INSURANCE FOR LEAKY CONDOS:

A SUBCULTURAL HISTORY

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I. Introduction

A new legal subculture has emerged in B.C. in the past five years. It has quickly developed a rich history, with rites of passage, levels of membership, societal norms, and punishments for aberrant conduct.

This subculture was created in order to handle the morass of exposure surrounding B.C.'s "leaky condo" phenomenon. After an initial period of chaos, the norms have developed to such a degree that this exposure is generally managed with a minimum of conflict. A cruel "state of nature" has been replaced with consistent expectations and results.

This paper reviews the development of this subculture and the rules which guide its present conduct.

II. Qualification

In any subsequent coverage petition brought against his insurer clients, the author of this cultural study reserves the right to argue that any commentary in this paper consists of the mad sputtering of a raving heretic.

III. History

A. Genesis

In the beginning, there were the CGL policies, and all was thought to be good. Leaky condo claims had begun, but insurers were denying all claims put before them.

The denials were generally based on the following exclusions:

> "Property damage" to "your product" arising out of it or any part of it.
>
> "Property damage" to "your work" arising out of it or any part of it and included in the "products-completed operations hazard."

The commentators provided solid policy rationales for such denials:

> In short, [the product] exclusion excludes indemnity for the cost of repairing the insured's product. The reason for this is that the CGL policy is not intended to be a performance bond, guaranteeing the effectiveness of the insured's product. The insuring intent is that the insured will be covered for the possibility that its product, once completed, may cause bodily injury or damage to property of others.
>
> …
>
> [The work exclusion] is principally designed to exclude the insured's liability to repair or replace its defective or deficient work product. Without this exclusion, the CGL policy would be transformed into a performance bond-a guarantee of the insured's contractual performance.[1]

In relation to general contractors and developers, support for a blanket denial of insurance coverage can be found in the B.C. Supreme Court's decision in *Privest Properties Ltd. v. Foundation Co. of Canada*.[2]

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1 Bates and Clements, "Exclusions Applicable to Product Liability Claims," (1994) 4 C.I.L.R. 246.

2 (1991), 6 C.C.L.I. (2d) 23 (B.C.S.C.).

In *Privest*, the Court was considering coverage for a claim demanding removal of defective asbestos fireproofing material. In analyzing these exclusions, the Court stated:

> The authorities to which I have referred have satisfied me that "product" of a head contractor is the structure erected or improvements made pursuant to its contract with the owner …
>
> All of the authorities to which I have referred thus far, were cases in which the contractor had built an entirely new building. In those circumstances courts have generally found that the entire structure was the work/product of the contractor.

Using *Privest*, the insurer could argue that the entire building was excluded from coverage because it was the developer or general contractor's product. However, this comment was strictly *obiter* in that the Court in *Privest* concluded that in the case before it the additional work done was to an existing structure. As such, it was possible that damage was done to the existing structure as well as the new "product" of the contractor. That issue was put over to trial.

B. Paradise Lost

There was evil in paradise, and its name was *Axa Pacific v. Guilford Marquis*. Insurers were well aware that this coverage petition by a general contractor against its insurer was weaving its way through the system. Concerns arose. Insurers began to evaluate their position more carefully, and discovered problems.

First, the definition of "your product" had been changed in most policies in the late 1980s.[3] A restriction was added so that the definition now read:

> Any goods or products, *other than real property*, manufactured, sold, handled, distributed or disposed of by you … (emphasis added)

Second, the "work" exclusion was modified in many policies so that it only excluded "that part of such work which is defective."

Third, the "work" exclusion was found to include a restriction in many policies as follows:

> This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

The implications were far-reaching.

In relation to the first flaw, with the exclusion of "real property" from the definition, it was far more difficult to argue that the entire leaky condo project constituted the insured's product. A condo could easily be interpreted to be "real property."[4] It was already clear that "resultant damage" to property other than the insured's own product or work or product would be covered. As such, if the whole project was not excluded by the product exclusion, it then became possible to argue that there was resultant damage to material that was not the insured's own product or work.

In relation to the second flaw, even if the entire leaky condo project was a "product," the exclusion did not exclude it entirely. Rather only that part which was defective was excluded.

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3 It is not clear what wordings were before the Court in *Privest*. The judgment does not discuss the definition of "your product" from any of the policies.

4 See F. Malcolm Cunningham "Insurance Coverage in Construction – The Unanswered Question," 33 *Tort & Ins. L.J.* 1063 (Summer 1998).

In relation to the third flaw, if there is a subcontractor downstream from the insured whose work was damaged, that damage would be covered.

Overarching these three flaws was the broad scope of the duty to defend. Even if it appeared that the scope of covered claims was very limited, that did not provide a complete answer. The obligation to defend is one which is triggered by the pleadings. Where there are mixed claims, some attracting coverage and some not, the insurer is obliged to at least defend those that are the subject of coverage; and it is generally understood that where, with respect to the balance, it is unclear or the uncovered claims are intertwined with covered matters, the insurer is obliged to defend the entire claim.

Insurers began to quietly accept the defence obligation when pressed even in advance of the *Axa v. Guildford* decision. However, any innocence was lost once *Axa* was decided.[5] The Court concluded that there was a duty to defend a leaky condo claim against a general contractor. Given the language in the *AXA* policy, the Court relied primarily on the second of the three flaws identified above.

The nail was put in the coffin by *Hearn/Actes v. Commonwealth*,[6] the insurer's last "Hail Mary" attempt to avoid the defence obligation in this area. The Court essentially adopted the *AXA* analysis.

The *Axa* and *Hearn/Actes* decisions are attached as Appendices A and B.

IV. Relations with the Insured: Making the Best of a Bad Situation

A. Non-Waiver Agreements and Reservation of Rights

All was not lost under the two decisions. In particular, both acknowledged that certain aspects of the claims were unlikely to be covered. However, managing that reality for the benefit of the insurer is often challenging.

First, given that the insurer is going to have to investigate and defend the covered aspects of the claim, there is a concern that the insurer will be deemed to have waived its rights to deny other aspects of the claim.[7] To protect against that possibility, many insurers have insisted on the provision of non-waiver agreements from the insured. An example of these agreements is attached as Appendix C.

If the insured refuses to execute the non-waiver agreement, then the insurer must decide whether to go to court to secure a declaration of the respective obligations of the parties up front as in *AXA*, or whether it will be content with a unilateral reservation of rights. An example of a reservation of rights letter is attached as Appendix D.

B. Defence Costs Allocation with the Insured

Should the insured be required to pay for the portion of claims that are not covered? Ideally, there would be a clear division between covered and uncovered claims and separate counsel could be appointed to defend each set of allegations. However, this is generally not practical.

In *Axa*, the Court stated the following with respect to this issue:

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5 2000 BCSC 0197.

6 2000 BCSC 764.

7 The courts have recognized that an insurer who has a non-waiver agreement in place is in a superior position to that of an insurer who simply has a reservation of rights: see *Ward Estate v. Olds Aviation Ltd.*, [1996] 10 W.W.R. 666 (Alta. Q.B.), appeal dismissed, [1996] A.J. No. 1048, *Allstate Insurance Company v. Foster*, [1972] I.L.R. 1-470.

> Axa acknowledges that a duty to defend arises under the policy in respect of claims 'which may be argued to fall under the policy': *Nichols v. American Home Assurance Co*., [1990] 1 S.C.R. 801, 68 D.L.R. (4th) 321, 45 C.C.L.I. 153, at 812 of S.C.R.
>
> Here, as Axa has admitted in respect of resultant damage claims, and as I have explained in respect of the exception to exclusion 6(b), there are claims which fall under the policy.
>
> We do not now know their extent. The claims excepted from exclusion 6(b) will only be known with certainty after the difficult findings of fact are made by the trial judge after trial. The quantum of Axa's 'resultant damage' category must similarly await trial. I agree with Mr. Peters that the Scott schedule prepared by the plaintiff in the underlying action cannot be taken as a definitive statement of the amount of these claims at this time.
>
> The claims, then, represent a mix of those within and those without coverage and there should be an apportionment of defence costs between the covered and non-covered claims: *Surrey (District) v. General Accident Assurance Co. of Canada* (1994), 92 B.C.L.R. (2d) 115, [1994] 7 W.W.R. 226, 24 C.C.L.I. (2d) 34 (S.C.), (1996), 19 B.C.L.R. (3d) 186, [1996] 7 W.W.R. 48, 35 C.C.L.I. (2d) 154 (C.A.).
>
> However, in my view, it is premature to consider a fair allocation of defence costs at this time. In the circumstances that should await trial and it should be undertaken retrospectively: *Continental Insurance Co. v. Dia Met Minerals Ltd*. (1996), 20 B.C.L.R. (3d) 331, [1996] 7 W.W.R. 408, 36 C.C.L.I. (2d) 72 (C.A.).

In certain situations, insureds have agreed to address this issue in advance notwithstanding the result in *Axa*. An allocation is agreed upon. This is obviously to the insurer's advantage and should be pursued where possible. However, in the leaky condo context, this is often impossible due to the fact that the insured contractors are defunct or inactive companies that are not in a position to fund the defence, even in part.

V. Relations with other Insurers

A. Which Policies are Triggered?

Obviously one of the best ways to manage pain is to share it with others. That is essentially what has occurred amongst the CGL insurers on risk for contractors.

CGL policies for contractors are generally triggered based on property damage occurring within the policy period. What does this mean in the leaky condo context?

There are four trigger theories discussed in the case law:

(a) The exposure theory: Coverage is triggered by the first exposure to the condition which causes bodily injury or property damage.

(b) The injury-in-fact theory: The date of the occurrence is the date that the bodily injury or property damage actually occurs.

(c) The continuous or triple trigger theory: Under this theory bodily injury is said to occur throughout the period from initial exposure to the harmful material to diagnosis of injury.

(d) The manifestation theory: Property damage is said to occur when the plaintiff first becomes aware of property damage or becomes aware that he or she has a disease or other bodily injury.

Without a direct judicial determination of this issue in B.C., the insurers have generally adopted the "continuous trigger" theory as the best reflection of the policies and the nature of leaky condo damages.

There is some judicial support for this approach from outside B.C. In *Alie v. Bertrand*,[8] a concrete company sought to trigger policies in relation to allegations made about its defective concrete, which was alleged to have caused damage to the foundations of a number of homes. The Court stated that all policies in effect from completion of the work until discovery of the problem were triggered. The Court's analysis was as follows (at paras. 344-49):

> The Continuous or Triple Trigger Theory
>
> Under this theory, injury or damage to property is said to occur from the time of the initial exposure to the harmful substance to the time that injury is discovered. It often has been described by authors as the 'continuous or repeated injury in fact theory.' There are a number of very good reasons why the application of this theory is best suited to our facts.
>
> There is ample case law where the continuous trigger theory has been applied. See *Gruol Construction Co. Inc. v. Insurance Co. of North America*, 524 P.2d 247 (Wash. App. 1974). In *Surrey (District) v. General Accident Assurance Co. of Canada* (1994), 92 B.C.L.R. (2d) 115 (S.C.), at p. 124, Allen J. stated:
>
> > In view of the difficulties in allocating the damage, I conclude that if there were a series of known insurers on the risk, it would be appropriate to hold them jointly and severally liable to the Insured for the entire risk.
>
> This decision was sustained on appeal. Another helpful decision in the continuous trigger is *Zurich Insurance Co. v. Trans-America Insurance Co*., 34 Cal. Rptr. 2d 913 (Cal. App. 4th Dist. 1994). At page 922, the Court concluded:
>
> > The manifestation rule developed in the first party context is not appropriately applied across the board. Instead, in this liability context, a 'continuing injury' trigger should be used, because property damage occurred beginning in 1976 and continued throughout the filing dates of the underlying lawsuits. Because these claimants alleged continuous and repeated exposure to a continuing series of loss-causing events, under these policies, a continuous trigger of coverage should apply. All carriers who were on the risk from the inception of harm to the time the loss was no longer contingent should be liable to the insured. And, as we discussed above, the loss could still be deemed contingent so long as it was unknown when the insurance was issued whether the insured's activity would result in a claim for property damage that occurred within the policy period.
>
> On our facts, applying this principle, all of the primary and, if necessary, umbrella insurers from 1986 to 1992 would have their policies triggered. Clearly, after the experts on behalf of the Program plaintiffs completed their testing in 1992, the loss was no longer contingent. They concluded that all of the plaintiffs' (Program) foundations would have to be replaced.
>
> Another helpful precedent in applying the Injury In Fact and the Continuous Trigger Theory is a case of *Sentinel Insurance Co. v. First Insurance Co. of Hawaii*, 875 P. 2d 894 (Hawaii 1994). Conceptually, the injury-in-fact trigger and the continuous trigger are on the same continuum and are complimentary, rather than mutually exclusive. In that case, the Court states as follows at p. 917:
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> > [W]here injury-in-fact occurs continuously over a period covered by different insurers or policies, and actual apportionment of the injury is difficult or impossible to determine, the continuous injury trigger may be employed to equitably abortion liability among insurers.

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8 2000 OJ 1361 (S.C.).

That decision has been applied in the U.S. in subsequent cases.

A number of the parties have brought to my attention the case of *Montrose Chemical Corporation of California v. Admiral Insurance Co*., 913 P.2d 878 (Cal. 1995). I found this decision very helpful in understanding the wording of the C.G.L. policies and the relationship with the different trigger theories. To quote from the decision at p. 903:

> Indeed, the drafting history of the standard occurrence-base CGL policy reflects that not only did the drafters understand the term occurrence to mean an accident or exposure to injurious conditions resulting in the occurrence of damage or injury during the policy period, they specifically considered and rejected the suggestion that language establishing a manifestation or discovery trigger of coverage be incorporated into the standard form CGL policy. Among the reasons relied on for rejecting the incorporation of such limitations into the standard definition in the coverage clauses were several stated equitable concerns: the difficulty of applying such limitations or requirements in cases of continuing damage or injury over the course of successive policy periods, the uncertainty of who would bear the burden of discovery requirements (i.e., the insured or third party claimants), the arbitrariness, from the carrier's perspective, of telescoping all damage in a continuing injury case into a single policy period, and the fear that policyholders could be disadvantaged by such an approach … In short, the insurance industry is on record as itself having identified several sound policy considerations favouring adoption of a continuous injury trigger of coverage in third party liability insurance context.

(e) Conclusion

Therefore, in applying a combination of Injury in Fact and Continuous Trigger Theory, I have the comfort of knowing that they are the theories that are:

* the most consistent with the language of the policies and the intention of the parties;
* the most equitable to both the insured and the insurers;
* the remedy that was intended by the insurance industry in drafting C.G.L. policies.

This approach was affirmed on appeal.[9] The Court of Appeal held:

> If the full extent of the damage has become a certainty at a point in time before it is discovered, the injury in fact has occurred by that point in time. Consequently, the fact that there may be further deterioration after that point does not trigger any policies in place after that point, because the damage is already complete. It will be a matter of evidence at the trial as to when the damage became complete. The point when the full extent of the damage becomes known is the manifestation date. In this case, there was no evidence acceptable to the trial judge that the damage was complete before the experts did conclusive testing in 1992. Therefore, that date was accepted as the date when the damage became complete.
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> Because it was not possible on the evidence to determine how much of the damage occurred during any particular policy period, the application of the continuous trigger theory was appropriate in order to allow the trial judge to apportion the damage on a pro rata basis through the affected policy periods.

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9 2002 OJ 4967 (C.A.), leave to appeal dismissed, [2001] S.C.C.A. No. 418.

In terms of the precise formula adopted in B.C. for leaky condo claims, almost all CGL insurers for contractors have adopted the following "time on risk" formula:

> Start Date: Substantial Completion of the project.
>
> End Date: The earliest of (1) commencement of remediation, or (2) service of the writ on the insured.

So to use an example, if a project was completed on January 1, 1990, and remediation commenced on January 1, 2000, the time on risk is 10 years. If 10 different insurers each have one year policies, they will each be responsible for 10% of the defence costs.

The theory behind the substantial completion start date is that the project cannot start leaking until it is finished. Further, most policies include exclusions for property on which work continues to be conducted.

The theory underlying the first option for the end date is that the project stops leaking once the tarps go up on the building. The insurers use the date on which the major remediation effort commences, as opposed to minor interim repairs. It could be argued that this date extends the time on risk beyond the end date suggested by *Alie v. Bertrand*, which seemed to place greater emphasis on the identification of the problem by experts. However, there is a practical and legal distinction with *Alie*. First, from a practical perspective, the leaky condo evaluation by the strata will normally involve a series of reports making it almost impossible to choose which of these tests or reports was "conclusive." The start of major repairs has the benefit of certainty. Second, the nature of the leaky condo damage is that the damage does continue to accrue over time with each new rainstorm. As such, damage identification is not as simple as identifying that the foundations were defective (as in *Alie*).

The alternate writ service end date is also driven by both convenience and theory. From a convenience standpoint, it is normally necessary to consider the appointment of defence counsel once the writ has been served, whether or not the project has been remediated. As such, some formula must be developed with the facts then available. It will not be possible to hire defence counsel and tell them that payment for their bills will be sorted out later. Second, the writ service date serves as a proxy for arguments regarding misrepresentation or known risk. In other words, once a claim has been served, an insured who then proceeds to purchase a new policy without advising the new insurer that they intend to make a defence costs claim under the new policy the next day for an ongoing lawsuit, will have misrepresented the conditions on which the policy was purchased. Further, it is difficult to view such a loss as an "accident" since the need to defend was a certainty when the post-writ policy was purchased.

The development of this formula was not without its tensions. Obviously those insurers at the outset of the period initially sought to argue that it was obvious that there would not be much damage at the beginning of the period. Conversely, insurers at the end sought to argue that all the damage must have accrued at the beginning. As the number of cases mounted, however, the insurers realized that dancing on the head of this pin served no purpose, and that it was more important to maintain a consistent simple approach in the hope that any possible injustice would "come out in the wash."

B. Uncovered Years

There may be situations where the insured is not covered throughout the relevant period. In an ideal world, the insured would simply pay its own "self-insured" allocation for this period. However, in the vast majority of cases, the contractors no longer have any assets, making it impossible to allocate a percentage to the contractor. In these situations, the calculation is altered such that it only includes the covered years.

C. Wrap Up Policies

Some complexity is added in situations where there are "wrap up" insurance policies. These policies are usually purchased by the developer and general contractor, and provide liability coverage for all named insureds and contractors working on the project. They will usually have coverage extending after completion of the project for 12 or 24 months. As such, the availability of wrap up coverage will often create overlapping coverage with the CGL insurer for a particular trade for this period. There was some initial jostling in which both wrap up insurers and CGL insurers attempted to argue that the other was primary. However, in most cases the wording of the policies provides that both are primary. As such, the usual approach has been to simply divide the overlapping period equally between the wrap up insurer and the CGL insurer.

D. Interim Agreements

These "time on risk" agreements are said to be interim, and to relate to defence costs only. As such, all insurers are reserving their rights to argue that, once all the facts are known, it may be possible to determine with greater precision when the "injury in fact" actually occurred.

However, in practice the agreed percentages are almost invariably maintained throughout the litigation, and are used to determine the appropriate share of any settlement contribution.

E. Selection of Defence Counsel

The insurer with the largest percentage is usually given the right to appoint defence counsel, although input will be sought from the other insurers.

F. Coverage for Professionals

The insurance coverage situation for professionals is much simpler. Given that the policies are generally "claims-made," it is only the policy in place when the claim is advanced that will be triggered. There is no need to consider trigger theories or sharing arrangements.

VI. Initial File Management

The following are the usual checklist steps undertaken by our office in terms of organizing the coverage of a leaky condo file for an insurer.

(1) ensure that a reservation of rights letter has been sent out by the insurer;

(2) review the pleading to ensure that it alleges resultant damage, or damage by a subtrade attributable to the insured;

(3) secure an extension to the time necessary to file an appearance by the insured;

(4) obtain copies of the policy to ensure that there are no unique features;

(5) determine the substantial completion, writ service, and remediation dates;

(6) ensure that all insurers on risk over the relevant period have been placed on notice;

(7) investigate whether the general contractor or developer purchased wrap-up coverage, and if so, trigger same;

(8) secure a non-waiver agreement from the insured;

(9) calculate the time on risk percentages;

(10) secure the agreement of the other insurers to the calculation;

(11) appoint defence counsel under the agreed formula.

VII. The Mediation Phase

A. Introduction

Once defence counsel has been appointed, the insurer will monitor the ongoing conduct of the litigation.

The next key step is the mediation. Mediations have generally been very successful in this area. From the insurer's standpoint, there are a number of issues that arise in relation to the mediation.

B. Authority

It will be necessary to meet with defence counsel to determine the appropriate level of contribution for that particular subtrade.

Generally, the authority will track the proportionality between parties suggested by the Scott Schedule produced by the plaintiff. However, this may vary depending on whether the other parties above or below the insured on the Scott Schedule have assets or insurance throughout the relevant period. It is important that this information regarding the other parties be considered, as an insular approach could lead to the wrong result.

Mediators in this area have become more aggressive at securing disclosure of insurance issues for each party prior to the mediation in order to determine any limitations early. In the author's view, such disclosure is appropriate, since the information always ends up being disclosed by the end of the mediation in any event (as the other parties seek to understand why the contribution is not consistent with expectations).

C. Interaction with the Insured

The best opportunity to review this issue with the insured is just prior to the mediation (rather than reserving the insurer's rights to pursue contribution from the insured at some later date). The more funds made available at the mediation proper, the better.

This will often be a very short conversation if the insured is out of business and without assets. However, if there remain assets and the insurer has a proper non-waiver agreement, then there is real financial exposure that the insured should be interested in closing off.

D. Interaction with Insurers for other Defendants

At the mediation, it will be important to establish whether other parties have insurance restrictions that alter the appropriate proportionality. Conversely, it is important to determine if there are any parties that have not triggered the full array of possible insurance coverage.

Once all the information is known, then a rough proportionality established by the Scott Schedule and the insurance issues will usually govern respective contributions between the parties.

E. Interaction with the Plaintiff

Although plaintiff's counsel in this area have slowly become more sophisticated regarding these issues, it is sometimes important to re-emphasize the basic coverage limitations, in terms of the "product" and "work" exclusions. Further, it will often be necessary to review the more unique coverage limitations that may exist in the particular case. For example, if a defunct general contractor only has coverage for 1 of 10 years, then a hoped-for 50 cents on the dollar settlement may need to become 25 cents on the dollar.

VIII. Conclusion

After a few chaotic years of in-fighting, the leaky condo insurance subculture has reached a level of maturity and relative predictability. There are still hard-fought battles, but they are generally around the edges. The core values have been established. Efforts to interfere or undermine the status quo are swiftly punished with non-co-operation on the next file. Insurers have stopped incurring unnecessary expense on internecine conflict, and now generally stand united in an effort to minimize expenditures globally for the benefit of all.