs. The court decided that all three policies should respond to the claim, and divided the defence obligation between the insurers on an equal or per capita basis, notwithstanding different time on risk.

---

<sup>92</sup> (2000) 24 C.C.L.I. (3d), 229 (Ont. S.C.J.)

Other approaches to allocation, albeit in a non-sexual abuse context, have been seen in *Alie v. Bertrand*<sup>93</sup> and *St. Paul Fire & Marine Insurance Co. v. Durabla Canada Ltd.*<sup>94</sup> In *Alie v. Bertrand* the Ontario Court of Appeal endorsed a pro rata approach by policy years engaged and then allocated that amount equally between the primary and all excess/umbrella insurers engaged within each policy year. This approach was followed in *Royal & SunAlliance v. Fiberglas Canada*<sup>95</sup>, in which an insurer was ordered to contribute to defence costs in accordance with time on risk over the involved period<sup>96</sup>.

#### **IV. Insured's Post-Incident Obligations**

Following an incident, the policyholder has several very specific obligations imposed upon it. These obligations are set out in its insurance policy, generally in the section entitled "Conditions". Note, however, that some important requirements can be found in the very language of the insuring agreement. Other obligations are derived from common sense and are steps taken to minimize liability and ensure the post-incident investigation is conducted efficiently and carefully.

Immediately following an incident, the insured should be prudent in its post-incident note taking and accident reporting. Post-incident handling can have a dramatic impact on a damages award. In this respect, the insured must follow its risk management guidelines. As well, it should conduct a thorough investigation immediately following any loss. Whenever possible, the investigation should involve the insurer and include witness interviews.

---

<sup>93</sup> (2002) 62 O.R. (3d), 345 (C.A.).

<sup>94</sup> (1996) 29 O.R. (3d), 737 (C.A.).

<sup>95</sup> (1999) 12 C.C.L.I. (3d) 282, (Ont. S.C.J.).

<sup>96</sup> The insurer was required to fund 40% of the defence costs.

It is critical that any incident which a reasonable person could expect will result in a lawsuit is reported to the insurer in a timely fashion and in accordance with the requirements of the policy. One area of frequent coverage litigation is the failure of the policyholder to comply with reporting requirements. The requirements of a professional liability insurance policy and other errors and omissions policies can be quite stringent and failure to strictly comply with the terms can result in a denial of coverage.

Most E&O forms are “claims made” policies. These respond only to claims for compensation first brought against the insured during the policy period. More recently, many such forms contain even more restrictive language, requiring the claim to be brought *and reported* to the insurer during the policy period. These are known as “claims made and reported” policies. It is the claim being made during the policy period and the *reporting of that claim during the policy period* that is typically the event triggering coverage.

Depending on the policy wording, the requirement to report a claim may constitute either a “requirement after loss” or a “condition precedent”. The former category requires substantial compliance with the policy condition or coverage may be forfeited. However, if there has been imperfect compliance with a requirement after loss, most provincial Insurance Acts permit a court to grant relief from forfeiture. This is an exercise of the court’s discretion whereby the policyholder’s error is forgiven, provided the insurer has not been unduly prejudiced. On the other hand, if the requirement to report a claim is integral to the insuring agreement or is expressly declared to be a condition precedent to coverage, no coverage can exist unless and until the policyholder complies with the strict requirements. A failure to comply cannot be forgiven by

exercise of the court's discretion and coverage will be denied.<sup>97</sup> Most "claims made and reported" policies are framed such that a failure to report during the policy period results in loss of coverage.

Because of the stringent reporting requirements, policyholders are strongly advised to document when and how it reported the commencement of a lawsuit or the happening of events which might give rise to a lawsuit in the future. The reporting must be in accordance with the procedures set out in the policy. For example, it is common for a policy to require notice to the insurer in writing. There have been cases, particularly in the U.S., where oral notice to the insurer did not satisfy a notice provision requiring written notice.

Very recently, the Supreme Court of Canada considered the notice requirements in the context of a sexual abuse class action. The *Jesuits Fathers of Upper Canada v. Guardian Insurance Co. of Canada*<sup>98</sup> case involved allegations of abuse occurring at a residential school operated by the Jesuits between the late 1800s and 1969. Indications of problems involving the administration of the school surfaced at the end of July 1988. These problems consisted of "harsh discipline" and the negative impact the school had on Aboriginal culture. In 1991, a former student informed his parish priest of abuse he had endured during his time at the school. An investigation into these allegations was commenced by the Jesuits.

On June 30, 1993, the Jesuit's investigator interviewed someone (a credible witness employed in various Aboriginal communities) who had come into contact with persons claiming to be victims of abuse. By January 1994, the Jesuits were aware of both general and specific allegations of abuse.

---

<sup>97</sup> As harsh as this result seems, the courts will enforce a condition precedent quite strictly because it represents a fundamental feature of the insuring agreement and the bargain between the insurer and the policyholder. See *Stuart v. Hutchins* (1999), 40 O.R. (3d) 321 (C.A.).

<sup>98</sup> *Jesuits Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, [2006] 1 S.C.R. 744.

The former student retained a lawyer sent a demand letter to the Jesuits. The letter detailed how the student had suffered physical and sexual abuse while at the school. The letter also alleged the Jesuits had failed to adequately supervise the offending teachers. The lawyer enquired about the possibility of a negotiated settlement.

In 1994, following receipt of the demand letter, counsel for the Jesuits wrote to its insurer and suggested the Jesuits might be facing similar claims in the near future. The letter identified the offending Jesuits, the dates and locations of the offending acts, and the nature of the possible claims. It also provided the names of ten victims, including the student who had sent a demand letter. In May 1995 the former student issued a claim against the Jesuits, who sought a defence and coverage from their insurer, which had issued an E&O policy between 1988 and 1994. The E&O coverage was available for “claims ... first made ... during the policy period”.

After the policy expired, over 100 claims were ultimately issued against the Jesuits. The insurer accepted that the demand letter sent by the former student in 1994 was a claim made during the policy period. The insurer denied, however, that it had any obligations in respect of the many claims commenced after the policy expired.

In response, the Jesuits argued that the letter it sent to the insurer in 1994 contained sufficient information to constitute notice of all of the 100 claims against it and that such notice was therefore given within the policy period. The Supreme Court of Canada disagreed. The court stated that in order for a claim to have been made, certain information must be communicated to the policyholder by the claimant or the claimant’s representative. In particular, a “claim” at common law requires that a third party communicate an intention to hold the insured responsible for damages.

The court found it significant that the basis for the information set out in the Jesuits' letter did not originate from the actual victims. Rather, the basis for the letter derived from information obtained from the Jesuits own investigation and not actual demands made by victims. The Supreme Court of Canada was not satisfied that the Jesuits letter set out a list of victims who, at that time, had an actual intention to seek compensation. The letter did not directly or indirectly communicate the victim's intention to hold the Jesuits responsible for damages during the policy period. Thus, the duty to defend those claims was not engaged, as the claims had not been reported during the policy period.

The *Jesuit* decision clearly clarified the law as to what constitutes a "claim" when that term is undefined in a claims-made policy. The Supreme Court of Canada's decision stands for the proposition that a "claim" is the communication by the victim or the victim's representative of a clear intention to pursue the insured for compensatory damages. The "claim" must communicate the intent of the claimant with the claimant's full knowledge and approval.

Once a claim has been properly communicated to the insurer, the insured's obligations are not over. All policies contain provisions which require a policyholder to cooperate fully with the insurer in the investigation of the claim and the conduct of the defence. Often, the insurer will appoint an independent adjuster to conduct an investigation of the circumstances. If the claim is straightforward and there are no insurance coverage issues which may result in a denial of coverage, cooperation with this adjuster should be uncontroversial. If there are potential coverage issues facing the policyholder, it may be prudent for the institution to seek legal advice concerning those issues as early as possible. The policyholder should not, however, refuse to speak with the insurer or its investigator as such cooperation and assistance is required, lest coverage be forfeited.



The purpose of the insurer's investigation is twofold: to determine if coverage exists and to accumulate evidence in advance of trial. The insurer is entitled to review all relevant evidence and factual information in the possession of the policyholder. Withholding information can result in forfeiture of coverage. In this respect, all potentially relevant correspondence, legal or non-legal, should be forwarded to the insurer. Post-incident correspondence is often time sensitive and must be addressed promptly. Failure to respond to such correspondence can, more often than not, prejudice the insurer's intentions and efforts to quickly resolve the dispute.

Assuming the loss is covered, the insurer will then appoint defence counsel to act on behalf of the insured. Some insurance policies may permit the policyholder to appoint counsel itself and be reimbursed for the expense. In all cases, however, the insurer will expect to be fully informed of all steps in the litigation and will have ultimate decision making control over decisions to make any indemnity payments by way of settlement. As discussed above, relations between the policyholder and the insurer are not always rosy, but their interests are ultimately shared as it relates to the outcome of the litigation.

In the abuse context and particularly when it involves institutions, there is a great deal of public pressure applied by way of media disclosure. There will be demands for apologies and interim compensation. In many cases, it may be possible to do both of these things. However, the insurer must be consulted and agree with any such public statements since they could have an impact on the lawsuit.

In circumstances where the institution is entirely satisfied the claims against its employees are false or frivolous, there will be an obvious desire to support the employee or professional. This may take the form of public support or even assistance with legal bills. Neither one of these represents a breach of the policyholder's duty to cooperate with the insurer, but any such acts should be done

carefully.<sup>99</sup> At no time should the institution attempt to conduct a joint defence with the alleged perpetrator, since that is a situation rife with potential conflict of interest.

## **V. Conclusion**

Although the rules applicable to obtaining coverage for abuse claims appear to be well-settled, there remain inconsistencies in judicial decisions. These inconsistencies may create ways to trigger or defeat coverage. This paper has provided a broad overview of the most common coverage issues arising in relation to abuse claims. We caution and stress that the individual policy wordings must be reviewed and will determine the issues. As the Supreme Court of Canada stated: “the proper instrument to determine the liability of each insurer is the policy itself”.<sup>100</sup>

---

<sup>99</sup> *Preferred Risk Mut. Ins. Co. v. Peterson*, 179 F.Supp. 652.

<sup>100</sup> *Family Ins. Co. v. Lombard Canada*, [2002] 2 S.C.R. 695.