

CANADA / JUDGMENT

Surespan Structures Ltd. v. Lloyds Underwriters

2021 BCCA 65

COURT

British Columbia Court of Appeal

DECIDED

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2021 BCCA 65 Surespan Structures Ltd. v. Lloyds Underwriters

COURT OF APPEAL FOR BRITISH COLUMBIA

Citation:

Surespan Structures Ltd. v. Lloyds Underwriters,

2021 BCCA 65

Date: 20210212

Docket: CA46681

Between:

Surespan Structures Ltd.

Respondent

(Plaintiff)

And

Lloyds Underwriters, QBE Lloyd's Syndicate 1886

and QBE Lloyd's Syndicate DCH 386

Appellants

(Defendants)

Before:

The Honourable Mr. Justice Willcock

The Honourable Madam Justice Fenlon

The Honourable Mr. Justice Voith

On appeal from: Orders of the Supreme Court of British Columbia, dated January 10, 2020 (Surespan Structures Ltd. v. Lloyds Underwriters, 2020 BCSC 27, Vancouver Docket S1810530) and April 23, 2020 (Surespan Structures Ltd. v. Lloyds Underwriters, 2020 BCSC 617, Vancouver Docket S1810530).

Counsel for the Appellants (via videoconference):

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K. Johanson

Place and Date of Hearing:

Vancouver, British Columbia

November 27, 2020

Place and Date of Judgment:

Vancouver, British Columbia

February 12, 2021

Written Reasons by:

The Honourable Mr. Justice Voith

Concurred in by:

The Honourable Mr. Justice Willcock

The Honourable Madam Justice Fenlon

Summary:

The summary trial judge found that no policy limit applied to the mitigation of loss coverage in a professional liability insurance policy. The judge also found that the respondent was entitled to special costs, subject to certain limitations. The insurers appeal both conclusions. Held: Appeal dismissed. There is no basis to interfere with the judge's approach to interpreting the policy or his conclusion that the terms of the policy are unambiguous and that other considerations do not overwhelm that unambiguous language. There is no basis to interfere with the award of special costs, which was supported by the judge's findings in relation to the appellants' litigation conduct.

Reasons for Judgment of the Honourable Mr. Justice Voith:

- [1] This is an appeal from a summary trial in which the judge determined, in reasons for judgment that are indexed at 2020 BCSC 27 (the "Reasons"), that no policy limit applied to the mitigation of loss coverage in Professional Liability Policy Number SPRO10778 (the "Policy"). The appellants also appeal the subsequent determination of the trial judge, indexed at 2020 BCSC 616 (the "Special Costs Reasons"), that the respondent was, subject to certain limitations, entitled to special costs.

1. Overview

- [2] In the Reasons, the trial judge described the general background that gave rise to the dispute between the parties and that underlay aspects of the Special Costs Reasons:

The Project

- [2] The plaintiff, Surespan Structures Ltd. ("Surespan"), is a design-build contractor. Its work includes designing, manufacturing, and erecting precast concrete structures.
- [3] On June 25, 2014, the Vancouver Island Health Authority entered into an agreement with THP Partnership ("Project Co.") whereby Project Co. agreed to design, build, finance, maintain and perform life cycle rehabilitation for two new acute care facilities and associated parkades in Campbell River and Comox (the "Project").
- [4] Project Co. subcontracted the design-build portion of the Project to Graham Design Builders LP ("Graham"), pursuant to a design services agreement (the "DSA").
- [5] Graham in turn engaged Stantec Architecture Ltd. ("Stantec") to undertake the design portion of the Project and to retain the necessary sub-consultants. Graham also entered into subcontracts with Surespan whereby Surespan agreed to provide services regarding the parkade structures, including the design, supply and installation of all the precast concrete components.
- [6] Surespan then entered into its own subcontracts with HGS Limited ("HGS"), whereby HGS agreed to perform professional services with respect to the design of the parkades.

The Parkade Problem

- [7] In late November and early December 2016, Graham advised Surespan of the discovery of cracks in the load-bearing precast elements of the parkades (the "Parkade Defects") and asked Surespan to investigate. Surespan notified HGS of the Parkade Defects and sought its input on remediation.
- [8] On January 24, 2017, Graham demanded that Surespan repair the Parkade Defects.
- [9] Surespan engaged a structural engineer, Kassian Dyck & Associates ("KDA"), to review HGS's design and remediation recommendations. KDA prepared a report that identified a series of errors made by HGS.

The Parkade Remediation

- [10] HGS produced designs for the remedial work to address the Parkade Defects. KDA reviewed and revised these recommendations (the "Remediation Design"). Graham requested that Surespan perform remediation work in accordance with the Remediation Design in order to satisfy its obligations under its subcontract and to mitigate the Project delay.
- [11] Surespan undertook the remedial work. Surespan incurred over \$9.9 million in this effort. Surespan borrowed money to help finance this work and incurred financing charges as a result. Surespan sought reimbursement for the amounts it expended under an insurance policy issued by the defendants ("QBE").

The Policy

- [12] Pursuant to the DSA, Graham was required to obtain project specific professional liability insurance to cover not just Stantec and its sub-consultants, but all other consultants providing services to Graham. Graham obtained the Project Professional Liability Policy No. SPRO10778 (the "Policy") from QBE covering all parties providing professional services to the Project.

QBE's Response to Surespan's Request for Coverage

- [22] On January 13, 2017, Surespan gave notice to QBE of potential costs that would need to be incurred to remediate the parkades. Surespan sought QBE's consent to incur repair costs without prejudice to the QBE's other rights.
- [23] On January 30, 2017, having received no response, Surespan again wrote to QBE requesting coverage under the Policy.
- [24] QBE did not respond until March 31, 2017 when it wrote to Surespan acknowledging the request, but denying coverage on the basis that Surespan was not a named insured under the Policy.
- [25] On August 2, 2017, Surespan brought an action against HGS for negligence and breach of contract (the "HGS Litigation"). HGS then advanced third party claims against Stantec and KDA on September 8, 2017. Graham was added as a defendant on April 24, 2018. On November 21, 2018, Graham advanced a third party claim against HGS and a counter-claim against Surespan.
- [26] On August 29, 2017, Surespan filed a Petition (the "Surespan Petition"), seeking a declaration that it was insured under the Policy. HGS filed a similar petition. On June 27, 2018, Justice Winteringham issued an order (the "Winteringham Order"), declaring that:
- a) Surespan and HGS are each an insured under the Policy;

- b) On or before 30 January 2017, QBE received a notice of a claim and a claim for coverage under the Policy from Surespan and HGS;
 - c) QBE, having received Surespan's notice of claim, was required to provide its written position on coverage and the reasons for it, and pay all covered claims within 60 days of the order, i.e. by 27 August 2018; and
 - d) By consent, Surespan would receive special costs for the hearing of the Surespan Petition
- [27] On August 15, 2018, on behalf of QBE, Charles Taylor Adjusting (the "Adjuster") contacted Surespan for the first time. The Adjuster requested additional information. Surespan provided that information. Thereafter, the Adjuster requested, and Surespan provided, further information about Surespan's expenses.
- [28] On August 20, 2018, QBE requested from Surespan an extension of the time to pay the claim under the Winteringham Order. Surespan agreed to extend the deadline to September 10, 2018.
- [29] On September 10, 2018, QBE wrote to Surespan suggesting that it would be necessary for a court to first pronounce judgment on Surespan's claim against HGS in the HGS Litigation in order to determine whether its expenditures arose from professional services under the Policy. QBE did provide Surespan with a cheque for \$47,978.71, but this was only for Surespan's defence costs incurred to defend the allegations made by Graham against Surespan in the HGS Litigation.
- [30] On September 28, 2018, Surespan filed this action to enforce the Winteringham Order and obtain payment under the Policy.
- [3] I have throughout these reasons used the same defined expressions that the trial judge did.
- [4] The appellants rely on certain other facts as part of the relevant factual matrix evidence. This includes the fact that the total cost for the project--the design and construction of two new acute care hospital facilities and associated parkades--slightly exceeded \$400 million. It also includes the fact that the various claims under the Policy, including Surespan's mitigation work, exceeded what they argue was the \$10 million limit of the Policy.
2. The Issues on Appeal
- [5] The primary issue raised by this appeal is whether the mitigation of loss coverage under the Policy is outside the scope of any stated limit in the Policy. The appellants argue that the trial judge committed several errors in interpreting the Policy. There is some interrelationship between these various arguments. In the main, they argue that the trial judge focused on the mitigation of loss coverage language in the Policy without sufficient attention to the language of the Policy as a whole. They further argue that the trial judge failed to identify any commercial explanation for why the parties to the Policy would expect to receive an unlimited coverage grant in return for the payment of a fixed policy premium.

- [6] The appellants also argue that, if successful on this appeal, the trial judge's special costs award should be set aside and they should be awarded the costs of the underlying summary trial and of this appeal.
- [7] The trial judge addressed several further questions in the Reasons that are not at issue in this appeal.
3. Issue 1: Interpretation of the Policy--Is the Mitigation of Loss Coverage Limited?
- (i) Standard of Review
- [8] The appellants argue that the appropriate standard of review is correctness. They do so partly because they argue that the appeal "involves a determination of whether an unlimited policy limit can be implied into an insurance policy, despite the payment of a fixed premium and the existence of a stated policy limit", and partly because they assert that the determination that an insurance policy "operates without limits is of broad importance to insurers and insureds."
- [9] I do not agree with either of these assertions. First, the appellants concede that the trial judge instructed himself correctly regarding the principles of law applicable to the interpretation of the Policy. Their objection, properly viewed, is based on how the trial judge applied that law to the particular facts before him. In *Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co.*, 2016 SCC 37 at para. 33, Justice Wagner (as he then was), for the majority, citing *Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 S.C.R. 748 at para. 35, said: "Questions of law are 'about what the correct legal test is'", but the application of a legal standard to a set of facts is a question of mixed fact and law on which appellate courts are to defer to the trial judge. See also *Heritage Capital Corp. v. Equitable Trust Co.*, 2016 SCC 19 at paras. 21-24.
- [10] Second, it is true that, on occasion, a less deferential standard of review may be applied to standard form insurance policies on the combined grounds that (a) their interpretation "is of precedential value", and (b) "there is no meaningful factual matrix that is specific to the particular parties to assist the interpretation process" because "the parties do not negotiate terms and the contract is put to the receiving party as a take-it-or-leave-it proposition": *Ledcor* at paras. 4, 24, 28. Neither of these factors pertains to the circumstances of this case. It is common ground that the Policy was not a standard form contract but was, in fact, negotiated. Other policies, with different wording, may be subject to different interpretations. Furthermore, the appellants seek to rely on both the specific factual matrix and on specific extrinsic evidence that pertain to the circumstances of the creation of the Policy.
- [11] Accordingly, I am satisfied that the question before the Court is one of mixed fact and law and that this Court ought not to interfere with the decision of the trial judge in the absence of a palpable and overriding error: *Ledcor* at para. 21; *Heritage Capital* at paras. 21-24; *Sattva Capital Corp. v. Creston Moly Corp.*, 2014 SCC 53 at para. 50.

(ii) The Relevant Legal Principles

- [12] The appellants accept that the trial judge "generally correctly stated the legal approach" to the interpretation of insurance policies. Specifically, the trial judge, relying on *Ledcor*, said:
- [48] The general principles governing insurance policy interpretation are summarized in [*Ledcor*]:
- [49] The parties agree that the governing principles of interpretation applicable to insurance policies are those summarized by Rothstein J. in *Progressive Homes*. The primary interpretive principle is that where the language of the insurance policy is unambiguous, effect should be given to that clear language, reading the contract as a whole
- [50] Where, however, the policy's language is ambiguous, general rules of contract construction must be employed to resolve that ambiguity. These rules include that the interpretation should be consistent with the reasonable expectations of the parties, as long as that interpretation is supported by the language of the policy; it should not give rise to results that are unrealistic or that the parties would not have contemplated in the commercial atmosphere in which the insurance policy was contracted, and it should be consistent with the interpretations of similar insurance policies
- [51] Only if ambiguity still remains after the above principles are applied can the contra proferentem rule be employed to construe the policy against the insurer *Progressive Homes* provides that a corollary of this rule is that coverage provisions in insurance policies are interpreted broadly, and exclusion clauses narrowly.

[Citations omitted.]

- [13] The trial judge acknowledged that both parties argued that the Policy "is clear and unambiguous", as they did on appeal. He agreed "that the Policy [could] be interpreted without resort to the principles applicable in the case of an ambiguity."
- [14] Still further he said:
- [51] Given that the *Winteringham* Order already established that *Surespan* is insured and it is QBE that relies on a limit to its coverage, the burden rests on QBE to establish the extent of any limit: *PCL Constructors Westcoast Inc. v. Royal & Sun Alliance Insurance Company of Canada*, 2019 BCSC 822, at paras. 31-32; *Lombard Canada Ltd. v. Zurich Insurance Co.*, 2010 ONCA 292, at para. 34.
- [52] The Mitigation of Loss Coverage should be interpreted broadly in favour of coverage: *Derksen v. 539938 Ontario Ltd.*, 2001 SCC 72 at para. 49.
- [15] The trial judge did not expressly deal with those authorities that address the use of factual matrix evidence in the interpretation of contracts. Having said this, if a policy, read as a whole, is unambiguous, effect should be given to its clear language: *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada*, 2010 SCC 33 at para. 22; *Economical Mutual*

Insurance Company v. Gill, 2017 BCCA 351 at paras. 27-28. This principle is further developed in G.R. Hall, *Canadian Contractual Interpretation Law*, 3rd ed (Toronto: LexisNexis Canada, 2016) at 33-34:

Yet a further limitation on the scope of the factual matrix is the imperative that the contextual analysis mandated by the factual matrix must not overwhelm the language of the contract: "While the surrounding circumstances will be considered in interpreting the terms of a contract, they must never be allowed to overwhelm the words of the agreement." [relying on *Sattva* at para. 57.] Interpretation involves a consideration of the words in their context and ideally the two can be reconciled to achieve an interpretation which accords with both, but such is not always possible. Given the paramount importance of the words, being the very language agreed upon by the parties to govern their legal obligations, in cases of conflict the words will always prevail over the context. Thus while the factual matrix can be used to clarify the parties' intentions as expressed in a written agreement, it cannot be used to contradict that intention, create an ambiguity which otherwise does not exist in the written document, or have the effect of making a new agreement. "The interpretation of a written contractual provision must always be grounded in the text and read in light of the entire contract." [relying on *Sattva* at para. 57.]

[Footnotes omitted.]

(iii) Interpretation of the Policy

- [16] The trial judge, under the heading "The Policy," first described the various provisions in the declarations pages to the Policy (which he defined as the "Declarations") and in the body of the Policy itself that had relevance to the question before him. Specifically, in relation to the provisions within the body of the Policy, he described the clauses that addressed "Insurance Coverage" and that expressly addressed the limits of liability in the Policy, which he defined as the "Limits of Liability Clause." He referred to a "Schedule" that was referenced in the Limits of Liability Clause and elsewhere. He further addressed provisions that he defined as the "Action Against Insurer Clause" and the "Policy Period Clause." Finally, he described various "Definitions" found within Part 1 of the Policy under the heading "DEFINITIONS."
- [17] Though I intend to turn to most of these provisions, I have not, so as to avoid being redundant, described them at the outset as the trial judge did. Nevertheless, it is important to recognize how the trial judge approached the problem from the outset. This is so for three reasons. First, he recognized that the Declarations, the Schedule, and the body of the Policy were all part of the Policy. Each such component of the Policy has contractual force. Each page of the declarations states at the top: "THIS COMMERCIAL INSURANCE POLICY CONSISTS OF THIS (THESE) DECLARATIONS PAGE(S) ALONG WITH THE 'GENERAL CONDITIONS' (OR 'STATUTORY CONDITIONS'), AS WELL AS ALL COVERAGE WORDINGS, RIDERS OR ENDORSEMENTS THAT ARE ATTACHED HERETO."

- [18] Second, though the appellants have shifted their submissions on some issues and raised additional issues on appeal, there is no suggestion that the trial judge failed to consider any provision within the Policy that was brought to his attention and that might have relevance. Third, his identifying all of the language or provisions within the Policy that had potential relevance to the issue before him is consistent with his recognizing his obligation to interpret the Policy "as a whole."
- [19] Thus, when the appellants argue that the trial judge failed to address the issue before him having regard to "the Policy as a whole," it is important to recognize at the outset that the trial judge properly stated the relevant legal principles, including the need to read the contract as a whole. He also described the language and provisions that the parties identified as being relevant and he then addressed each such clause or provision. Thus, he did not fail to consider a required element of a legal test or fail to consider a relevant factor when interpreting the policy.
- [20] The trial judge started his analysis with the four separate coverages that are provided for in the body of the Policy. The appellants in their factum, conversely, start their analysis with various provisions in the Declarations that they say "set the architecture for the Policy." It will be seen that some language in the Declarations fixes a limit for "[a]ny one claim and in the aggregate" of \$10 million.
- [21] I do not consider that there was necessarily a correct or prescribed way for the trial judge to undertake his analysis. It is generally considered appropriate to start the analysis of an insurance policy by identifying the grant of coverage. Certainly, in the circumstances of this case, it made good sense to begin that analysis with a consideration of the specific provision where the mitigation of loss coverage first appears (indeed the only place it appears) and with the specific Limits of Liability Clause.
- [22] The insurance coverages that are provided under the Policy are addressed in Part II of the Policy and provide:

PART II - INSURANCE COVERAGE THE INSURER'S OBLIGATIONS

THE INSURER is formally undertaking to fulfil the following four (4) obligations for the INSURED'S benefit. The INSURED'S POLICY EXCESS applies to all the obligations.

1. DAMAGES

In excess of the INSURED'S EXCESS, THE INSURER will pay on behalf of the INSURED all sums which the INSURED becomes liable to pay as DAMAGES arising out of a CLAIM In regard to the PROJECT, providing the INSURED'S liability is the result of an error, omission or negligent act of the INSURED or those employees or sub-consultants or sub-contractors for whom the INSURED is legally liable, in the performance of PROFESSIONAL SERVICES.

The maximum amount THE INSURER will pay for each CLAIM and in the aggregate for all CLAIMS made against the INSURED during the POLICY PERIOD and covered by this POLICY is, no matter how many INSUREDS there are under this POLICY or how many persons or organizations make a CLAIM, as shown on the SCHEDULE page of this POLICY as the Limits of Liability per CLAIM and Aggregate Amount Payable respectively.

2. MITIGATION OF LOSS

The INSURERS will additionally indemnify the INSURED against the costs of remedying defects in the WORKS in order to fulfil contracts undertaken for others where such costs are necessarily incurred prior to SUBSTANTIAL COMPLETION with the prior written consent of THE INSURER (such consent not to be unreasonably withheld).

Provided that such defect in the WORKS must result from an error, omission or negligent act in the performance of PROFESSIONAL SERVICES by the INSURED or those employees or sub-consultants for whom the INSURED is legally liable and the onus of satisfying this provision rests with the INSURED.

3. DEFENCE

THE INSURER has the obligation and right to defend the INSURED in any civil suit or arbitration proceeding arising out of a CLAIM in regard to the PROJECT for which coverage is provided by this POLICY, even if the allegations against the INSURED are groundless, false or fraudulent. THE INSURER will conduct such investigation, negotiations and defence as it deems expedient. THE INSURER'S obligations to defend the INSURED cease as soon as THE INSURER'S Limits of Liability have been exhausted.

4. SUPPLEMENTARY PAYMENTS

Until THE INSURER'S Limits of Liability have been exhausted, THE INSURER will pay, for each CLAIM covered by this POLICY, the following:

- a) CLAIM EXPENSES;
- b) all premiums on appeal bonds and bonds to release attachments, where such bonds are in regard to judgements which ought reasonably to be appealed and which fall within the remaining Limits of Liability at the time of appeal or attachment. THE INSURER has no obligation to furnish such bonds but only to pay the premiums thereon;
- c) all costs taxed against the INSURED, all court and arbitration costs owed by the INSURED, and all interest upon that part of the judgement which falls within the remaining Limits of Liability at the time.

[23] The Limits of Liability Clause provides:

THE INSURER'S LIMITS OF LIABILITY

The maximum amount THE INSURER will pay for each CLAIM and in the aggregate for all CLAIMS made against the INSURED during the POLICY PERIOD and covered by this POLICY are, no matter how many INSUREDS there are under this POLICY or how many persons or organizations make a CLAIM, as shown in the Schedule Page of this POLICY as the Limits of Liability per CLAIM and in the aggregate for the POLICY PERIOD.

THE INSURER'S obligations to defend and make supplementary payments is included in the INSURER'S Limits of Liability.

[24] In relation to the various coverages, and specifically what he defined as the "Mitigation of Loss Coverage," the trial judge said:

[53] As outlined above, there are four separate coverages provided by the Policy:

- a) Damage Coverage;
- b) Mitigation of Loss Coverage;
- c) Defence Costs Coverage; and
- d) Supplementary Payments Coverage.

[54] Does the \$10 million limit apply to all four? I find that it does not.

[55] First and most importantly, as a matter of pure textual construction, the subparagraphs granting the Damages, Defence Costs, and Supplementary Payments Coverages each expressly refer to and apply a limit of liability. Notably, the grant of Mitigation of Loss Coverage includes no such reference.

[56] I find this absence of limits language in one of the four coverages of particular significance to the proper interpretation of the Policy. In the world of statutory interpretation, this is referred to as a "failure to follow a pattern of express reference". Ruth Sullivan describes the principle as follows in *Construction of Statutes*, 6th ed. (Markham: Lexis Nexis, 2014) at 251:

As much as possible, drafters strive for uniform and consistent expression, so that once a pattern of words has been devised to express a particular purpose or meaning, it is presumed that the pattern is used for this purpose or meaning each time the occasion arises. This convention naturally creates expectations that may form the basis for an implied exclusion argument. This point is made by Iacobucci J. In *R. v. Ulybel [Enterprises] Ltd.* when he writes:

[H]ad Parliament intended the phrase "any proceeds of its disposition" [in s. 72(1) of the Fisheries Act] to be limited to proceeds of [seized] perishables, it could have done so expressly, as it did in ss. 72(2) and 72(3). Instead, a pattern in the use of the phrase at issue is evident whereby in some sections it is expressly limited to the proceeds of perishables and in other sections it refers more generally to all forms of property seized under the Act and proceeds thereof.

Patterns in legislation are assumed to be intended rather than inadvertent. Once a pattern has been established, it becomes the basis for expectations about legislative intent.

[Footnotes omitted.]

- [57] "Just as in statutory interpretation, so also in contract interpretation.": *Jacobsen v Bergman*, 2002 BCCA 102 at para 4. See also *Hanna Collision Repair (1984) Ltd. v. Insurance Corp. of British Columbia*, 2010 BCCA 490 at para. 58.
- [58] I see no grammatical or textual reason why the Mitigation of Loss Coverage would not also require an express reference to the limit, had that been a proper expression of the parties' intent.
- [59] QBE suggests the limits language may have been omitted because the Mitigation of Loss Coverage is subsidiary to the Damage Coverage, i.e. the Mitigation of Loss Coverage is designed to avoid the potential for a Damage Claim, and hence is subsidiary to that coverage and can effectively "free ride" on the reference to the limit in the Damage Coverage.
- [60] However, were that analysis correct, the Defence Costs Coverage would be even more subsidiary. Indeed, there is never a need for defence costs to be incurred unless and until a claim for damages is made against an insured. Nonetheless, the Defence Costs Coverage still specifically references the limit.
- [61] The Mitigation of Loss Coverage is less subsidiary than the other coverages. As QBE acknowledged, it is more in the nature of first party coverage. Under this coverage, expenses incurred by the insured are reimbursed to the insured, rather than being losses of a third party paid to a third party. There is no need for a claim by a third party in order to trigger the coverage. The amount paid under such coverage does not reflect damages suffered by another, but rather the "costs of remedying defects in the WORKS in order to fulfil contracts".

[Emphasis in original.]

[25] In relation to the Limits of Liability Clause, the trial judge said:

- [62] A second basis supporting Surespan's interpretation is the language of the Limits of Liability Clause. This clause specifically refers to the limit being applicable in the case of "CLAIMS made against the INSURED". However, in the case of the Mitigation of Loss Coverage, there is no need for a "CLAIM" to be made against the insured. Indeed, the purpose of the provision is clearly to avoid the prospect of a Claim being advanced against the insured, by allowing defects to be corrected before the situation necessarily develops into a Claim. The potential for a claim is precisely what is being "mitigated". Indeed, as QBE conceded, it is possible for a mitigation of loss claim to be made by an insured without the owner or head contractor ever knowing that the problem existed. Further, as noted above, payment under the Mitigation of Loss Coverage is made to the insured, not to a third party who has advanced a claim against the insured.

[63] Surespan's position is further supported by the reference in the Limit of Liability Clause to the Schedule. The Schedule again refers to the limit being applicable to "any one claim and in the aggregate".

[Emphasis in original.]

[26] The appellants do not argue that any of the principles of construction that the trial judge relied upon when he addressed these provisions were inappropriate. They do argue that he was mistaken in asserting that there was no "textual reason" within the Mitigation of Loss Coverage that "would not also require an express reference to the limit, had that been a proper expression of the parties' intent."

[27] Specifically, the appellants argue that both the Damages Coverage and the Mitigation of Loss Coverage address "an error, omission or negligent act of the INSURED or those employees or sub-consultants for whom the INSURED is legally liable". They argue that the two provisions are "integrally connected" or "zippered together", in that they address the same issue and there was, accordingly, no need to again refer to the "limits of liability" or to "limits language" within the Mitigation of Loss Coverage provision. They say that a reasonable insured would understand that the limits of liability that pertained to the Damages Coverage would also pertain to the Mitigation of Loss Coverage.

[28] Conversely, they argue, in relation to both the Defence Coverage and the Supplementary Payments Coverage, that a reasonable insured might want to know whether the insurer's limits of liability pertained to these additional coverages.

[29] There are various difficulties with the position being advanced by the appellants. First, while there is likely to be some relationship, in some cases, between the Damages Coverage and the Mitigation of Loss Coverage, there are also significant differences in those coverages. As a starting point, the Damages Coverage pertains to "sums which the INSURED becomes liable to pay as DAMAGES arising out of a CLAIM in regard to the PROJECT".

[30] Broadly speaking, and without yet turning to the definitions of DAMAGES and CLAIM, the Damages Coverage is more comprehensive than the Mitigation of Loss Coverage. For example, the Damages Coverage could extend to third-party tort liability claims, to potential environmental harm, and to other forms of CLAIM that are not addressed in the Mitigation of Loss Coverage. The Mitigation of Loss Coverage is intended to "indemnify" an INSURED and it is limited to "remedying defects in the WORKS in order to fulfil contracts undertaken for others".

[31] Aspects of the foregoing conclusions are both supported and further developed in the definitions of DAMAGES and CLAIM.

[32] DAMAGES is defined in the Policy as:

Compensatory DAMAGES payable to claimants but does not include interest, fines, penalties (whether contractual or other), or liquidated, punitive or exemplary damages, or fees which have either not been paid to the INSURED or which the INSURED has been asked to return.

- [33] This definition further confirms that the liability of the INSURER under the Damages Coverage to pay DAMAGES on behalf of an INSURED may well have little to do with an INSURER under the Mitigation of Loss Coverage "indemnify[ing] an INSURED" against the costs of remedying defects in the WORKS in order to fulfil contracts for others. Certainly it would not be accurate to describe the two coverages as being "zippered together."
- [34] The definition of CLAIM is particularly relevant. It is relevant because it further informs the issue of whether the Damages Coverage and the Mitigation of Loss Coverage are "zippered together." More fundamentally, it identifies a significant point of departure between the parties and their analysis of the issues. Thus, the appellants in their factum repeatedly state that the policy only provides for one policy limit, that being "\$10 million in the aggregate". These limits are found both in the Declarations and the Schedule, which I will return to.
- [35] The respondent, conversely, repeatedly emphasizes in its factum that the policy limits found in the Declarations and the Schedule is \$10 million for "claims-made coverage" and that the Mitigation of Loss Coverage is "not subject to the claims-made coverage's \$10 million limit."
- [36] These differing positions also explain why starting the relevant analysis with the Declarations, and then asserting that this sets the "architecture for the Policy," is not necessarily accurate or helpful.
- [37] CLAIM is defined in the Policy as:
- a) a written or an oral demand for money or services, or
 - b) a written or an oral allegation of breach in the rendering or failure to render PROFESSIONAL SERVICES; received by the INSURED and resulting from a single error, omission or negligent act.

All CLAIMs arising from a single error, omission or negligent act shall be considered a single CLAIM regardless of the number of INSUREDS or the number of persons or organizations making a CLAIM.

- [38] It will be apparent that the Damages Coverage pertains to circumstances where the INSURED becomes liable to pay "DAMAGES arising out of a CLAIM". Similarly, the Limits of Liability Clause addresses "[t]he maximum amount the INSURER will pay for each CLAIM and in the aggregate for all CLAIMS made against the INSURED". The Mitigation of Loss Coverage does not, however, rely on a CLAIM to be effective, nor does it rely on a CLAIM that is made against the INSURED.

- [39] Before the trial judge, the appellants argued that the word "claim", found in the Declarations and the Schedule, had a different meaning than the defined word CLAIM. The trial judge addressed this submission and said:
- [75] QBE relies on the fact that the word "claim" is in lower case in the Declarations. QBE argues that Surespan cannot rely on the defined term in upper case ("CLAIM") to assist its position. Indeed, QBE suggests that the use of lower case in the Declarations must mean that "claim" is actually intended to have a different and broader meaning that includes the Mitigation of Loss Coverage.
- [76] QBE places too much weight on the form of the Definitions language. The Definitions do not affirmatively state that the same word cannot have the same meaning absent capitalization when used outside the core Policy language. This interpretation is supported by the fact that the Declarations do not use capitalized terms outside of its headings. For example, it uses the words "Insurer", "Insured" and "Professional Services", all without using the capitalized form found in the Definitions.
- [77] As Surespan argued, an insurer who uses an undefined term to exclude or limit coverage does so at its peril. Such terms will generally be construed in favour of coverage for the insured, in order to avoid a "trap for the unwary": *Axa Insurance (Canada) v. Ani-Wall Concrete Forming Inc.*, 2008 ONCA 563 at para. 17. In my view, allowing "claim" to have a broader scope than "CLAIM" for the benefit of the insurer would be such a trap.
- [40] The appellants no longer argue that the words "claim" and "CLAIM" have different meanings. They accept that the two words, found in different places in the Policy, have the same meaning, but they now argue that the word CLAIM should be interpreted broadly and, to that end, they rely on a dictionary definition that they argue is "similar" to the defined term CLAIM. The respondent, conversely, asserts that the appellants "ought not to be permitted to advance a new, inconsistent, position on appeal."
- [41] The appellants appear to have both abandoned certain arguments that were made before the trial judge and to raise new arguments on appeal. This is somewhat different from changing or resiling from a particular position that was taken before the trial judge. There are circumstances where this Court will not permit a party to resile from a position that it adopted at trial. I do not consider that this is such a circumstance. Such changes in position may well, however, signal a lack of coherence in a party's position.
- [42] I accept that the word CLAIM can be interpreted broadly and that it should be interpreted in a way that best gives effect to the parties' intentions. Nevertheless, a broad interpretation cannot, as the respondent argues, convert "night into day." Furthermore, Hall at 115-16 observes: "If the parties have expressly defined a word or phrase to have a particular meaning, interpretive accuracy simply cannot be achieved without giving effect to the meaning agreed by the parties . even if a dictionary definition might support [a broader definition]". See also *JEKE Enterprises Ltd. v. Northmont Resort Properties Ltd.*, 2017 BCCA 38 at paras. 53-54.

- [43] The defined meaning of the word "CLAIM" is clear and does not accord with the position advanced by the appellants. Specifically, the appellants argue that "[n]othing in the definition of CLAIM requires that it be made by a third party." This is not convincing as a matter of grammar. In the definition of CLAIM, the sentence-ending phrase "received by the INSURED and resulting from a single error, omission or negligent act" is preceded by a semi-colon, meaning that what follows modifies both the preceding clauses in the sentence. In other words, CLAIM includes "a written or an oral demand for money or services received by the INSURED and resulting from a single error, omission or negligent act." It does not, as the appellants contend, include a written or oral demand by the INSURED for money or services from the INSURER.
- [44] This interpretation is also supported by the Limits of Liability Clause, which expressly pertains to "[t]he maximum amount THE INSURER will pay for each CLAIM and in the aggregate for all CLAIMS made against the INSURED during the POLICY PERIOD".
- [45] It is further supported by a clause in the Policy that the trial judge defined as the "Policy Period Clause," and which provides:

POLICY PERIOD

THE POLICY covers CLAIMS made against the INSURED for the first time during the POLICY PERIOD no matter when the actual or alleged error, omission or negligent act took place

.

Any such CLAIM shall be subject to the Limits of Liability and EXCESS in effect at the time the circumstances were reported to THE INSURER.

- [46] It is also relevant that the appellants, before the trial judge, took the position that the Mitigation of Loss Coverage was "in the nature of first party coverage." Hence the trial judge reasoned: "Under this coverage, expenses incurred by the insured are reimbursed to the insured, rather than being losses of a third party paid to a third party. There is no need for a claim by a third party in order to trigger the coverage."
- [47] On appeal the appellants raise a further issue in relation to the definition of CLAIM that does not appear to have been argued before the trial judge. They argue that CLAIM must include claims made by third parties and requests for coverage because otherwise the Policy would be missing "information or direction with respect to how, when, or where recovery for Mitigation of Loss Coverage is available." Specifically it is argued that the trial judge's interpretation must be wrong because it means that the deductible, territory, policy period, policy limit, general conditions, and exclusions would not apply to the Mitigation of Loss Coverage, which, the appellants argue, would be commercially unreasonable.
- [48] I do not consider that I need address each of these provisions. Instead, a few examples are sufficient:

- i) Deductible: This is an issue I will return to but, before the trial judge, the appellants accepted that no deductible applies in the circumstances.
- ii) Supplementary Payments: These too appear to be irrelevant. They include CLAIM EXPENSES, which are defined as the INSURER's expenses "to investigate, defend, mitigate, settle, arbitrate, or litigate a CLAIM covered by this POLICY." They also include premiums on appeal bonds and costs taxed against the INSURED, all of which appear to relate to third-party CLAIMS and legal proceedings against the INSURED.
- iii) Policy Territory: This clause, by its terms, applies "to CLAIMS arising out of actual or alleged errors, omissions or negligent acts in regard to the PROJECT which occur anywhere in the world, provided the CLAIMS are made and proceedings instituted in Canada." The words "CLAIMS are made and proceedings instituted in Canada" are directed to third-party claims. They have little to do with an INSURED seeking indemnification for "the costs of remedying defects in the WORKS". Further, for that reason there is no need to define a policy territory. No absurdity arises from the fact there is no territory defined in relation to mitigation expenses.
- [49] There is a further point of distinction between the Damages Coverage and the Mitigation of Loss Coverage. The latter coverage expressly provides: "The INSURERS will additionally indemnify the INSURED". The word "additionally" suggests that the Damages Coverage and the Mitigation of Loss Coverage are not coextensive. Instead they pertain to different things and the Mitigation of Loss Coverage is "in addition" to the Damages Coverage.
- [50] Ultimately, I am satisfied that this first part of the trial judge's analysis was coherent and comprehensive. That analysis established:
- i) there is an explicit limit of liability in each of the Damages, Defence, and Supplementary Payments Coverages;
- ii) each of the Damages, Defence, and Supplementary Payment Coverages arise out of or are triggered by a CLAIM;
- iii) the Policy covers CLAIMS made against an INSURED. The Mitigation of Loss Coverage pertains to requests for consent (which consent is not to be unreasonably withheld) made by an INSURED to the INSURER for indemnity against the costs of remedying defects in the WORK;
- iv) the foregoing propositions are accurate and consistent in both the Insurance Coverage provisions and the Limits of Liability Clause;
- v) the Mitigation of Loss Coverage is "additional" to other forms of coverage, it is not triggered by a CLAIM, it is not based on DAMAGES arising out of a CLAIM, and it does not make any reference to a "Limit of Liability";
- vi) the Limits of Liability Clause is not explicitly referenced in the Mitigation of Loss Coverage, though it is expressly referenced in each of the other forms of coverage provided for in the Policy; and

vii) the Limits of Liability Clause does not make any reference to the Mitigation of Loss Coverage, though it expressly does so in relation to each of the other forms of coverage provided for in the Policy.

[51] I have paused here, not for any principled reason, but rather because the clauses and definitions I have thus far identified deal with the question before the court in the most specific manner and with the most explicit language. Having said this, it was necessary for the trial judge to consider other parts of the Policy and to ensure that his interpretation was consistent with the Policy as a whole.

[52] Thus, the trial judge considered a number of provisions in the Declarations that the appellants emphasized. Specifically, he addressed the pre-printed, small-font statement at the top of each declarations page that he defined as the "Limit Requirement Preamble" and that provides:

INSURANCE IS PROVIDED ONLY FOR THOSE COVERAGES FOR WHICH A SPECIFIC LIMIT OF INSURANCE IS SHOWN - ON TERMS AND CONDITIONS CONTAINED IN THE FORMS INDICATED.

[53] In relation to this provision, the trial judge said:

[67] First, QBE cannot argue that the Limit Requirement Preamble actually creates the limit on the Mitigation of Loss Coverage. Rather, applied independently, if there were no Limit of Liability found elsewhere in the Policy, the implication of the Limit Requirement Preamble would be that there would be no Mitigation of Loss Coverage at all. However, QBE does not go this far. QBE agrees that the Policy must be interpreted so as to maintain the Mitigation of Loss Coverage. As such, QBE is left arguing that this preamble is more in the nature of an interpretative aid, rather than driving QBE's proposed result on its own.

[68] Hence this case is not akin to that in *Yip v. Davies*, [1999] B.C.J. No. 1836 (S.C.), where the court allowed a broad exclusion to cover a situation where there were also specific exclusions governing specific situations. Here, there is no overarching limit clause that overlays the Mitigation of Loss Coverage. At best the Limit Requirement Preamble sets out what would happen if there is no limit. It does not impose an overarching limit on its own.

[69] QBE's second difficulty is that the Limit Requirement Preamble itself states that it applies "on terms and conditions contained in the forms indicated". In other words, it is subject to the rest of the Policy. This makes sense since, as QBE acknowledged, the Declarations pages are only a summary of some of the Policy's key terms: Alan S. Rutkin and Robert Tugander, *The Reference Handbook on the Commercial General Liability Policy*, 2nd ed. (Chicago, IL: American Bar Association, 2014) at 3.

[70] Once one accepts that the Policy is to be interpreted as a whole, there is far more detailed and specific language on the applicability of the limit in the body of the Policy itself. We have already carefully examined these detailed words in the body of the Policy, and illustrated how the specific language does not favour QBE's interpretation.

[Emphasis in original.]

[54] Aspects of the trial judge's analysis and the language of the Limit Requirement Preamble are problematic. The trial judge reasoned that, if the Limit Requirement Preamble applied literally, then if there was no limit of liability for the Mitigation of Loss Coverage there would be no such coverage and he noted that the appellants agreed with this. Nevertheless, this appears to ask the wrong question and it presupposes an answer. The corollary of this conclusion is that for there to be Mitigation of Loss Coverage, such coverage would have to contain a limit of liability.

[55] On appeal, the respondent argues that the words "ON TERMS AND CONDITIONS" pertain to the various limitations that are included in the language of the Mitigation of Loss Coverage provision. Counsel for the respondent identifies five such limitations including, for example, that the costs for such coverage had to be incurred prior to SUBSTANTIAL COMPLETION (a defined expression) and that the INSURED could only move forward with the prior written consent of the INSURER. I do not consider this persuasive. The words "FOR WHICH A SPECIFIC LIMIT OF INSURANCE IS SHOWN" contemplate a specific dollar limitation as opposed to various functional limitations.

[56] Nevertheless, the trial judge noted that the appellants agreed that the Limit Requirement Preamble was "more in the nature of an interpretive aid". Counsel for the appellants, though he correctly emphasizes that the provisions in the Declarations have contractual force, similarly accepts that the Limit Requirement Preamble is in the nature of an "interpretive note."

[57] More importantly, the trial judge reasoned that the Limit Requirement Preamble was, by its terms, subject "to the rest of the Policy" and that the language in the body of the Policy contained "far more detailed and specific language on the applicability of the limit".

[58] The respondent, in its factum, refers to various American authorities that conclude that the declarations in an insurance policy are a general statement of the types of coverage offered and are subject to the more specific coverage in the policy terms. The trial judge similarly referred to various American authorities in support of "the view that a policy's declaration pages are generally subordinate to specific terms in the policy absent specific language to the contrary." I do not consider that I need to address whether that is, in all circumstances, necessarily so.

[59] It is, however, clear that as a matter of interpretation, specific language tends to govern over more general language. Accordingly, an apparent conflict between a general term and a specific term "may be reconciled by taking the parties to have intended the scope of the

general term to not extend to the subject-matter of the specific term": BG Checo International Ltd. v. British Columbia Hydro and Power Authority, [1993] 1 S.C.R. 12 at 24; Douez v. Facebook, Inc., 2017 SCC 33 at para. 46; Fuller v. Aphria Inc., 2020 ONCA 403 at paras. 60, 83.

[60] Next, the trial judge addressed language in the Declarations that he described as the "Declarations Limit Language" and that provides:

FORM NO.

TYPE OF COVERAGE

DEDUCTIBLE

LIMIT OF

COINS. % INSURANCE

Liability

Professional Liability (Claims Made)

Type of professional services

Consultant

Limit of Liability

Any one claim and in the

aggregate including costs

and expenses

10,000,000

Deductible

Any one claim including

costs and expenses

500,000

[61] In relation to the Declarations Limit Language, the trial judge said:

[72] QBE argues that the Declarations Limit Language must be read as creating a limit for all coverages, including the Mitigation of Loss Coverage. However, this argument faces similar challenges to those discussed above.

[73] First, although this summary language refers to the Policy being "claims made" and the limit applying to "any one claim and in the aggregate", we have already noted that the specific Mitigation of Loss coverage at issue does not in fact require that a claim be made. It is more

akin to first party coverage that can be triggered in the absence of a claim. This suggests that the Declarations are not intended to be a comprehensive free-standing statement of the details of the specific coverages provided by the Policy. The Declarations Limit Language is summary, short-form, and not stated in complete sentences. For these reasons, it is difficult for QBE to argue that the Declarations Limit Language should be given greater weight than the comprehensive language found within the Policy itself.

[Emphasis in original.]

- [62] No error arises from these statements and general propositions. Furthermore, aspects of these statements were accepted by the appellants before the trial judge. The trial judge further considered three specific elements of the Declarations Limit Language. First, he addressed the meaning of the word CLAIM as opposed to "claim." I have earlier identified his comments in relation to this issue and I have further developed the defined meaning of the word CLAIM to address the further submissions made by the parties on appeal.
- [63] The trial judge also addressed the meaning of the words "in the aggregate" and said:
- [78] Next, QBE relies on the language, "in the aggregate", to argue that this must be intended to capture all types of coverage under the Policy. The main problem with this argument is grammatical. I find that the words "in the aggregate" are intended to modify the noun "claim", rather than purporting to alter or add a new noun of a different character.
- [64] I agree with the analysis of the trial judge in this respect. I have identified that each type of coverage in the Policy, other than the Mitigation of Loss Coverage, is expressly based on a CLAIM being made against an INSURED. So too the Limit of Liability Clause prescribes "[t]he maximum amount THE INSURER will pay for each CLAIM".
- [65] The word "aggregate" necessarily modifies a CLAIM. Without a CLAIM, there is nothing to "aggregate."
- [66] The fact that it is CLAIMS which are being "aggregated" for the purpose of the Limit of Liability under the Policy is further confirmed in the Damages Coverage, which provides: "The maximum amount THE INSURER will pay for each CLAIM and in the aggregate for all CLAIMS made against the INSURED is as shown on the SCHEDULE page of this POLICY as the Limits of Liability per CLAIM and Aggregate Amount Payable respectively." Almost identical language is found in the Limit of Liability Clause.
- [67] Finally, the trial judge addressed the meaning of the words "costs and expenses" and said:
- [79] QBE argues that the reference to "costs and expenses" in the Declarations must be a reference to the "costs of remedying defects" available through the Mitigation of Loss coverage. However, I find that this expression more logically refers to the Defence Costs and Supplementary Payments Coverages. Because it is in such close proximity to the word "claim", it is more logical that "costs and expenses" refers to these costs and expenses associated with defending a "claim". This is consistent with the language of the coverage

grant within the Policy which does impose the limit on the Damage, Defence Costs and Supplementary Payments coverages.

[68] Aspects of this interpretation of the words "costs and expenses" might normally be strained. But in this case it is supported by the observations of the trial judge and by two further considerations. First, the expression CLAIM EXPENSE is defined in the Definitions as follows:

All the expenses THE INSURER incurs to investigate, defend, mitigate, settle, arbitrate, or litigate a CLAIM covered by this Policy. This includes costs and fees for the hiring of investigators, adjusters, experts, consultants, arbitrators, mediators, and lawyers and also court and arbitration costs and costs for the attendance of witnesses other than the INSURED.

[Emphasis added.]

[69] Thus, the defined expression CLAIM EXPENSE, by its express terms, includes various types of costs or expenses. Further, the expenses that are addressed in this definition are expenses that are paid by the insurer and not expenses incurred by an insured to mitigate, for which the insured is indemnified.

[70] Second, the language of the Declarations Limit Language, under the heading "DEDUCTIBLE," repeats the same phrase and states "[a]ny one claim including costs and expenses". The question of whether the \$500,000 deductible under the Policy extends to the Mitigation of Loss Coverage was not argued before the trial judge. Instead, he provided counsel with an opportunity to do so after the Reasons were issued. In the Special Costs Reasons, the appellants advised the trial judge "that [they] no longer dispute[d] that no deductible should apply in the circumstances." It is not clear to me whether that concession was made on account of the language in the Policy or was based on what the trial judge had said in the Reasons.

[71] Having said that, the appellants now argue that the Mitigation of Loss Coverage is necessarily subject to the Deductible that is identified in the Declarations Limit Language. They advance this submission in aid of the position that mitigation coverage is not unlimited. Instead, it is both limited in amount and subject to a deductible.

[72] It may be here that it is most apparent that aspects of the Declarations and the body of the Policy were, as counsel for the respondent accepted, "cut-and-pasted together." Thus the Declarations Limit Language speaks of a "Deductible," while the Policy uses the defined expression EXCESS. Counsel for the parties agree that the words "Deductible" and EXCESS are to be treated as synonymous. Furthermore, it is conceded that the Declarations are not expressly referred to in the body of the Policy.

[73] The word EXCESS was originally defined as follows:

The first portion of the DAMAGES payable by the INSURED for each CLAIM and which amount the INSURED has agreed to pay in consideration for a reduced premium for this POLICY.

[74] That definition was expressly deleted in a "change endorsement" and replaced with the following language:

EXCESS

The first portion of the DAMAGES and/or CLAIMS EXPENSE payable by the INSURED for each CLAIM and/or CLAIM EXPENSE which amount the INSURED has agreed to pay under this POLICY.

[75] I have earlier (at paras. 32, 37, 68) provided the defined meaning of the words DAMAGES, CLAIM, and CLAIM EXPENSE respectively. The EXCESS, as reworded, is limited to the "first portion of the DAMAGES and/or CLAIM EXPENSE payable by the INSURED for each CLAIM". The Mitigation of Loss Coverage does not arise in the context of "compensatory DAMAGES [being] payable to claimants" (the definition of DAMAGES), and it does not arise in the context of a CLAIM.

[76] If the EXCESS does not extend to the Mitigation of Loss Coverage, then the words "costs and expenses" in the Declarations Limit Language, under the heading "Deductible," similarly cannot extend to the Mitigation of Loss Coverage. It must necessarily pertain to something else. Further, the revised definition of EXCESS is expressly tied to the definition of CLAIM EXPENSE.

[77] There is one other aspect of the language of the Policy that pertains to the EXCESS coverage. The main coverage provision in the Policy is prefaced with the words:

The INSURER is formally undertaking to fulfill the following four (4) obligations for the INSURED'S benefit. The INSURED'S POLICY EXCESS applies to all the obligations.

[78] The respondent argues that this provision must be read down so that its broad terms are subject to the specific language of the definitions of EXCESS and DAMAGES. The difficulty is that this language is also specific. It refers to "four" obligations and it states that the "EXCESS applies to all the obligations."

[79] The reality is that there is no principled way to read down these introductory words to the general coverage provision. They are, however, as the respondent notes, directed to EXCESS coverage and not to Mitigation of Loss Coverage, though there is some overlap in these two concepts.

[80] Finally, the trial judge addressed the Schedule that is referred to in the Damages Coverage provision and in the Limit of Liability Clause. A portion of the Schedule states:

Limit of Indemnity: CAD \$10,000,000 any one claim and in the aggregate including costs and expenses

Uninsured Excess: CAD \$500,000 each & every claim including costs

and expenses

[81] The trial judge said:

[63] Surespan's position is further supported by the reference in the Limit of Liability Clause to the Schedule. The Schedule again refers to the limit being applicable to "any one claim and in the aggregate".

[82] I agree with these conclusions. I have already addressed the trial judge's conclusions in relation to each of the words "claim," "in the aggregate," and "costs and expenses." I have also addressed the meaning of the words "deductible" and "EXCESS." Those words must have the same meaning as "Uninsured Excess" and would be subject to the same limitations. That is, the "Uninsured Excess" pertains to and is limited to DAMAGES or "compensatory damages" payable when a CLAIM is advanced.

[83] The appellants argue that the trial judge made a further error in failing to arrive at a result that was "consistent with the commercial reality". They argue, relying on Consolidated-Bathurst v. Mutual Boiler, [1980] 1 S.C.R. 888 at 901-02, which in turn was relied upon in Ledcor at para. 78, that courts must "avoid interpretations that would bring about unrealistic results or results that the parties would not have contemplated in the commercial atmosphere in which they sold or purchased the policy."

[84] In this case, the appellants argue that it is commercially unrealistic that an insurer would, on a construction project having a value of approximately \$400 million, provide mitigation of loss coverage that was unlimited. They further rely on the evidence of Mr. Pidduck, an underwriter for the appellants who the trial judge noted "was not directly involved in the negotiation of the Policy". These two considerations are different in nature, in that the evidence of Mr. Pidduck is extrinsic evidence of the parties', or at least of the insurer's, commercial expectations.

[85] There is a principled issue that arises from the submissions of the appellants. Because that issue does not, in the circumstances of this case, result in two different answers, and because the issue was not developed in the arguments of the parties, I do not consider that I should address it. Nevertheless, I do not wish these reasons to be taken as endorsing an interpretive framework that does not accord with the governing authorities.

[86] The question is the extent to which the commercial nature of an insurance contract is considered at the outset when seeking to determine the intentions of the parties. This was described as "step one" in Consolidated-Bathurst at 900. Step two was "the application, when ambiguity is found, of the contra proferentem doctrine": at 900.

- [87] Some more recent cases suggest that the commercial expectations of the parties, or interpretations that would avoid windfalls to either party, should only be considered where there is an ambiguity in the terms or language of an insurance policy. See *Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, 2006 SCC 21 at paras. 27-30; *Progressive Homes* at paras. 22-23; *Ledcor* at paras. 49-50; B. Billingsley, *General Principles of Canadian Insurance Law*, 2nd ed (Markham: LexisNexis Canada, 2014) at 146-47, 151-53.
- [88] The trial judge concluded that the language of the Policy, in failing to place any limit on the Mitigation of Loss Coverage, was unambiguous. I agree with that conclusion. It is important to understand that a contract whose terms may, in some respects, be unclear or imprecise, is not ambiguous. So too, a contract that contains some language that is troublesome or that that does not align with the contract as a whole or that cannot be fully reconciled with other aspects of the contract is not necessarily ambiguous.
- [89] A contract is ambiguous when there are "two reasonable but differing interpretations of the policy": *Sabean v. Portage La Prairie Mutual Insurance Co.*, 2017 SCC 7 at para. 42, relying on Billingsley at 147; see also *Progressive Homes* at para. 23. The Policy, though awkward in some respects, does not give rise to "two reasonable but differing interpretations".
- [90] Accordingly, if a court is only to consider the commercial expectations of the parties in circumstances where an insurance policy is ambiguous, there is no place for that analysis in the present case.
- [91] If, on the other hand, step one requires the court, when interpreting the language and meaning of an insurance policy, to consider the reasonable commercial expectations of the parties, that consideration is still otherwise constrained. The primary consideration when interpreting an insurance policy is necessarily the language that the parties have used: *Sattva* at para. 57; *Black Swan Gold Mines Ltd. v. Goldbelt Resources Ltd.* (1996), 78 B.C.A.C. 193 at paras. 19-21 (C.A.).
- [92] What the appellants seek to do, in relying on the commercial context or purpose of the Policy, is not to inform the wording of the Policy, but rather to transform its meaning.
- [93] The evidence of Mr. Pidduck is subject to other concerns. The trial judge admitted his evidence but gave it little weight. It is not clear that Mr. Pidduck's evidence was admissible. A resort to extrinsic evidence of the parties' commercial expectations may first require a finding of ambiguity: *Eli Lilly & Co. v. Novopharm Ltd.*, [1998] 2 S.C.R. 129 at para. 55. There is, again, no such ambiguity in this case.
- [94] Furthermore, the reasonable commercial expectations of the parties must necessarily be objective and not subjective. This requires an examination of the "general commercial atmosphere" rather than the "subjective belief" of either party or of the "concerns" that an insurer alone might hold. This latter form of evidence is not admissible: *Nodel v. Stewart Title Guaranty Company*, 2018 ONCA 341 at para. 18; *Sattva* at paras. 59-61; *Family Insurance Corp. v. Lombard Canada Ltd.*, 2002 SCC 48 at para. 36.

- [95] In this case, the affidavit of Mr. Pidduck sought to do various things. It addressed internal policies that described the appellants' underwriting "appetite," it described QBE's internal practices for evaluating construction policies, and it described some of the circumstances in which a construction policy "would be declined automatically and [where] no discretion could be exercised." Still further, it interpreted documents that were signed by a Mr. Thompson, who actually underwrote the Policy. There are thus some hearsay concerns with this latter evidence.
- [96] To the extent any remaining portions of Mr. Pidduck's evidence were admissible, I am satisfied that the trial judge correctly concluded that the weaknesses of that evidence "greatly reduce[d] its weight."
- [97] A further issue that is somewhat related to the parties' commercial expectations and the assertion of "commercial absurdity" was addressed by the trial judge:
- [105] I am left with a suspicion that the failure to include limits language for the Mitigation of Loss Coverage may have been an oversight on the part of QBE. The available evidence suggests that such coverage is not a common element of Canadian insurance policies. The parties were unable to find any Canadian cases interpreting this type of coverage. The Policy was individually negotiated. The potential for errors and mistakes is heightened in such a situation.
- [106] I have a suspicion that there may have been an underwriting error in granting Mitigation of Loss Coverage in a situation where all professional design professionals were covered under the policy, which impinges on the ability of the insurer to seek subrogation for its mitigation losses against the ultimate wrongdoer.
- [107] But the potential remedy for any policy drafting mistakes is rectification, which itself is controlled by a strict legal test: 5551928 Manitoba Ltd. v. Canada (Attorney General), 2019 BCCA 376. No such application for rectification was made here. Absent rectification or the applicability of some other equitable doctrine, the unambiguous words of the Policy govern, even if there has been a unilateral mistake by the insurer: PCL Constructors, at paras. 41-43; Probyn v. Sovereign Life Assurance Co. of Canada (1952), [1953] O.R. 361 at 363.
- [98] The foregoing comments address the subtext of many of the appellants' submissions insofar as it is argued that the trial judge's conclusions give rise to the unlikely result that the mitigation of loss coverage in the Policy, on a \$400 million construction project, was unlimited. However, absent a plea of mistake and rectification, neither of which is advanced in this case, it is the language of the Policy, read as a whole, that governs the relationship between the parties.
- [99] The trial judge went on, in the alternative, to develop his conclusions on the basis that the Policy was ambiguous. On account of the conclusions I have expressed, I do not consider that there is any need to do so.

[100] Accordingly, I am satisfied that this ground of appeal should be dismissed. The trial judge properly identified the legal principles that were pertinent to the question before him, and I am of the view that he properly applied those principles to his interpretation of the Policy.

4. Issue 2: Special Costs

[101] In the Special Costs Reasons, the trial judge addressed the issue of special costs in some detail. No issue is taken with the legal principles he relied upon. Instead, the appellants argue that, if successful, they should be awarded the costs of the underlying summary trial and of this appeal on the basis that "the fundamental issue below was whether the Policy Limit applies to the Mitigation of Loss Coverage."

[102] As the appellants have not succeeded on the first issue they raised, there is no basis to interfere with the award of special costs that the trial judge made.

[103] I should say, however, that I would not in any event have interfered with that special costs order. First, the trial judge expressly exempted "Surespan's costs reasonably attributable to the preparation of materials and argument of its position in relation to the applicability of the limit to the Mitigation of Loss Coverage," and in relation to two other issues that were concurrently argued by the parties and that the appellants have not appealed from the special costs order.

[104] Second, the special costs order was based on various forms of "reprehensible" conduct that were addressed in some detail by the trial judge. This included, inter alia:

- i) the appellants' failure to abide by the terms of the Winteringham Order: Special Costs Reasons at paras. 12-13, 23;
- ii) the appellants' failure to make a payment into court or to seek a stay of the Winteringham Order: at paras. 16, 18;
- iii) the appellants raising issues that they abandoned after the respondent "was forced to produce vast volumes of quantum material": at para. 15;
- iv) the appellants "ma[king] the resolution of this claim more difficult than it should have been: at para. 20; and
- v) the appellants "initially misrepresent[ing] the status of monies said to be owing": at para. 14.

[105] None of these conclusions is contested. Individually, and particularly in combination, they support the discretionary order that the trial judge made. I would also dismiss this aspect of the appellants' appeal.

5. Conclusion

[106] I would dismiss the appeal.

"The Honourable Mr. Justice Voith"

I AGREE:

"The Honourable Mr. Justice Willcock"

I AGREE:

"The Honourable Madam Justice Fenlon"

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