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TYPICAL ISSUES IN ERRORS AND OMISSION CLAIMS

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TYPICAL ISSUES IN ERRORS AND OMISSIONS CLAIMS

I. Introduction:

When a claim for coverage under an Errors & Omissions policy ("E&O Policy") is made by the insured there are a number of issues that typically must be considered by the claims handler. Does the claim potentially fall within coverage? Are there any allegations which do not fall within coverage? What exclusions are applicable to the allegations made against the insured? If there are allegations that fall both within the scope of the policy and allegations which do not, what are the insurer's defence obligations? When a number of claims are advanced against the insured during the policy period, what are the insurer's indemnity obligations? If multiple claims will potentially exceed the policy limits, when do the insurer's duties to defend and indemnify end?

This paper will provide an overview of the types of claims made against professionals which raise issues that those involved in the insurance industry may have to consider in the course of investigating a claim or assessing the availability of coverage; whether it is a question from an insured seeking to purchase or renew an E&O Policy; issues which must be investigated to address both coverage and liability; factors that must be addressed in order to assess the exposure of the insurer under the policy or the insured as a result of the claim; or determining what proactive steps can be taken by the claims handler to limit the insurer's exposure to protracted litigation and defence costs.

A. Claims Examples:

The following is a brief overview of the types of claims that are typically made against certain types of professionals.

1. Lawyers:

In *Lombard Financial Group Inc. v. Davies & Co.*,[1] a lawyer was sued by his client for professional negligence. The lawyer had told his client that a prospective employee, with whom the lawyer also had business dealings, required stock options as an inducement to accept a management position with the client. Additionally, the lawyer was designated to act as the custodian of the shares during the period they were subject to the option. The Court found that the statements made by the lawyer were fraudulent misrepresentations. In addition, in breach of his role as custodian, the lawyer had

[1] 2005 ABQB 387

facilitated a loan for the potential employee so that the employee could exercise the options. The Court awarded $220,000 damages as the value of the shares that had been sold to the prospective employee pursuant to the options.

2. Real Estate Appraisers:

Royal Bank v. Richardson Appraisals Inc.[2] involved a negligence claim against an appraiser by a bank. The appraiser had been retained by the vendor of a property to conduct two appraisals of the property to be sold to the purchaser. These appraisals, and a third one commissioned directly by the bank, had been relied upon by the bank in agreeing to extend financing to the purchaser for the transaction. When the purchaser defaulted on the mortgage and the bank commenced foreclosure proceedings, it discovered that the appraiser had appraised an adjacent property, which had a building constructed on it, and not the property bought by the purchaser, which did not have a building on it. The Court concluded that the appraiser was negligent for relying solely upon the information from the vendor as to the location of the property and failing to take any steps to independently verify that the property appraised was the property subject to the purchase and sale agreement. The shortfall between the mortgage amount and the amount realized by the bank in the foreclosure proceedings was awarded as damages.

3. Dentists:

In *Finch v. Carpenter*,[3] the Plaintiff had an irrational fear of dentists resulting in poor oral health. Removal of her wisdom teeth was necessary but the dental surgeon did not inform the Plaintiff that there was a risk that one or more of the teeth could be displaced into the sinus cavity requiring a painful operation to remove. That is exactly what happened and the dental surgeon was found liable for failing to obtain the informed consent of the Plaintiff. The Court asked the rhetorical question "If the plaintiff had been informed of the risk, would she have provided her consent?" Ordinarily, dental patients usually consent to the suggested procedure once it is explained to them. When this occurs, the dentist has a strong defence to any claim alleging lack of informed consent. However, in this case the Court came to the opposite conclusion "because the evidence ... about the plaintiff's history of refusing dental treatment and ignoring her oral health except when driven by pain to seek treatment" satisfied the Court that this particular Plaintiff would have refused the extraction if properly informed of the risk.

[2] 2003 BCSC 718
[3] 1993 CarswellBC 1966 (S.C.)

4. Architects and Engineers:

In *Cohen v. Ostry*,[4] the architect, in addition to providing sketches of a proposed housing development, contracted to obtain reasonable assurances from municipal authorities that the project would be approved. The architect met with junior planning authorities who were encouraging but he did not meet with the senior planner, although he could have. The Plaintiff purchased the property but the development project was not approved by the City. The Plaintiff sued for the resale loss on the property. The Court found the architect negligent for failing to consult the senior planner and failing to advise the client that he did not consult the senior planner although he could have, and that the senior planner's decision would be determinative. However, the Court only awarded as damages the amount incurred in pursuing approval of a development permit, having found that the Plaintiff would have removed the subject clauses and been bound to purchase the property by the time the architect could have met with the senior planner.

5. Financial Planners:

In *Hawkenson v. Rogers*,[5] the Plaintiff sought damages for losses incurred in a company investment account managed by the Defendant. Over the course of approximately six months, the account had accumulated a concentration of speculative investments in excess of the investment objectives indicated in the account application. The account had initially done well, however, as a result of the fall in value of some of the speculative investments, the Plaintiff lost a significant sum of money. The trial judge's decision that the Defendant was negligent in his duty to advise the Plaintiff to mitigate his losses and divest numerous speculative investments was not challenged on appeal. The result was that the Defendant was liable for the difference between the actual performance of the account and the performance of a hypothetical account which would have been in place had the Defendant not breached his duty of care.

B. The Duty to Defend and "Mixed Claims":

The nature of the allegations in the pleadings determines the insurer's duty to defend while the facts proven at trial determine the duty to indemnify. In many cases, it is clear that the allegations against an insured in a Statement of Claim, if proven, would trigger coverage under an E&O Policy. However, this is not invariably the case. What then, are the insurer's obligations when the Statement of Claim includes allegations

[4] (1994), 89 B.C.L.R. (2d) 231 (C.A.)
[5] 2006 BCCA 177

that, if proven, would attract coverage, and allegations which, if proven, could not possibly attract coverage?

Suppose a claim is made against a design professional in a "leaky condo" claim and the policy contains a water ingress exclusion. Will the insurer have to defend the insured in the litigation? This question may require resolution if some of the allegations in the lawsuit concern a "water ingress" claim and yet other parts of the lawsuit relate to pure construction deficiencies. Is the insurer obliged nonetheless to defend the design professional in such circumstances? The answer is probably "yes", based on the B.C. case law concerning the "duty to defend" in the event of "mixed" claims.

In the case of *AXA Pacific Insurance Co.* v. *Guildford Marquis Towers Ltd.*,[6] the insured general contractor and developer sought coverage for three kinds of repairs resulting from water ingress:

1) repairs of the defective parts of leaky condo buildings;

2) repairs to parts of the buildings damaged as a result of defects in other parts, such as drywall damaged by water ingress through poorly caulked joints; and

3) repairs to third party property damaged by water ingress.

The general liability insurer for the contractor refused to afford a defence on the basis that the damage pleaded was pure economic loss, and as such, it did not fall within the policy coverage for "injury to or destruction of property". The parties to the application agreed that the damage was economic loss. The Court stated that the damages alleged were more properly construed as "resultant damage" and so covered. However, consistent with the parties agreement, the Court analyzed the case on the basis of whether or not the damages were economic loss. On the strength of *Privest Properties Ltd.* v. *Foundation Co. of Canada Ltd.*[7] the Court ruled that the insurer's property damage coverage did extend to economic loss like that claimed in the underlying action.

As an insurer is only obliged to provide a defence to those aspects of the underlying claim which fall within the insuring agreement, the insurer, in theory should be entitled to apportion defence costs with the insured. However, consistent with the B.C. Court of Appeal reasoning in *Continental Insurance Co.* v. *Dia Met Minerals Ltd.*[8] and having

[6] 2000 BCSC 197
[7] (1991), 57 B.C.L.R. (2d) 88, 6 C.C.L.I (2d) 23 (S.C.)
[8] (1996), 20 B.C.L.R. (3d) 331

regard to the imprecise and difficult task of apportioning defence costs at the "duty to defend" stage, the Court decided that it was premature to consider a fair allocation of defence costs between covered and non-covered claims. In the result, the liability insurer was obligated to pay for 100% of the costs of the defence notwithstanding that portions of the pleaded claim were outside of coverage. It was, however, entitled to seek to "claw back" a portion of the defence costs from the insured upon conclusion of the matter.

Given the current state of the law in British Columbia, the overwhelming judicial trend, at least at the "duty to defend" stage, is to compel an insurer to pay for 100% of the costs of the defence, notwithstanding that the claim falls only partially within coverage. Allocation of defence costs is deferred until the case is tried or settled.

However, even though the duty to defend is determined by the pleadings, where the allegations cannot possibly trigger the duty to indemnify, then there will be no duty to defend.

In *Non-Marine Underwriters, Lloyd's of London* v. *Scalera,*[9] the insurer sought a declaration that it was not required to defend the insured against the Plaintiff's allegations of sexual assaults by the insured. The Plaintiff also alleged, *inter alia*, that the insured's acts were negligent and a breach of fiduciary duty. The policy contained an intentional act exclusion.

The Supreme Court of Canada concluded that the insurer had no duty to defend because the Plaintiff's Statement of Claim made no allegation that could potentially give rise to indemnity under the policy. An insurer only has a duty to defend when a lawsuit against the insured raises a claim that could potentially fall within coverage. The insurer's duty to defend is related to its duty to indemnify, so if an insurance policy excludes liability arising from intentionally caused injuries, there will be no duty to defend actions based on such injuries.

The Court then went on to formulate a three-step process that must be applied to determine whether a claim could trigger indemnity. First a court should determine which of the plaintiff's legal allegations are properly pleaded. In doing so courts are not bound by the legal labels chosen by the plaintiff because a plaintiff cannot change an intentional tort into a negligent one simply by choice of words. When ascertaining the scope of the duty to defend a court must look beyond the choice of labels and examine *the substance and true nature* of the allegations contained in the pleadings.

[9] [2000] 1 S.C.R. 551, 2000 SCC 24

Next, the court should determine if any claims are entirely derivative in nature. A duty to defend will not be triggered simply because a claim can be cast in terms of both negligence and an intentional tort. If both the negligence and intentional tort arise from the same actions and cause the same harm, the negligence claim is derivative and it will be subsumed into the intentional tort for the purposes of the exclusion clause. A claim for negligence will not be derivative if the underlying elements of the negligence and intentional tort are sufficiently disparate to render the two claims unrelated. Finally, the court must decide whether any of the properly pleaded, non-derivative claims could potentially trigger the insurer's duty to defend.

In *Scalera* the Court concluded that the Plaintiff's claims of negligence and breach of fiduciary duty were either not properly pleaded or were subsumed into the sexual assault because these claims were based on the same facts and resulted in the same harm. Accordingly, there could be no duty to indemnify and therefore no duty to defend.

C. Typical Exclusions:

There are certain exclusions which are common to most E&O Policies and should be considered by claims handlers in most cases. These exclusions can be categorized according to the underlying rationale for the exclusion, which are most commonly one of the following:

1. The exclusion of claims which can and should be covered by another type of insurance;

2. The exclusion of claims involving illegal or dishonest acts by the insured; and

3. The exclusion of claims by someone insured under the policy.

1. The claim should be covered by other insurance:

Claims arising out of the provision of professional services are excluded under a standard comprehensive general liability policy. An E&O Policy is designed to fill that gap and not to replace other forms of insurance. As such, claims which could and should be covered under another type of policy will generally be excluded from coverage under the E&O Policy.

To a large extent, the grant of coverage and associated definitions will narrow the scope of coverage. However, it is also necessary to incorporate into an E&O Policy various exclusions designed to limit the E&O coverage to its intended scope.

Examples of typical E&O exclusions with this underlying rationale include the following:

(a) claims alleging bodily injury to, or sickness, disease or death of any person;

(b) claims alleging damage to or destruction of property;

(c) claims alleging breach of trust;

(d) claims arising out of the activities of any insured in relation to an employee pension or benefit plan; and

(e) claims relating to the discharge, release or use of pollutants or toxins.

Such claims are appropriately covered by a variety of other policies, including auto, CGL, fiduciary liability or environmental coverage.

2. Dishonest or criminal acts:

As is common with most forms of insurance, professional liability policies typically exclude claims alleging fraud, dishonesty or criminal acts on the part of the insured. Some policies provide for reimbursement of defence costs in the event of a judgment favourable to the insured.

One issue that may arise in this context is the extent to which dishonest or criminal acts of one insured are attributable to another for the purpose of applying the exclusion. Again, this will depend upon the wording of the policy. Typically, the policy will state that the coverage applies to each insured as though insured under a separate policy of insurance. It follows that the dishonest conduct of one insured will not normally be attributable to another.

As always, however, much depends on the wording of the exclusion. An exclusion that applies to a claim alleging dishonest or criminal conduct on the part of *any* insured will likely preclude coverage whether or not the insured in question participated in or had knowledge of that conduct.

3. Insured v. Insured:

Most insurance policies of any type contain some degree of exclusion for claims by people insured under the policy. Such exclusions are generally broader in an E&O Policy, or a director's and officer's liability policy, than the limited exclusions contained in a comprehensive general liability policy.

E&O Policies may contain more than one such exclusion. Typically claims "brought by one insured" under the policy "against another insured" will be excluded. In addition, there may be a broader exclusion for claims arising out of or connected with professional services provided to any person or entity insured under the policy, as well as any related or affiliated person or entity. This will include persons or entities which control an insured, or which are controlled by the insured, as well as an entity in which an insured is a shareholder, director, officer, or partner.

The underlying justification for the exclusion of such "insured versus insured" claims is the lack of an "arms length" relationship between the claimant and the insured. Such non-arms-length relationships raise concerns of "moral hazard", both in terms of a lack of independent skill and judgment brought to bear in the provision of the services and, more significantly, the possibility of actual collusion on the part of claimants and insureds.

4. "Water ingress" exclusion:

In British Columbia, professional liability insurers writing policies in the design and construction sector have had to deal with the claims fallout from the "leaky condo" crisis. Since E&O Policies are typically written in a "claims made" form, insurers have been able to adapt relatively quickly to limit their monetary exposure to future claims. Generally speaking, they have done so through one or more of the following approaches:

1. Ceasing to offer coverage for construction-related professionals in British Columbia;

2. Selectively offering coverage to such professionals who are not involved in residential construction;

3. Selectively offering coverage with a sub-limit for water ingress claims that is substantially lower than the overall aggregate limits of the policy; or

4. Continuing to insure such professionals in British Columbia with an "absolute water ingress" exclusion.

Where a water-ingress exclusion is included, the wording is typically very broad, so as to cover any claim associated with the ingress of water and associated damage. One formulation that has been used excludes any claims "alleging, arising out of, based upon or attributable to the infiltration of moisture or precipitation into a building envelope or any part thereof…"

In some cases, the exclusion will be limited in time to the period in which leaky buildings were endemic – *i.e.,* before "rainscreen" technology was standard in multi-family construction – or limited to buildings in which "rainscreen" technology was not incorporated.

As discussed above, when confronted with a "leaky building" claim and a water-ingress exclusion, one question that will arise is whether certain aspects of the claim could be covered. In general, any non-water-ingress claims would be covered, at least at the duty to defend stage, depending on the specific wording of the exclusion and the pleadings. For example, if there is a claim against an architect involving both water ingress and a structural failing based on unrelated design issues, the latter would likely be covered even though the former is not.

D. Duty to Defend v. Duty to Indemnify:

Where it is unclear if there will be coverage under the E&O Policy, but the insurer proceeds to investigate and defend a claim because some of the allegations are potentially covered (or to avoid a bad faith claim by the insured), then how can the position of the insurer be protected if there ultimately proves to be no coverage? Typically, either a reservation of rights letter or a non-waiver agreement is used to permit the insurer to recover from the insured any amounts paid for investigation or defence costs prior to a final determination on coverage being made.

First, some definitions:

- *Non-waiver agreement*: an agreement signed by the insured which acknowledges that the insurer's rights to deny coverage have been preserved.

- *Reservation of rights letter*: a unilateral written declaration by the insurer to the insured that the insurer is reserving all of its rights to deny coverage.

In either case, it is necessary to explain to the insured right away that there may be a problem with coverage and that the insurer is reserving its rights to deny coverage, should it be necessary to do so. Letters and agreements should address the specific facts of the case so that there is no mistake as to what is being agreed upon. Wise insurers will also encourage their insureds to seek independent legal advice. Down the road, the courts will be less sympathetic to insureds who have received independent counsel.

An effective non-waiver agreement will have the following ingredients/qualities:

- written form;
- plain language that addresses the circumstances of the claim;
- a proper signature by the insured, appropriately witnessed;
- an acknowledgement by the insured of the coverage problem necessitating the execution of a non-waiver agreement;
- an acknowledgement that the insurer may later deny coverage or seek repayment of monies;
- a consent or request by the insured that the insurer at its sole discretion investigate, negotiate, settle and/or defend the claims arising out of the loss, without any waiver or estoppel being created;
- a pledge by the insured that in any proceedings it would not plead or allege waiver or estoppel on the part of the insurer; and
- an agreement by the insured to repay any monies in the event that the insurer establishes lack of coverage.

In trying to put a non-waiver agreement or a reservation of rights letter into place, a claims handler should also beware of certain problems which can crop up in any contract situation:

- duress on the part of the insured;
- a finding that the insured was asked to sign an agreement which was improperly or inadequately explained as to its content and effect;
- a legal disability (e.g. under-age, mental infirmity) of the insured;
- no independent legal advice; and
- privity of contract issues: i.e., the agreement will be effective only as against the signing party, therefore if there are multiple insureds, all should sign.

When presenting a non-waiver agreement for signature, claims handlers should therefore be careful to:

- evaluate that the insured has the legal and mental capacity to sign the agreement;
- ensure that no pressure (situational, economic or otherwise) is exerted upon the insured to sign the agreement;
- explain the agreement fully and properly to the insured and recommend that the insured seek independent legal advice before signing; and
- ensure that all beneficiaries under the contract which the insurer wishes to be bound by the non-waiver agreement, have signed the agreement.

Where an insured refuses to sign a non-waiver agreement, this should be a clear warning signal to the insurer to make an election *immediately* on whether to affirm or to deny coverage.

Such agreements are a good step toward avoiding the pitfalls of waiver and estoppel but they are by no means a guarantee of same. Given the risk posed by waiver and estoppel, such agreements should be put into place as a minimum precaution in most cases.

Waiver and estoppel are related concepts. In both instances, the insurer is deemed to have *affirmed the contract (*or *insurance coverage)* by either words or conduct that later make it unfair for the insurer to deny coverage and the court prevents it from doing so. The two concepts do have their differences, however:

- *Waiver* arises where the insurer, in *writing* and with *full knowledge* of the insured's breach or failure to meet conditions of the policy, *intentionally relinquishes* the right to void the policy and treats the contract or obligation as subsisting.

- *Estoppel* arises in insurance contracts where the insurer, by its conduct which amounts to a representation, intentionally *induces the insured to act* upon the representation and the *insured actually relies* upon the representation *to his/her detriment.*

Obviously, the effect of waiver and estoppel can be extremely detrimental to an insurer. In some cases, the doctrines have been used to even *create coverage* where none existed before - even in the face of clearly applicable exclusions. Aggressive plaintiff's counsel will use the doctrine of waiver and estoppel not only as a shield but as a sword.

E. Per Event and Aggregate Limits:

If there are multiple claimants and/or multiple claims under an E&O Policy, what are the insurer's indemnity obligations? When do these obligations come to an end?

A typical E&O Policy will have two types of limits, and potentially sub-limits for particular types of claims. At a minimum, limits of insurance will be specified for (1) each event, occurrence or wrongful act, and (2) the aggregate of all claims during the policy period.

Though each policy will have its own definitions and wordings, it will invariably contain such specified limits on the declarations page, as well as an explanation of the application of those limits, typically within a section of the policy wording. It is critical to clearly define the limits of insurance to avoid ambiguity and a potential adverse judicial finding.

Whether the "per event" limit is specified in terms of an event, occurrence or wrongful act, the concept will be the same. The limit will be the most the insurer will pay for all claims arising out of the same act or set of circumstances, regardless of the number of claims or claimants.

Similarly, the aggregate limits of insurance is the most the insurer will be obligated to pay regardless of the number of claims, claimants or insureds. The latter is critical in circumstances where more than one person or entity is insured under the policy. Without the appropriate clarity, a court may find that each insured is entitled to the per-event and aggregate limits of insurance, particularly in the face of a policy provision stating that each insured is covered as though separately insured.

To avoid liability in excess of the stated limits of insurance, it is important that the policy clearly state that the limits are the most that will be paid irrespective of the number of insureds.

Where there is a duty to defend, the insurer's defence obligations may be in addition to the limits of insurance, or included within it. In the latter case, any defence costs incurred serve to reduce the remaining per-event and aggregate limits of insurance. The limits represent the extent of the insurer's maximum liability – and the insured's maximum benefit – under the policy.

E. Excess Insurance:

If it appears that the indemnity for a claim is going to exceed the policy limits, what additional investigations should the claims handler undertake to protect both the insurer's and the insured's interests?

Professionals with significant liability exposure will often have excess insurance, in addition to the underlying E&O Policy. This gives rise to two key issues:

1. What are the obligations of the underlying insurer to the excess insurer where the excess policy may be triggered?

2. What are the obligations of the excess insurer to contribute towards defence costs, if the policy contains a duty to defend?

Most primary and excess liability insurers in Canada are signatories to the Insurance Bureau of Canada's "Agreement of Guiding Principles Between Primary and Excess Liability Insurers Involving Claims" (the "IBC Agreement"). The basic obligations of primary and excess insurers are set out in the IBC Agreement.

The foremost obligation of the underlying insurer is to handle the claim appropriately, including the steps taken in defence of the claim and the reasonableness of any

settlement. In addition, the following additional duties are imposed upon the underlying insurer:

1. To advise the insured to notify excess insurers if it appears the claim could exceed the primary limits;

2. To co-operate with the excess insurer, upon request, to assist the excess insurer in assessing its exposure;

3. To provide information to the excess insurer which could impact the excess insurer's assessment of its exposure;

4. To not tender the primary limits to the excess insurer without prior discussion; and

5. To promptly notify the excess insurer if a judgment is rendered against the insured, in excess of the primary limits.

The IBC Agreement also contains obligations for the excess insurer. These include the following:

1. To identify its interest to the primary insurer and provide contact information for the claims handler;

2. To independently investigate and assess its exposure and share that information with the other involved insurers;

3. To conduct itself in such a manner as to avoid unreasonable defence costs or delays in achieving settlement;

4. To refrain from insisting upon settlement within the primary limits; and

5. To co-operate with the underlying insurer to protect the interests of the insured.

The IBC Agreement also provides for the sharing of costs of the defence where an excess policy may be triggered. The key provisions are as follows:

1. If the excess insurer wishes to participate in the investigation and defence of the claim, then the primary insurer must provide all

information to the excess insurer and the excess insurer must share equally the costs of such investigation, *regardless of the ultimate outcome of the case*;

2. Legal fees are shared equally, subject to adjustment following final resolution, to reflect each insurer's pro rata share of indemnity; and

3. The excess insurer retains the right to carry out its own independent investigation.

Where an agreement between insurers does not govern the allocation of defence costs, the court will exercise its "equitable jurisdiction" and allocate costs in a manner that it deems just and equitable in the circumstances.[10] There is no single formula for allocation of costs by the court. It can be a 50-50 split, or allocation on a pro rata basis. It may even be that the court will not allocate a share of defence costs to the excess insurer.

It is important to note that the above analysis assumes a concurrent duty to defend as between the primary and excess insurer. In circumstances where the primary policy limits are exhausted, the primary insurer may not have a duty to defend the claim and the sole responsibility for defence costs may lie with the excess insurer.[11] Similarly, where an excess insurer is not notified of a claim, no duty to defend arises and a court may conclude that no contribution towards defence costs is warranted.[12]

It is also possible for an excess insurer to take over conduct of the defence in circumstances where the excess insurer's exposure is clearly greater than the primary insurer's.[13]

F. Solutions Not Involving Litigation:

What happens when the insurer is faced with multiple claims against the insured that exceed the insured's aggregate policy limits and there is no excess insurance? Rather than incurring mounting defence costs and facing uncertain indemnity exposure, an insurer in such a situation would be well advised to explore creative, coverage-driven

[10] *Alie et al v. Bertrand & Frere Construction Company et al* (1997), 30 C.C.L.I. (3d) 166 (Ont. S.C.)
[11] *Boreal Insurance Inc. v. LaFarge Canada Inc.* (2004), 10 C.C.L.I. (4th) 212 (Ont. S.C.J.)
[12] *ING Insurance Company v. Federated Insurance Company* (2005), 22 C.C.L.I. (4th) 1 (Ont. C.A.)
[13] *Economical Mutual Insurance Company v. I.C.B.C.* (1986) 44 Alta. L.R. (2d) 242 (Q.B.)

solutions to ascertain and limit its defence and indemnity exposure. Payment of policy limits into court has been a successful strategy in meeting this challenge.

If an insurer is faced with likely exposure in excess of the insured's aggregate policy limits, continuing to defend the action will only drive up the insurer's total monetary exposure as defence costs continue unabated. From the insurer's perspective, it is preferable to be released from its defence and indemnity obligations in exchange for tendering the policy limits.

Section 23 of the *Insurance Act*[14] provides a procedural mechanism that allows the insurer to pay money into court and extinguish any further liability. The payment of policy limits into court affords the insurer protection from claims by other defendants for contribution and indemnity through third party proceedings or joint and several liability. The various claimants will then determine, through litigation or negotiated settlement, how the policy proceeds will be distributed.

Section 23 reads as follows:

> **Payment by insurer into court**
>
> **23** (1) If an insurer cannot obtain a sufficient discharge for insurance money for which it admits liability, the insurer may apply to the court without notice to any person for an order for the payment of it into court, and the court may order the payment into court to be made on terms as to costs and otherwise the court directs, and may provide to what fund or name the amount must be credited.
>
> (2) The receipt of the registrar or other proper officer of the court is a sufficient discharge to the insurer for the insurance money paid into court, and the insurance money must be dealt with according to the orders of the court.

Where such a strategy is appropriate, the insurer should attempt to secure a settlement with the various claimants, according to which the claimants will discontinue any actions against the insured and covenant to forego any damages for which the insured would, directly or indirectly, be held responsible. In exchange for this immunity for the insured, the insurer will pay the policy limits into court for the benefit of the settling claimants. Ideally, this will permit both the insurer and the insured to retire the claims

[14] R.S.B.C. 1996, c. 226

at a cost, in terms of both time and money, significantly less than if the claims were litigated.

The effectiveness of this strategy will depend primarily upon the following factors:

- the willingness of the claimants to enter into a comprehensive settlement;
- the terms of the settlement;
- the nature of the policy ("occurrence" or "claims made"); and
- the policy wording with respect to the insurer's duty to defend.

The willingness of the claimants to settle, the terms of any settlement and the nature of the policy will determine whether and to what extent the insurer continues to face liability with respect to a given policy period. The policy wording in relation to the insurer's duty to defend will determine whether, and to what extent, the insurer has a continuing duty to defend with respect to any other liability the insured may face.

Why would the claimants agree to completely release the insured for the policy limits when that figure represents significantly less than the insured's likely exposure? For the claimants, the payment into court represents a certain recovery, without the need to prove liability against the insured. Accepting the policy limits eliminates the risk of non-recovery and reduces the claimants' legal costs. Even where the risk in litigating against the insured is low, there may be a high risk that the insured will be unable to pay any judgment in excess of the policy limits. Without a fund set aside for the benefit of the claimants, the claimants would be in a "race to judgment", with the first claimants to have judgment in their favour exhausting the policy limits, leaving subsequent claimants with little or no monetary recovery. The payment into court also provides funds with which the claimants can pursue other defendants.

Typically, where such an agreement is possible, it will attract participation from all claimants. It makes little sense for a claimant to be on the outside of an agreement that provides for guaranteed settlement funds and probably represents the extent of the insured's ability to pay. It follows that such an agreement will be more difficult to enter into where the claimants sense that the insured has "deep pockets" or excess insurance coverage.

G. Summary

This paper has afforded an overview of the types of claims made against professionals that may have to be considered under an E&O Policy. It has also discussed certain common issues that arise in the various stages of handling a claim, from determining whether there is a duty to defend to resolving issues arising from multiple claimants or claims in one policy period.