INSURANCE ISSUES IN CLASS ACTIONS

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I. Introduction

A class action can be an insurer's worst nightmare. All the careful underwriting and claims management can be wiped out in an instant by a class action filing.

Insurance issues arise throughout the conduct of any class action, from considerations as to whether to file the claim in the first place, through settlement, and to final resolution should the case go to trial. This paper reviews insurance issues that are particular germane to class actions.

II. Is this Claim Worth Pursuing?

If a defendant to a potential class action has limited funds of its own, its ability to trigger insurance coverage should be considered in the plaintiffs' decision to sue. This is so because the defendant's insurance policy may be its only remaining asset, and therefore the only source of funds available to satisfy a judgment or settlement.

In routine claims, the need to consider this issue is less central. It is the magnitude of class action claims that brings this to the fore. Class actions are often brought after a major corporate error. That corporate error will often put the company on the brink of bankruptcy even disregarding the class action. Hence the magnified importance of insurance.

The problem for plaintiffs' counsel is the difficulty in determining the extent of the available insurance prior to recovery. Sometimes it is necessary to file first, and ask the insurance questions later.

From a class action defendants' point of view, this dynamic calls for early investigation and disclosure where appropriate. Specifically, if the defendant is able to show that the combination of corporate assets and available insurance is low, then the proposed class counsel may be convinced to discontinue or settle on favourable terms. This is because the class lawyer is working on contingency, and there is a general "rule of thumb" that the class claim must be at least $2 million in order to sustain efforts required to advance a class proceeding.

III. The Effect of Insurance Policy Limits and Deductibles on Potential Recovery

From the plaintiffs' perspective, there are numerous insurance issues which ought to be considered in deciding whether there is a potential source of insurance money available to make the claim worth pursuing either before or after filing.

Key preliminary issues are insurance policy limits and deductibles. There are different sorts of policy limits including "aggregate limits";[1] "*per* occurrence limits" or *per* claim limits;[2] "personal injury limits"; "tenants' legal liability limits", etc. The policy limits are typically set out in the declaration page of the insurance policy. These limits represent the most the insurer will pay under the policy depending on the nature of the claim.

While policy limits represent the upper-limit or ceiling of the insurer's obligations, the policy deductible or self insured retentions represents the floor. Policy deductibles play a crucial role in determining whether claims will be recoverable against a defendant with limited assets.

Most modern Commercial General Liability policies are referred to as "occurrence" policies. Under this type of policy, coverage is triggered by property damage or bodily injuries occurring during the period of the insurance contract. For example, the insuring agreement may require the insurer "To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of property damage or bodily injury caused by an occurrence". The word "occurrence" is typically defined in policies as "an accident or a happening or an event or a continuous or repeated exposure to conditions which unexpectedly and unintentionally results in personal injury, property damage or advertising liability during the policy period."

E&O policies, which are often claims-made policies, may use particular definitions for "occurrence", or rely upon policy limits for "claims". For example, consider the following lawyer's professional liability policy wording: "Occurrence shall mean any alleged act, error or omission of an Insured which occurs in the performance of Professional Services for others; provided, however, that if more than one act, error or omission occurs or is alleged to have occurred in relation to the same professional service then all such acts, errors and omissions shall be deemed to be a single Occurrence."[3]

In the context of a class action, the question is whether the policy *per* occurrence limits or the deductible applies to each individual class member's injury, damages or claim; or whether the limit applies once and for all in relation to the entire class' claim. The answer to this question may result in a wide variance in coverage available to the insured and, therefore, to the class.

For example, if the *per* occurrence policy limit is stated as $1,000,000, and there are 2,000 class members, each with a $50,000 claim, the policy limit may drastically curtail individual class member recovery (total claim = $50,000 x 2,000 class members = $100,000,000 total claim). However, if each class members' individual claim represents a separate "occurrence", then the $1,000,000 *per* occurrence limit may be sufficient to satisfy all claims.

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[1] The aggregate limit is the most the insurer will pay under a policy regardless of the total number of occurrences or claims made against the insured.
[2] The most the insurer will pay for any one occurrence or claim.
[3] Discussed in *Yang v. Canadian Lawyers' Insurance Assn* (1997), 147 D.L.R. (4th) 31 (Alberta C.A.)

Conversely, consider the situation of the policy deductible. Policy deductibles typically apply on a *per* occurrence basis. If the policy deductible applies to each class members' claim, the class may be unable to access the defendant's insurance. For example, consider again the case of the 2,000 class members, each with a $50,000 claim against the defendant. The total of all class members' claims is $100,000,000 (2,000 class members x $50,000). Assume a policy *per* occurrence limit of $1,000,000. Assume each class member's claim was the result of a separate occurrence. Assume a deductible of $100,000 applicable on a *per* occurrence basis. As each claim falls below the *per* occurrence limit, the defendant is unable to recover from its insurer thus potentially frustrating the class members' ability to recover their judgment.

Following, we discuss the various approaches adopted by the courts in determining the number of occurrences flowing from a defendant's alleged wrongs. Of note, Canadian courts have not addressed the issue directly in relation to standard Commercial General Liability coverages although there is some discussion of the issue in the E&O policy context. In contrast, the American courts have considered the issue in detail. We therefore begin with a discussion of the issue as developed in the United States. We then discuss the various Canadian cases which touch on the issue.

In the United States, courts have adopted two different approaches to determine the total number of occurrences: the "cause theory" and the "effect theory".[4]

The effect theory, which is the minority American view,[5] "determines the number of accidents or occurrences by looking at the effect an event had, *i.e.*, how many individual claims or injuries resulted from it."[6] Thus, the "occurrence" is considered from the perspective of the injured party.[7]

In contrast, the cause theory, which has been adopted by a substantial majority of the American courts,[8] looks to the cause of the damages to determine the number of occurrences. The Supreme Court of Illinois explained the difference between these theories with reference to the following hypothetical example:[9]

> The difference between these two approaches is illustrated by the following hypothetical. Assume that a motorist is traveling down a street lined with parked cars. Looking away from the roadway to change the station on his car's radio, the motorist allows his vehicle to wander. As a result, his car strikes the sides of three of the parked cars in succession, damaging each of them. The owners of the three damaged vehicles sue, and the vehicle owner seeks indemnification from

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[4] S. Plitt, J. Rogers and S. Gross, "Progressive Losses: Triggers of Coverage, Number of Occurrences and Allocation among Successive Policies", in *Construction Defects – Claims and Coverage* (DRI, Chicago, Illinois: 2007), Part II, Chapter 3 at p .227.

[5] Snowden and Lichty, *Annotated Commercial General Liability Policy* (Canada Law Books, Aurora, Ontario, Loose-leaf edition, April 2008 Release) at 36:20.3. And see *St. Paul Mercury Indemnity Co. v. Rutland*, 225 F.2d 689.

[6] *Nicor, Inc. v. Associated Elec. & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407 (Ill., 2006)

[7] S. Plitt *supra*.

[8] S. Plitt *supra*.

[9] *Nicor, Inc. v. Associated Elec. & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407 (Ill., 2006)

> his automobile insurance carrier. Under the effect theory, the fact that three cars were damaged and three claims were filed would mean that there were three "occurrences" for purposes of determining liability coverage, absent specific policy language to the contrary. Under the cause theory, on the other hand, the fact that the damage to all three vehicles resulted from the same conditions and was inflicted as part of an unbroken and uninterrupted continuum would yield the conclusion that there was only one occurrence.

One U.S. Court recently defined the cause theory as follows: "Under the 'cause' analysis, the proper focus in interpreting 'occurrence' under a liability policy is on the number of events that cause the injuries and give rise to the insured's liability, rather than the number of injurious effects."[10] Another Court noted that the inquiry focuses upon whether "[t]here was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damage. If so, there has been but one occurrence, even though several discrete items of damage resulted."[11]

An example of the effect theory is found in *Lombard v. Sewerage & Water Bd.*,[12] in which 17 consolidated suits involving 119 plaintiffs were presented for review. The plaintiffs sought awards for damages allegedly caused to various buildings (their residences, a church, etc.). The damages were alleged to have been caused by activities in connection with a canal construction project and the city of New Orleans, the Sewerage and Water Board of New Orleans, a construction company and their insurer were named as defendants. The insurer argued that "the work carried on . . . falls within the definition of a single occurrence, for it is, in fact, an exposure to 'substantially the same general conditions.' Therefore, each policy limit of $50,000 is applicable." The Court disagreed, considered the matter from the plaintiffs' perspective, and found that there were numerous occurrences:

> As a rational matter, however, it can hardly be said that this construction project lasting more than one year is a single "occurrence" within the contemplation of the quoted clause. Rather, we think it is more logical to view this project as a series of "occurrences" resulting in damages during the course of this prolonged undertaking. The word "occurrence" as used in the policy must be construed from the point of view of the many persons whose property was damaged. . . .

Another effect theory example is the *Exxon Corp. v. St. Paul Fire and Marine Ins. Co.*[13] case, which involved exposure of five individuals to fumes while transporting sludge from insured's gas treating facility to waste facility. The Court found five separate "occurrences or accidents" within meaning of hull, protection and indemnity (P& I) and water pollution insurance policy, rather than a single occurrences. The alleged injuries were found to be discrete and occurred over a period of time, and the policy failed to define "occurrence" (resulting in the pro-policyholder interpretation).

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[10] *Lennar Corp. v. Great Am. Ins. Co.*, 200 S.W.3d 651, 682 (Tex. Ct. App., 2006)
[11] *Barthlomew v. Ins. Co. of N. Am*, 502 F. Supp. 246, 251, quoting *Truck Ins. Exch. V. Rohde*, 49 Wash. 2d 465, 471.
[12] 284 So. 2d 905 (La. S.C., 1973)
[13] 129 F.3d 781

The cause theory, which is the majority view, has not been applied in an identical fashion across the United States. Two divergent approaches have developed to determine the causative act or acts and therefore the number of occurrences.[14] Courts either focus upon the nature of the insured's liability (the "Insured's Liability Approach"), or they take an immediate cause viewpoint (the "Immediate Cause Approach"). Both approaches find the same number of occurrences where the liability inducing act is also the most immediate cause of the damage. However, there are situations in which the specific liability inducing event is further removed from the actual damage suffered, and where that is the case the two approaches may result in a different answer to the number of occurrences.

An example of a case based upon the Insured's Liability Approach is seen in *Appalachian Ins. Co. v. Liberty Mutual Ins. Co.*[15] In *Appalachian*, the insured (Liberty Mutual) settled a class action suit brought by a class of Liberty Mutual employees alleging sex discrimination as a result of employment policies adopted by Liberty Mutual in 1965. The insured then sought indemnification under an umbrella liability policy issued to it by Appalachian Ins. Co. in 1971. The district court found in favor of Appalachian.

The U.S. Court of Appeals, Third Circuit, affirmed the district court's judgment. It found that the Appalachian insurance policy was an "occurrence" policy and that there was one occurrence for purposes of policy coverage. The court found that the single occurrence was Liberty Mutual's adoption of discriminatory employment policies in 1965 even though that initial liability inducing event caused numerous individuals to suffer damages.[16]

The following passage from the court's reasoning exemplifies application of the cause theory and the Insured's Liability Approach, *i.e.*, a focus upon the insured's liability as the "occurrence" or "occurrences" (citations and footnotes omitted):

> . . . the Appalachian policy is of the "occurrence" variety because coverage is provided only when there is an occurrence within the policy period. The policy states that the insurer will indemnify Liberty for "all sums" which it "shall be obligated to pay by reason of the liability imposed upon (Liberty) by law ... for damages on account of:-(i) Personal Injuries ... caused by or arising out of each occurrence...." Although this language is sufficient for us to classify the policy as an "occurrence" policy our conclusion is reinforced by the fact that under the policy the deductible of $25,000 is applied on a per occurrence basis.
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> In order to ascertain whether there was an occurrence within the policy period we must identify the occurrence and then determine when it took place.

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[14] S. Plitt *supra*

[15] 676 F.2d 56 (3d Cir. 1982)

[16] The court also applied the "effect" test to determine when the occurrence took place. The court held that the occurrence took place when the injuries first manifested themselves. Injuries to Liberty Mutual's employees took place immediately upon promulgation of the discriminatory employment policies. Therefore, the court held that Appalachian did not have to indemnify Liberty Mutual because the occurrence predated the effective date of the policy, and it was a known loss in progress when Appalachian came on risk.

> The general rule is that an occurrence is determined by the cause or causes of the resulting injury. "(T)he majority of jurisdictions employ the "cause theory'. Using this analysis, the court asks if "(t)here was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damage.'"
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> Applying the general rule to the facts of this case we agree with the district court's finding that there was but one occurrence for purposes of policy coverage. The injuries for which Liberty was liable all resulted from a common source: Liberty's discriminatory employment policies. Therefore, the single occurrence, for purposes of policy coverage, should be defined as Liberty's adoption of its discriminatory employment policies in 1965. [Emphasis added]
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> The fact that there were multiple injuries and that they were of different magnitudes and that injuries extended over a period of time does not alter our conclusion that there was a single occurrence. As long as the injuries stem from one proximate cause there is a single occurrence. Indeed, the definition of the term "occurrence" in the Appalachian policy contemplates that one occurrence may have multiple and disparate impacts on individuals and that injuries may extend over a period of time.

While many female employees had suffered injuries or damages as a result of the insured's wrongful act, the Court found only a single occurrence. As such, had the policy been triggered (it was not triggered for other reasons), only a single *per* occurrence policy limit would have applied.

The Ninth Circuit Court of Appeals adopted a similar causal approach in a coverage dispute flowing from a mass tort police brutality case, *Mead Reinsurance v. Granite State Insurance.*[17] In *Mead* the insured City had a self insured retention of $100,000; a Mead primary layer CGL for $900,000; and a Granite State excess policy for $5,000,000. The City and Mead wanted to minimize the number of occurrences in order to decrease their contributions to the damages award (presumably, total damages did not threaten to exceed the $6,000,000 total limit). Granite State wanted to increase the number of occurrences, which would extinguish or minimize its obligations by increasing contributions from the primary insurer and from the City because the self insured retention and CGL layer would be triggered multiple times.

In the underlying action, the insured City had been sued for certain statutory violations with multiple complaints alleging excessive police force, and one complaint alleging police harassment. The lower court declared the complaints constituted two occurrences. However, Granite State as excess insurer argued that the allegations arose from different police actions involving different injured parties. The courts disagreed, finding that because 11 of the complaints were premised upon the City's deliberate indifference to the use of excessive force by the police, the fact that injured parties were different was not relevant in determining the number of municipal policies. The appellate court affirmed the lower court's decision holding that as only two alleged municipal policies existed, each of the policies constituted a separate "occurrence" For a total of two occurrences.

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[17] 873 F.2d 1185 (9thCir. 1988)

This same causal approach was relied upon in *Washoe County v. Transcon. Ins. Co.*,[18] in which an insured county was sued for breach of its duty to investigate employees of a day care center licensed by the county. Employees at the center molested numerous children over a three-year period. After achieving settlements in that action, the county sought indemnity from the insurer. The county argued that its liability stemmed from one ongoing act of negligence constituting one occurrence. Under its interpretation, the county would be able to recover on the combined settlement amount over $50,000. The insurer contended that the injuries to each child constituted separate occurrences and since none of the settlements exceeded the county's $50,000 retained limit, the insurer owed nothing.

The court held that the insurer's definition of occurrence improperly focused on the "effects" of the children's injuries rather than the cause of those injuries. Under the causal approach, there was only one occurrence. The county "caused" the children's injuries through its failure to act with the requisite care in the process of licensing the day care center. Its breach of this duty allowed the intervening conduct that directly injured the children. Thus, there was one occurrence and the policy was required to respond to the loss above the initial $50,000 retained limit (or deductible).

There are numerous other American examples similar to the above which focus upon the insured's liability inducing event to determine the number of occurrences. To note just a few, consider *Champion International Corp. v Continental Casualty Co.*,[19] in which the Court held that an insured's sale of defective paneling to twenty-six manufacturers of vehicles resulting in damage to 1,400 vehicles was one "occurrence"; *Colonial Gas Co. v. Aetna Cas. & Sur. Co.*,[20] where the insured utility used insulation that was later banned, and this constituted one "occurrence" even though it was installed in 390 homes; *Uniroyal, Inc. v. Home Ins. Co.*,[21] in which the court held that a manufacturer's numerous deliveries of agent Orange to the military constituted one "occurrence" despite the insurer's argument that each subsequent spraying in Vietnam constituted a separate "occurrence"; and *Southern International Corp. v. Poly-Urethane Industries, Inc.*[22] in which the policyholder's roof sealing substance failed to hold, causing leaking in several tenants' apartments with the Court finding this leaking constituted one occurrence and applied the lower "per occurrence" policy limit rather than the higher "aggregate" limit sought by the policyholder.

As noted above, there is another strand of the causal theory, the Immediate Cause Approach, which focuses upon the immediate cause of the injury or damage rather than the original liability inducing event. This approach is exemplified by *Norfolk & Western Railway Co. v. Accident & Casualty Ins. Co. of Winterthur*,[23] in which employees of the insured Railway company allegedly suffered hearing loss through exposure to noise and the Railway's failure to protect them from its hazardous effects. A dispute arose between

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[18] 110 Nev. 798, 801 (1994)
[19] 546 F.2d 502, 504-506 (2nd Cir. 1976)
[20] 823 F.Supp. 975, 983-84 (D. Mass. 1993)
[21] 707 F.Supp. 1368, 1380-87 (E.D.N.Y., 1988)
[22] 353 So.2d 646 (Fla. App. 1977) and
[23] 796 F. Supp. 929 (W.D. Va. 1992)

the Railway and its excess insurers concerning whether the underlying claims against the insured for noise-induced hearing loss could be aggregated to push through the insured's self-insured retention limits.

The insured Railway sought a declaration that the hearing loss was a bodily injury and that all of the underlying hearing loss claims arose out of one occurrence. In interpreting the policies, the court found the occurrence language was ambiguous but nonetheless denied the insured's motion after determining that its arguments constituted an "implausible" interpretation of the insurance contract language to the extent that plaintiff sought a declaration that the claims against it arose out of a single occurrence.

On the occurrence issue, the Court held as follows (citations omitted):

> The "cause" test is at the heart of the railroad's legal argument in support of its single occurrence position. According to this test, the number of occurrences is determined by focusing on the cause of the alleged injuries which give rise to the claims with respect to which the insured seeks indemnity. In *Owens-Illinois, Inc v. Aetna Casualty And Surety Company,* 597 F. Supp. 1515 (D.D.C. 1984), the court applied the cause test to hold an insulation manufacturer's manufacture and sale of a product containing asbestos to be a single occurrence for the purpose of determining liability with regard to numerous asbestosis claims against the manufacturer. The court explained: ". . . The calculation of the number of occurrences must focus on the underlying circumstances which resulted in the personal injury and claims for damage rather than each individual claimant's injury."
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> . . .
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> The railroad argues that the cause test, as applied to the facts of this case, dictates a holding of single occurrence. The difficulty that the court has with this argument is that it leads to a result which would defy common sense. The typical single occurrence giving rise to multiple claims is the automobile accident which gives rise to a chain of events which results in injury to several parties. . . . In this case, a wide variety of machines in a number of different locations' created a variety of sounds over the course of a number of years. Railroad employees working near these machines suffered injury to their hearing as a result of exposure to these sounds. The railroad contends that its alleged negligence in failing to protect its employees from the hazards of this noise was the cause of the claimants' injuries and therefore the single occurrence out of which all of these claims arose. <u>While the railroad's negligence may indeed have been a cause of the injuries, calling that negligence the single occurrence out of which the claims arose is nonsensical</u>. [Emphasis added]
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> The railroad's argument allows the cause test to sweep too broadly and arrives at a result which defies common sense. Many different sounds damaged the hearing of many employees in many places over the course of many years, making this case one in which multiple occurrences created multiple injuries. For the purpose of interpreting the policy language, a relevant occurrence might be the generation of noise by a particular machine or by a number of machines in a particular physical plant. It may even be the railroad's negligence with regard to employees

> who work around a particular machine or in a particular plant. The occurrence contemplated by the language of the policies cannot logically be the railroad's system-wide negligence with respect to its employees, however. The railroad's argument is flawed to the extent that it removes any limit from the category of things which might be found to be a cause. By moving the analysis of cause to a level sufficiently general to support an interpretation which would maximize coverage, the railroad has attempted to convert the cause test into a rubber stamp which would justify coverage in every case. This is a misapplication of the cause test which leads to an implausible interpretation of the occurrence language. An implausible interpretation may not be given effect, even under a rule which favors indemnity where contract language is ambiguous.

A number of decisions from other American jurisdiction apply a similar approach to that relied upon by the Court in *Norfolk Railway*, and look to the immediate cause of the injury as the occurrence.[24]

As is often the case, this issue has not been addressed with the same level of detail in Canada. Following we note several Canadian cases touching on the issue. Each is unique to its own facts and policy language. These cases do not answer definitively whether Canadian courts would adopt the effect theory or the cause theory; and, if the cause theory, whether they would apply the "Immediate Cause Approach" or the "Insured's Liability Approach".

It does, however, seem at least likely that the prevalent American view – the cause theory – would be relied upon in Canada to determine the total number of occurrences. For example, while the Court was not specifically concerned with the number of occurrences, in *Synod of the Diocese of Edmonton v. Lombard General Ins. Co.*,[25] the court held that "occurrence", in a CGL policy that did not define the word, is a "liability inducing event" and, at para. 72, "The realization of the extent of damages as a later date, even if genuine, does not constitute an occurrence for insurance purposes. It is not a 'liability inducing event.'" Taken one step further, this finding provides some support for adoption of the Insured's Liability Approach under the cause approach.

We now turn to the limited number of Canadian cases that have considered the issue of the number of occurrences under liability policies.

The issue has been reviewed specifically in the class action context in *Canadian Gas Association v. Guardian Insurance Co. of Canada*.[26] The Canadian Gas Association claimed that, under an E&O policy, the insurer (Guardian) was obliged to defend it with respect to claims brought against it for damages suffered by 10,000 homeowners. The Ontario New Home Warranty Program brought a class proceeding against the Canadian Gas Association on behalf of itself and the affected homeowners. Guardian claimed it was not obliged to defend the action on behalf of the Canadian Gas Association. It argued

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[24] See Plit, *supra* at p. 229. Examples, *Nicor, Inc. v. Associated Elec. & Gas Ins. Servs. Ltd.*, 362 Ill. App. 3d 745, 750 (Ill., 2005); *Koikos v. Travelers Ins. Co.*, 849 So. 2d 263 (Fla. 2003); *Metro. Life Ins. Co. v. Aetna Cas. & Sur. CO.*, 255 Conn. 295, 328 (Conn., 2001).

[25] 2004 ABQB 803

[26] [1998] O.J. No. 5260 (Ont. Ct. of Justice (Gen. Div.)

that the E&O Policy was applicable to the claims, but that the self-insured retention of $25,000 *per* claim applied separately to each of the 10,000 claims. It argued that as no single individual claim would exceed $25,000, it had no duty to indemnify or defend the Canadian Gas Association.

The Court disagreed, holding that at least with respect to a duty to defend, the self-insured retention of $25,000 was applicable once in respect of all of the claims in the action. The relevant E&O policy language provided as follows: "The insured shall retain as its own net retention loss as respects each claim that the amount stated ($25,000.)." And, "The limit of liability . . . applicable to 'each occurrence' is the total limit of the insurer's liability for loss on account of all claims made against the Insured arising out of any one occurrence."

The Court noted Guardian's reliance upon two American authorities for the proposition that each homeowner's claim was separate and distinct.[27] However, the Court distinguished these cases, noting that neither concerned a class action.

In a class action the Court noted that the trial court has the power to award aggregate damages (at para. 25): ". . . it cannot be said that the class action must of necessity be one in which there must be an individual assessment of the individual claims of each class member." Given this, the Court concluded that "It is, therefore, not clear at this point that the position of the respondent that there must be individual assessment of individual claims will in fact occur." As such, the Court found that the E&O policy applied to afford a duty to defend. In full, the relevant part of the Court's judgment follows (see commencing at para. 21):

> Counsel for the insurer referred to 2 U.S. cases *Burlington County Abstract Company v. QMA Associates Inc.* N.J. 400 A.2d 1211 and *Lamberton v. Travelers Indemnity Company* Del. Supr. 346 A. 2d 167, each of which emphasizes the individual nature of claims which may have multiple sub-causes as opposed to a cause giving rise to a claim. In *Lamberton* a deductible was applicable to each claim (accident) against the professional invoking an Errors & Omissions Policy and not each injury claim even though they arose from the same cause (accident). *Burlington* dealt with a single deductible arising from a single broadcast even though there were numerous plaintiffs. None of the multiple E & O claims in those cases occurred in the context of a class action.
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> The respondent also referred to Class Actions by Michael Cochrane (Toronto: Canada Law Book, 1993).

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[27] Subsequent to the Ontario decision, a similar American gas metering case found that each gas meter contamination event constituted a separate occurrence because the cause of damage in each individual claim was particular to the particular case: *Nicor Inc. v. Associated Electric and Gas Ins. Services Ltd.*, 841 N.E.2d 78 (Ill. App. 2005) (not a class action). Snowden and Lichty, *supra*, comment as follows (at 36:20.6): "The authors, while not disputing the result, note that such finding is dependent upon how the plaintiffs' claims are framed. If, instead of alleging merely contamination, the claims had asserted a common defect in the meters cuasing the mercurty to spill or a common removal practice with the same result, the cause may not have been identified as activity specific to the location of each loss."

On this analysis, class actions, which require plaintiffs to assert commonality, are more likely to result in the Court finding of a single occurrence rather than multiple occurrences.

> "A class proceeding is an action brought on behalf of or for the benefit of numer-ous persons having a common interest. It is a procedural mechanism which is in-tended to prove on an efficient means to achieve redress for widespread harm or injury by allowing one or more persons to bring an action on behalf of many."
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> With respect to assessment of damages, the authors [of Watson and McGowan, Ontario Civil Practice, 1998] note at p. 459 that the court is given a discretion as to how damages are to be assessed. In addition to individual proof and assessment of damages suffered by individual class members the court is given the power to direct a "aggregate assessment of damages" where the underlying facts permit is to be done with an acceptable degree of accuracy. Illustrations are given by the authors noting that "aggregate assessment" provides a particularly effective way of assessing damages where individual claims are small or where there is no economical way of determining each member's individual loss
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> From a review of the Statement of Claim in the Underlying Action it cannot be said that the class action must of necessity be one in which there must be an individual assessment of the individual claims of each class member. On the face of the pleading itself, the claim is one brought by ONHWP for recovery of the damages it has suffered.

The question remains as to how the issue would be addressed after trial. Specifically, if the court found that it was not appropriate to make an aggregate award under the *Class Proceedings Act*, would the court then find that there were multiple occurrences? Or would it still be open to the court to apply the Cause theory to find a single occurrence?

This issue was considered in a proposed representative action in *Kelly v. J.J. Lacey Insurance Ltd. (Trustee of).*[28] The Court touched on the issue in relation to consideration of deductibles under a claims-made policy, triggered on the commencement of a claim against the insured rather than the occurrence of damage. The defendant and its insurer applied for an order striking out the representative or class aspects of the plaintiff's claim, or, for an order that if the action were to continue as a representative action, a $10,000.00 policy deductible applied to each member of the class.

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[28] [1997] N.J. No. 182 (Nfld. S.C., Trial Div.)

The defendant J.J. Lacey Insurance Ltd. was an insurance agency. The plaintiff, as representative of approximately 22,000 policy holders, claimed damages from Lacey for negligence, breach of contract and breach of fiduciary duty because of its placing policies with Hiland Insurance Limited. Hiland was in liquidation and Lacey was bankrupt. The plaintiff Kelly put himself forward as representative and agent of some 22,000 policy-holders, asserting that, even though they may have been wronged individually as policyholders, they enjoyed a common right of recovery against Lacey's insurer because of a common breach of duty by Lacey.

The defendant's application was allowed. The representative aspects of the plaintiff's statement of claim were struck. Further, the Court held that in any event, the deductible of $10,000.00 in the insurance policy was applicable to the claim of each and every member of the class. Had the claim continued as a representative action, the insurance policy deductible would have applied to each claimant. The policy was not ambiguous. In this regard, the Court distinguished claims-made policies from occurrence policies. It noted that the deductible would apply to each individual claim made against the policy, not to each negligent act which may spawn a number of claims.

The Court reviewed the representative plaintiff's argument on the deductible issue as follows:

> [74] Kelly's position is that, reading the policy as a whole, the word "claim" was intended to refer to the totality of the loss arising out of a single fundamental negligent act or omission. Here, counsel suggested, there could in fact be one or two negligent acts, depending on the results at trial. That is, if liability were found on the basis of the allegations in paragraph 11(a) of the statement of claim, the policy would respond to one fundamental act and would apply one deductible; if liability were found additionally on the basis of the allegations in paragraph 11(b), counsel suggested that there would in such a case be two fundamental acts or occurrences, and two applications of the deductible and of the limit of liability. She argued that while the policy on its face appears to be a claims-made policy, it "has overtones" of an occurrence policy. Any ambiguity, she said, should be resolved in favour of the insured.
>
> . . .
>
> [80] There is no ambiguity in the policy. It is a claims-made policy, not an occurrence policy, although I recognize the caution expressed by McLachlin, J., in the *Reid Crowther* decision, *infra*. The deductible of $10,000 applies to each individual claim made against the policy, not to each negligent act which may spawn a number of claims.

Kelly therefore supports application of the causal theory in Canada to "occurrence" policies: the "occurrence" is the "negligent act" which may spawn a number of claims (although the comments were made in *obiter* as the case concerned a claims-made policy).

The occurrence issue was discussed in a mass tort context (not a class action) by the Alberta Court of Appeal in *Yang v. Canadian Lawyers' Insurance Assn*,[29] again under an E&O policy. Seven individuals (the "clients") retained the insured lawyer (Wiese) to handle their money and investments under an immigration investment program. The trial judge found Wiese committed several negligent acts and errors in the handling of the moneys of the clients. Each of the seven clients suffered damages of $250,000. The trial judge further concluded that each respondent received a separate and distinct professional service, constituting numerous "Occurrences" under the lawyers' professional indemnity policy. The appellant insurer argued that the professional service provided by the insured lawyer was as their real estate lawyer in the acquisition of a shopping centre which all of the clients as a group were engaged in acquiring. Therefore, it argued that there was only one Occurrence and liability should be limited to the policy limit of $1,000,000 (damages totaled $1,750,000).

The E&O policy obligated the insurer "To pay on behalf on the Insured all sums which the Insured shall become legally obligated to pay as damages arising out of an Occurrence . . ." The word "Occurrence" was specifically defined and differs from the definition used in most CGL policies: "Occurrence shall mean any . . . alleged act, error or omission of an Insured . . . and which occurs in the performance of Professional Services for others; provided, however, that if more than one act, error or omission occurs or is alleged to have occurred in relation to the same professional service then all such acts, errors and omissions shall be deemed to be a single Occurrence."

The Policy defined "Professional Services" as "those services normally provided by a lawyer or notary public . . . within the context of the usual solicitor-client relationship ..."

The clients argued that the insured lawyer performed a separate professional service for each of them that went beyond the real estate transaction for the group. There were seven separate retainers. The trial judge in the initial negligence action found that the lawyer represented each client individually. The clients agued that the acts did not all occur with respect to a real estate transaction to be carried out on behalf of a group, but occurred within the professional service being provided by Wiese to each of the of them individually. He acted for them individually with respect to their investment of funds. That being the case, all of the acts, errors and omissions done with respect to the handling of funds and securing the individual separate protection did not occur in the "same professional service", and it followed that there was more than one Occurrence.

The Alberta Court of Appeal agreed, holding as follows (para 35):

> The key phrase in the insurance provision is "same professional service", found in the *proviso* of the definition of "Occurrence". Under Coverage A.1, the insurer is obligated to pay "all sums which the Insured shall become legally obligated to pay as damages arising out of an Occurrence". If the definition of "Occurrence" is inserted, the insurer is obligated to pay "all sums which the Insured shall become legally obligated to pay as damages arising out of any act, error or omission ... which occurs in the performance of Professional Services for others",

[29] (1997), 147 D.L.R. (4th) 31 (Alberta C.A.)

> provided that if "more than one act, error or omissions occurs ... in relation to the same professional service, then all such acts, error and omissions shall be deemed to be a single Occurrence."
>
> I agree with the appellant [insurers] that the policy contemplates the possibility that multiple claimants may be subject to a single liability limitation by the finding of a single Occurrence. The phrase "same professional service" is, in my view, the policy's point of reference to determine whether multiple claimants are subject to such a limitation.
>
> It is only where the acts, errors or omissions are with respect the "same professional service" that they are deemed to be one Occurrence. Thus, it is first necessary to determine what professional service is being performed, and for whom. Only then can one assess whether the multiple acts or errors occur within that same professional service. In simple terms, who retained the lawyer to do what service?

The Court went on to conclude that the services performed on behalf of the seven clients did not arise out of the "same professional service", but arose out of separate retainers and separate professional services. As such, each client's damages were caused by a separate occurrence.

To summarize, while there are no cases clearly on point, the Canadian authorities reviewed suggests that Canadian courts may adopt the causal theory for occurrence policies (*Kelly v. J.J. Lacey Insurance* and in particular the Insured's Liability Approach to that theory (*Synod of the Diocese of Edmonton v. Lombard*). However, the courts will carefully consider the actual policy language in relation to the allegations in the underlying action to determine whether that is so in any particular case.

Interestingly, the Causal Theory + Insured's Liability approach helps the class in relation to a policy with low deductibles, but hurts the class in relation to policy with low per occurrence limits..

IV. The Aggregate Limit

For an insurer, the uncertainty regarding this debate can be mitigated by ensuring that careful attention is paid to the **aggregate** limit, which can control the ultimate extent of exposure regardless of the theory adopted. The aggregate limit is the most the insurer will pay for all occurrences falling under a single policy. For example, the policy may contain a $1,000,000 occurrence-limit, and a $5,000,000 aggregate limit. Consider a case of ten occurrences, each totaling $1,000,000, for a total claim against the insurer in the amount of $10,000,000. Despite the total claim, the insurer's obligation is capped by the aggregate limit of $5,000,000.

V. Is there Excess Coverage?

The stated policy limits noted in the Declaration page do not necessarily tell the whole story. Most importantly, the insured may have multiple coverage layers: a primary and excess policy. The primary policy provides liability coverage up to a first limit layer; and

then the excess policy takes over for a second layer of coverage. For example, the primary policy may provide a $1,000,000 *per* occurrence limit; and the excess policy may provide an additional $10,000,000 which is triggered once the primary policy has been exhausted. When seeking coverage information from the defendant in a class action, ensure the request is broad enough to include excess policies.

VI. Do Defence Costs Eat into Policy Limits?

Given the intense level of defence efforts devoted to class actions, this issue is vital. For example, it is not uncommon for defendants to devote between $250,000-$1,000,000 on the certification motion **alone**.

Commonly used CGL forms (such as IBC Form 2100) provide that defence and supplementary payments to the insured do not reduce policy limits. Where the policy is silent on the issue, the most prevalent approach is to find that the duty to defend does not deplete the limits. For example, in *Mead Reinsurance v. Granite State Insurance*,[30] the Ninth Circuit Court of Appeals held that because an insurer's duty to defend was separate from its duty to indemnify, its policy limits were not reduced by attorney's fees and costs. In reaching this conclusion, the appellate court concluded that the lower court had erred in including such fees in determining the primary insurer's ultimate net loss.

However, certain liability policies do provide that policy limits include defence and related costs. Depending upon the nature of the case, a $1,000,000 *per* occurrence policy limit might seem like a substantial source of funds; but those funds can be quickly depleted if the policy allows the insurer to draw upon the limits to fund the defence.

VII. Costs

The flip-side of the defence cost effort is the effort put in by class counsel. If costs are payable in excess of the limits, then this exposure can serve as an additional source of funds. However, it should be noted that in many jurisdictions, costs are not payable by the losing party in the class proceeding context.[31]

This issue can have an effect on cross-border negotiations, as costs are generally not payable in the U.S. As such, insurers may have an additional exposure in Canadian litigation that is not present in the U.S.

VIII. Conclusion

Follow the money. This mantra is the key to every class action. And in the class action context, where the company is already reeling from the underlying problem, this usually requires a careful consideration of the insurance situation. Keeping a careful eye on the above issues is essential to determine whether a class action in a viable enterprise.

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[30] 873 F.2d 1185 (9th Cir. 1988)

[31] Costs are generally not payable in B.C., Saskatchewan, Manitoba, and Newfoundland. They are payable in Quebec, but only at the Small Claims Court level. The notable exception is Ontario.

As a defendant in a class action, consider your policy early. If the reality of the insurance situation is that the claim is not economic, advise class counsel early. In this entrepreneurial litigation, class counsel is attuned to consider the cold, hard economics of the litigation.