IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Watt v. Health Sciences Association of British Columbia,* 2015 BCSC 1290

Date: 20150724
Docket: S134066
Registry: Vancouver

Between:

Nina Watt and James Hensman

Plaintiffs

And

**Health Sciences Association of British Columbia,
Reid Johnson, Valerie Avery and Bruce MacDonald in their capacity as the Trustees of The Health Sciences Association of B.C. Trust Fund and the said The Health Sciences Association of B.C. Trust Fund,
Reid Johnson, Bruce MacDonald and Marg Beddis in their capacity as the Trustees of the HSA Ltd Trust No. 2 and the said The HSA Ltd Trust No. 2,
Reid Johnson, Bruce MacDonald, Valerie Avery and Marg Beddis in their capacity as the Trustees of the HSA Ltd Trust No. 3 and the said The HSA Ltd Trust No. 3, and
Reid Johnson, Bruce MacDonald, Valerie Avery and Marg Beddis**

Defendants

Before: The Honourable Mr. Justice Punnett

REASONS FOR JUDGMENT ON CERTIFICATION APPLICATION

Counsel for the Plaintiffs:	D.P. Church, Q.C. I. Schildt
Counsel for the Defendant Health Sciences Association of British Columbia:	C.A.B. Ferris, Q.C. A.M. Nathanson
Counsel for the Defendant Trustees:	R. Davies, Q.C. L.A. Blake
Place and Date of Trial:	Vancouver, B.C. December 8-11, 2014
	Written submissions of the Plaintiffs received April 8, 2015
	Written submissions of the Defendant Health Sciences Association received April 8, 2015
	Written submissions of the Defendant Trustees received April 8, 2015
	Written reply submissions of the Plaintiffs received April 8, 2015
Place and Date of Judgment:	Vancouver, B.C. July 24, 2015

[1] This application for class proceeding certification arises from the defendant union's alleged assumption from the employer of "responsibility" for the provision of long-term disability benefits ("LTD benefits") to its members.

[2] Both of the plaintiffs hold membership in the defendant union, the Health Sciences Association of British Columbia ("HSA"), and receive LTD benefits associated with their membership in HSA. The plaintiffs say that HSA implemented changes to the plaintiffs' LTD benefits after they commenced receiving those benefits and so claim against HSA for breach of contract, breach of fiduciary duty, as well as contravention of the *Insurance Act*, R.S.B.C. 2012, c. 1, alleging that HSA satisfies the definition of "insurer" under that legislation. The plaintiffs also claim in negligence and for breach of fiduciary duty against the individual defendant trustees (the "Trustees") who administered certain trusts that paid the plaintiffs' LTD benefits. Claims against the trusts were dismissed by consent.

[3] On this application, I must determine whether the causes of action pleaded by the plaintiffs are supportable at law and appropriate for certification as a class action, assuming that the facts pleaded are true. While the merits of the action are not in issue, if it is plain and obvious a claim cannot succeed it should be struck.

Background

[4] The plaintiffs Nina Watt and James Hensman formerly worked as health care professionals in British Columbia and are HSA members. Mr. Hensman became disabled and in 1996 commenced receiving LTD benefits. Ms. Watt also became disabled and began receipt of LTD benefits in 2004. Both remain in receipt of LTD benefits.

[5] HSA is a union certified under the *Labour Relations Code*, R.S.B.C. 1996, c. 244 [*Labour Code*], representing as bargaining agent approximately 17,000 health care and social service professionals at over 250 facilities and agencies providing acute care, long-term care and community health services.

[6] The defendants Reid Johnson, Valerie Avery, Marg Beddis and Bruce MacDonald either are or were senior officers of HSA or members of HSA's Board of Directors at material times. They were also Trustees of trusts from which LTD benefits were paid to HSA members, referred to as Trust #1, Trust #2 and Trust #3.

[7] Prior to 1986, HSA members received LTD benefits through a plan provided by the employer, the Health Labour Relations Association of British Columbia ("HLRA"), and administered by the Health and Benefit Trust. HSA negotiated the terms of that plan with the employer on behalf of its members. The terms of the plan were set out in the applicable collective agreements. The plan also provided members with group life and accidental death and dismemberment coverage.

[8] However, by 1986, it became clear to HSA that its members accessed employer-provided LTD benefits at a usage rate well below members of other bargaining units covered by the same plan. Despite that fact, HSA's members contributed to the plan at the same rate as members of these other bargaining units. Accordingly, HSA determined that it could deliver cost-effective LTD benefits to its members through an alternative structure, and thereby obtain a salary increase for its members in excess of what otherwise would have been available under wage regulation guidelines in place at the time (including the *Compensation Stabilization Act*, S.B.C. 1982, c. 32).

[9] During negotiations leading up to the 1986-1989 collective agreement between HSA and HLRA (the "Master Agreement"), HSA proposed assuming responsibility for providing LTD benefits to its members in exchange for a wage increase from HLRA. HLRA accepted that proposal, which then became Article 34.04 of the Master Agreement:

> Article 34.04
>
> (a) The Employer shall provide a mutually acceptable long term disability insurance plan, for regular, full time and regular part time employees, providing for two-thirds (2/3rds) salary continuation until age 65 in the event of disability.
>
> Employer shall pay 100% of the premium.

> (b) Notwithstanding the foregoing, as soon as practical the union will assume responsibility for the LTD Plan. At such time the Employer agrees to implement a general wage increase of 1.6% to all employees. The Employer will sign up regular full-time and regular part-time employees, as a condition of continuing employment, on such forms as the Union, or the plan carrier designated by the Union may require. The Employer will deduct an amount equal to 0.8% of each regular full time and regular part-time employee's straight time wages and remit monthly to a trust fund as designated by the Union.
>
> [Emphasis added]

[10] Under the Master Agreement, funding for the LTD benefits plan would derive entirely from contributions by HSA members, deducted from their wages by the employer. These deductions, amounting to 0.8% of straight-time wages, would be remitted to a trust designated by HSA for the purpose of providing LTD benefits to the members. In exchange, HLRA agreed to raise HSA members' wages by 1.6%, meaning that the members ultimately enjoyed a net wage increase of 0.8% under the Master Agreement, accounting for the cost of LTD benefits deductions.

[11] In the January - February 1987 edition of the "HSA Report," a newsletter published by HSA for its members, HSA advised its members as follows:

> As specified in the master contract settlement responsibility for the Long Term Disability Insurance Plan will be assumed by the union. The transfer date has been set as March 1, 1987.
>
> At this time the Employers (who now pay 100% of the premium) will grant a 1.6% general wage increase to all employees. Also at this time a .8% deduction will be taken to fund the cost of the new LTD plan. The result will be a new union-run LTD plan with improved benefits as well as a net general wage increase of .8%. There will be a brochure made available on the details of the plan well before the March 1 implementation date.
>
> [Emphasis added]

[12] From March 1, 1987 to February 28, 1989, HSA arranged to provide LTD benefits through an insurance policy with the British Columbia Life & Casualty Company ("BC Life & Casualty"), a subsidiary of Pacific Blue Cross. That policy also provided HSA members with life insurance and an accidental death or dismemberment benefit of $30,000. At various times during this period HSA increased the premiums payable by its members.

[13] By early 1989, HSA apparently determined that its LTD benefits arrangement with BC Life & Casualty was too expensive and decided that it could better serve its members' interests by establishing a trust to fund provision of LTD benefits. Under this new arrangement, termed an "administrative services only" agreement, an insurer would continue to administer the LTD benefits program, but the trust rather than the insurer would be responsible for funding LTD benefits paid to HSA members.

[14] HSA then established the "Health Sciences Association of B.C. Trust Fund" ("Trust #1") on April 1, 1989 to facilitate provision of LTD benefits, life insurance, and accidental death or dismemberment benefits to members who became disabled on or after March 1, 1989. Trust #1 is constituted by a trust agreement ("Trust #1 Agreement") executed by HSA and the three original Trustees: Douglas Bentley, Leila Lolua and Cindy Stewart. HSA described this new LTD benefits arrangement to its members in the March 1989 issue of the HSA Report:

> There are administrative changes with the HSA run long term disability plan. … The "carrier" was BC Life and Casualty; now Metropolitan Life administers the plan. This change resulted from a review conducted at the end of the contract with B.C. Life.
>
> For HSA members, the only difference is that applications for LTD will go to Metropolitan Life. As well, premiums now will go to an HSA Group Insurance Fund, rather than B.C. Life.
>
> [Emphasis added]

[15] Article 6.4 of the Trust #1 Agreement provides:

> The Trustees are authorized to establish a Plan known as the HSA Group Benefit Plan. The Trustees have the exclusive power and discretion, subject to the terms of this Agreement, to:
>
> (a) formulate the Plan;
>
> (b) from time to time amend the Plan;
>
> (c) determine the nature and extent of benefits to be provided to members;
>
> (d) determine the qualifications and conditions necessary for members to receive benefits.

[16] Article 9.01 of the Trust #1 Agreement permits the Trustees of Trust #1 to amend the Agreement, while Article 9.2 allows amendment of HSA Group Benefit Plan ("Plan #1") established under Article 6.4. Those provisions read as follows:

> 9.01 Amendment of the Agreement
>
> The Trustees may, at any time, with the consent of the Union, modify or amend this Agreement, provided however, that no modification or amendment shall be made which:
>
> (a) Alters the basic principles of this Agreement; or
>
> (b) Eliminate the requirements for audits the results of which shall be available for inspection by any Trustee, the Union or Member.
>
> 9.02 Amendment of the Plans
>
> The Trustees may with the approval of the Executive Council, at any time, modify or amend the Plans, provided however, that no amendment shall be made which is inconsistent with the basic principles of this Agreement.
>
> [Emphases added]

[17] Both Trust #1 and Plan #1 were amended from time to time. According to a brochure issued to HSA members in March 1989, the LTD benefits under Plan #1 provided disabled members with a monthly payment amounting to 66.67% of their basic earnings to a maximum of $5,000 per month.

[18] During the first decade of Plan #1's operation, HSA members brought claims under the Plan at a rate materially higher than expected. Plan #1 became underfunded as a result. This led to the reduction of LTD benefits under Plan #1 in 1995, such that disabled members received the lesser of the following: 66.67% of basic earnings to a maximum of $5,000 per month, or 85% of net earnings.

[19] The Trustees reported on the underfunding of Trust #1 at a bargaining conference prior to the 1998 round of collective bargaining, indicating that Trust #1's actuaries estimated a $6,000,000 deficit. Accordingly, the Trustees recommended that the continued funding of Trust #1 should be a priority at the upcoming collective bargaining, which was endorsed at the bargaining conference.

[20] In 1998, HSA engaged in collective bargaining with employers represented by the Health Employers Association of British Columbia ("HEABC") resulting in

recommendations issued by Special Mediator Brian Foley on January 26, 1999. These recommendations acknowledged the underfunding of Trust #1 and Mr. Foley suggested the establishment of a new trust and a plan to provide LTD benefits for HSA members. HSA and HEABC accepted those recommendations, and in so doing secured a BC government contribution of $6,000,000 to establish the new trust ("Trust #2"). HSA then closed Trust #1 to members who became disabled after February 28, 1999. HSA members who became disabled on or after March 1, 1999 received LTD benefits pursuant to a new plan ("Plan #2") funded by Trust #2.

[21] Trust #2 was constituted by a trust agreement made between HSA, Her Majesty the Queen in Right of the Province of British Columbia, as represented by the Minister of Health and Minister Responsible for Seniors and the five original Trustees: Cindy Stewart, Kelly Finlayson, Faith Uchida, Reid Johnson and Rae Johnson. Trust #2 provided that HSA members disabled prior to March 1, 1999 would continue to receive benefits from Trust #1 under Plan #1.

[22] Trust #2 also stipulated that all HSA members would continue to contribute to Trust #1 until it attained sufficient funding, at which time member contributions would instead be directed to Trust #2. At the time, the Trustees and HSA understood Trust #1's to have an unfunded liability of $3,500,000. Members of HSA continued to make contributions to Trust #1 until February 28, 2001. Beginning March 1, 2001 their contributions were instead directed to Trust #2.

[23] The purpose of Trust #2 is set out in s. 2 of its constituting document (the "Trust #2 Agreement"):

> The Fund is established and it to be maintained, and the Trustees agree to receive the Fund and to hold and administer it, for the purpose of providing, to the extend the Fund permits, LTD benefits for Participating Employees, their eligible dependants, or eligible beneficiaries, if any, as authorized under the terms of this Agreement and in accordance with the Plan and for no other purpose except as specifically provided for in this Agreement.

[24] As was the case with Trust #1, Trust #2 permitted amendment of the Trust #2 Agreement and Plan #2, both of which were amended from time to time. The relevant provisions of Trust #2 read as follows:

> Section 9.01 Amendment of the Agreement
>
> The Trustees and HSA may, at any time, by mutual agreement, modify or amend this Agreement, provided however, that no modification or amendment shall be made which:
>
> (a) Alters the basic principles of this Agreement; or
>
> (b) Eliminates the requirements for audits the results of which shall be available for inspection by any Trustee, the HSA or any Participating Employee; or
>
> (c) Has the effect of directing the Fund or any part thereof to a purpose other than the purposes and uses herein provided for; or
>
> (d) Without the consent of the Ministry allows the Fund to be used for any purpose other than providing LTD benefits to Participating Employees in accordance with the Foley Recommendations.
>
> Section 9.02 Amendment of the Plan
>
> The Trustees may, at any time, modify or amend the Plan, provided however, that no amendment shall be made which is inconsistent with the basic principles of this Agreement. Without limitation, without the consent of the Ministry, no amendment shall be made which allows the Fund to be used for any purpose other than providing LTD benefits to Participating Employees in accordance with the Foley Recommendations.

[25] From the outset, LTD benefits under Plan #2 differed slightly from those under Plan #1, providing disabled HSA members with the greater of the following: 70% of the first $4,500 of pre-disability monthly earnings plus 50% of pre-disability monthly earnings over $4,500, or, 66.67% of pre-disability monthly earnings. Those figures gradually changed over time, rising to the greater of 70% of the first $5,175 of pre-disability monthly earnings plus 50% of the excess by March 2005.

[26] Unlike Plan #1, LTD benefits under Plan #2 were initially taxable. However, as of April 1, 2005, Plan #2 changed from a taxable to a non-taxable plan and all LTD benefits were re-calculated as of that date. This re-calculation ensured that the actual amount received by a beneficiary roughly equated the after-tax amount received by the beneficiary when the benefit was taxable. The LTD benefit calculation was also adjusted downwards at this time, providing eligible members with 66.67% of the first $3,000 of monthly pre-disability earnings, 50% of the next $2,000, and 41% of the excess over and above.

[27] Between September 30, 2000 and August 3, 2006, the Trustees were advised from time to time of the combined unfunded liability of Trusts #1 and #2, which ranged in that period between $2,200,000 and $8,400,000. This unfunded liability amounted to the difference between the current value of the assets held in the Trusts and their expected growth, and the cost, as estimated by the actuaries of Plans #1 and #2, of all the benefits due as of the date of the valuation. Where the cost of the benefits payable under the Plans exceeded the value of the assets in the Trusts, the difference was the unfunded liability.

[28] Given the unfortunate performance of the employee-funded LTD benefits Plans, HSA decided that its assumption of responsibility for LTD benefits no longer represented the best interests of its members. As part of its bargaining plan it resolved it would seek to return this responsibility to the employer.

[29] Between January 2006 and March 2006, HSA engaged in collective bargaining for a new collective agreement. At that time, Trusts #1 and #2 were understood by HSA to be in a combined deficit position of approximately $12,000,000. During those negotiations, the employers agreed to assume responsibility for providing LTD benefits to employees by way of membership in HSA, with contributions to be jointly funded by the employers and HSA members. This arrangement replaced Plan #2 going forward and applied to HSA members who became disabled on or after August 4, 2006. Contributions to Trust #2 ceased on August 3, 2006.

[30] However, the employer did not agree to take responsibility for members already receiving LTD benefits under Plans #1 and #2. Those members continued to receive benefits under those Plans, funded by their respective Trusts. The employer similarly declined to assume responsibility for the unfunded liability of the Plans.

[31] As part of the 2006 collective bargaining, the employer offered a signing bonus of $3,300 to each full-time employee or a pro-rated sum for each part-time employee upon acceptance and ratification of the new collective agreement. This bonus totalled $45,870,000. The bargaining committee agreed with the Trustees to

provide funds out of the signing bonus amounts to address the deficits in Trusts #1 and #2, supplemented by another $5,000,000 provided as a contingency fund for a total of $17,000,000 (the "LTD Stabilization Grant"). At the time, HSA understood that this figure would be sufficient to eliminate the accrued deficiency in the Trusts.

[32] HSA settled the LTD Stabilization Grant into a new trust in April 2006 ("Trust #3"), constituted by a trust agreement between HSA and the three original Trustees Cindy Stewart, Brian Isberg and Reid Johnson ("Trust #3 Agreement"). HSA intended for Trust #3 to provide funding for LTD benefits under Plans #1 and #2, once either or both of Trusts #1 and #2 became exhausted. Article 2.4 of Trust #3 allowed the Trustees to determine the nature and extent of the LTD benefits to be provided ("Plan #3"). Article 8.1 of Trust #3 allowed the trustees and HSA to amend the Agreement. Trust #3 and Plan #3 were amended from time to time.

[33] Article 2.2 of Trust #3 provides:

> 2.2 Purpose
>
> The Fund is established and is to be maintained, and the Trustees agreed to hold and administer it, for the purposes set out in Recital E of this Agreement and for no other purpose except as specifically provided for in this Agreement in accordance with the terms and conditions of this Agreement.

[34] Article 2.3 of Trust #3 provides:

> 2.3 Limitation on Rights to the Fund
>
> The following limitations shall apply to the rights to, interest in, or use of, the Fund:
>
> (a) Neither of the HSA nor any other person, firm, corporation, society or association shall have any right, title, interest, in or to the Fund, except as specifically provided by this Agreement;
>
> (b) Except as otherwise provided in this Agreement, no part of the Fund is to be used for or diverted to purposes other than those set forth in Article 2.2 hereof; and
>
> (c) No money, property, equity or interest of any nature whatsoever in the Fund or any benefits or monies payable therefrom shall be subject in any manner to sale, transfer, alienation, assignment, encumbrance, garnishment, lien or charge by any person in receipt of

> or eligible to receive LTD benefits hereunder or any person claiming through any such person.

[35] Article 2.4 of Trust #3 provides:

> 2.4 The Plan
>
> The Trustees are authorized and directed to establish a program of LTD benefits consistent with the purposes of the Fund set forth in Article 2.2 hereof and the Trustees have the exclusive power and discretion to:
>
> (a) Formulate the plan;
>
> (b) From time to time change or amend the plan or establish a successor plan with or without retroactive effect;
>
> (c) Determine the nature and extent of the LTD benefits to be provided; and
>
> (d) Determine the qualifications and conditions necessary to receive LTD benefits;
>
> Provided, however, that no modification or amendment to the plan shall be made which allows the Fund to be used for any purpose other than those set forth in Article 2.2 hereof.

[36] Article 8.1 of Trust #3 provides:

> 8.1 Amendment of the Agreement
>
> The Trustees and HSA may from time to time, by mutual agreement, modify or amend this Agreement as the HSA and the Trustees in their absolute discretion may decide, including without limitation modifications or amendments which revoke surplus entitlement under Article 8.5(c) or 8.5(d) upon wind up and termination, provided however that no modification or amendment shall be made which:
>
> (a) Eliminates the requirements for audits the results of which shall be available for inspection by any Trustee and the HSA; or
>
> (b) Has the effect of directing the Fund or any part thereof to a purpose other than the purposes and uses herein provided for.

[37] Unfortunately, the LTD Stabilization Grant fell short, as the unfunded liabilities under Trusts #1 and #2 were greater than anticipated. In February 2008, actuaries for the union advised that as a result of a change in their valuation assumptions, the increased liability now amounted to $16,000,000, almost the entirety of the funds in

the LTD Stabilization Grant. In September 2008, a further revaluation showed a combined unfunded liability for Trusts #1, #2 and #3 of $7,079,375.

[38] Further investigations resulted in the Trustees concluding in early 2010 that the cost of benefits under Plans #1 and #2 materially exceeded the assets available to pay those future benefits in Trusts #1, #2 and #3. This shortfall was caused by a number of factors including the cessation of contributions to the funds, a decline in the value of the funds' investments due to the economic downturn in 2008 and the underestimating of the shortfall by the Trustees' actuary. The Trustees of the three Trusts determined that action had to be taken to ensure the plans did not end up bankrupt. As a result the Trustees took a number of steps.

[39] In 2010, the Trustees of Trust #2 decided to suspend the indexing provision for future payments to LTD beneficiaries under Plan #2. In early 2010, the Trustees of all three Trusts began to consider other options available to address the unfunded liabilities, including:

a. reducing claims costs;

b. discontinuing indexing of benefits, reducing expenses;

c. utilizing other sources of income for people with disabilities that make them unable to work;

d. implementing early retirement programs;

e. reinstating contributions;

f. sharing the cost for the enhanced healthcare;

g. redesigning the benefit formula; and

h. possibly having a third party purchase the Plans.

[40] The Trustees determined that if the Trusts ran out of funds before all of the beneficiaries under the Plans turned 65, the youngest beneficiaries would be those

most severely affected, because of the terms of the pension plan and because these persons would have to wait for a greater period of time before becoming eligible to receive retirement benefits in lieu of LTD. By the end of 2010, the Trustees concluded that the options noted above would not adequately address the unfunded liabilities under the Plans, necessitating consideration of other more drastic measures such as a reduction to benefit levels or an assessment against active members.

[41] After communicating with the LTD benefit recipients in early 2012, the Trustees approved an option providing for a reduction in LTD benefits and early retirement. At this time, HSA and the Trustees had been advised that the unfunded liability under the Trusts amounted to approximately $31,000,000. In March 2012, the beneficiaries under Plan #1 were informed that one of three things was going to occur:

a. their claim would close due to mandatory retirement and if they qualified for a lump sum payment, the amount of that lump sum payment,

b. their claim would close due to voluntary retirement, or

c. their claim could remain active with reduced benefits or that their claim would remain active with reduced benefits.

[42] The proposed reduction would decrease by 7% the first $500 in gross benefit received, 13.9% for the next $500, with the reduction increasing by 7% per $500 tier thereafter until reaching a maximum reduction of 69.7% for gross benefits received over $5000 per month. Ancillary benefits such as life insurance and accidental death or dismemberment benefits would no longer be available to beneficiaries.

[43] As of March 27, 2012 all beneficiaries then receiving benefits from Trust #2 commenced instead to receive their benefits from Trust #3, Division 2.

[44] HSA membership declined to take action to rectify the underfunding of the Trusts. At HSA's 2012 Annual General Meeting, held in April of that year, the issue was discussed, and delegates asked to adopt an extraordinary resolution. This resolution would seek an increase in union dues to maintain the LTD benefits for disabled members under Plans members on disability under Plans #1, #2 and #3 at current levels. The issue went to a referendum vote in July 2012 as follows:

> *Do you support an increase of HSA union dues from the current rate of 1.6% of earning to 2% of earning in order to preserve long term disability benefits at January 2012 levels for HSA members covered by the HSA Ltd Trusts?*

[45] If successful, the dues increase would need to remain in place for ten years, generating a total of $31,000,000 in revenue for the Trusts. The Board of Directors of HSA opposed the increase in dues for a number of reasons, and indicated their opposition in referendum materials. They explained as follows:

> The board is opposed to the increase in dues. We arrived at this position based on the following:
>
> 1. The reduced benefits payable from the HSA LTD Trusts provide reasonable protection for disabled members. Those with smaller monthly benefits saw smaller percentage reductions in benefits than those with larger benefits. *After the reduction, the average monthly income for disabled members is around $2,100, tax free.*
> 2. Pensions for disabled members of the HSA LTD Trusts are often larger than those retiring from the active workforce. The average pensionable service for those disabled members moved to retirement was close to 26 years. The average pensionable service for those retiring from the active workforce is around 17 - 18 years. *Because of this service difference, disabled members moving to retirement will on average receive 40-50% higher pensions than those retiring from the active workforce. In addition, some of the disabled members moved to retirement will receive lump sum payments on closure of their LTD claim*.
> 3. Active members have already committed significant funds to the HSA LTD Trusts.
>
> a. Prior to August 2006, member premiums were increased to cover the shortfalls at the time.
>
> b. In 1998, $6 million was negotiated in bargaining to address the shortfall,

c. In 2006, $17 million of the signing bonus offered by government was directed to the Trusts to support the 350 members collecting benefits at that time.

4. Because of government restraint and "net zero" bargaining, active members have gained extremely low increases in pay for some time.

Your board of directors must act in the interests of all members. We believe that the changes put in place by plan trustees are the fairest to all parties. Disabled members in the HSA LTD Trusts will continue to receive reasonable protection. Active HSA members have made substantial contributions to the HSA LTD Trusts in the past. The board does not believe that another substantial commitment of active members to the HSA LTD Trusts is warranted.

We encourage you to read the information included in this package, and to talk to the stewards and members at your workplace who attended the convention, or your representative on the Board of Directors, so that you can make an informed decision about whether to increase your union dues to fund the HSA LTD Trusts.

[46] HSA detailed the history of the Trusts as follows in the referendum materials:

For the past several years, LTD Trustees have been struggling with the union's long term disability Trusts (A), which were heading to insolvency. Bankruptcy was not an option, and a viable financial rescue plan could not be found. In February this year, after much deliberation, the Trustees changed the trust rules to reduce the number of people collecting LTD payments, and reduced benefits paid out in order to avoid bankruptcy of the Trusts, which would have occurred in as little as five years. Without those changes, the Trusts would be bankrupt and members on LTD would receive no payments at all by 2017.

The issue of reducing benefits to the 220 members on the HSA Trusts was raised at the union's convention in April 2012. Delegates and members requested the union's board of directors to ask all HSA members if they would consider an increase in union dues to maintain the monthly benefits of those LTD beneficiaries at the level they were prior to the changes implemented by the Trustees.

If monthly benefits were maintained at an unreduced amount, [that is], at the level they were prior to the changes implemented by the Trustees, the Trusts would incur a $31 million unfunded liability. HSA members currently pay 1.6% of income in dues. In order to offset this liability, union dues for all HSA members would increase to 2% of income (a 25% increase) for the next 10 years.

HISTORY OF THE LTD TRUSTS

In the late 1980s, the union decided that because the government refused to pay for wage increases in the public sector under wage restraint legislation, HSA would look for money somewhere else to ensure members got a raise. In 1989, thousands of members were paying into the government-

> administered LTD fund. The usage rate by HSA members was well below other health care workers, but HSA members were paying the same premium rate as others. The union decided to take over the plan. HSA members got an income increase by paying a lower amount for the LTD plan.
>
> However, the usage rate started to rise significantly and costs escalated in order to pay members on LTD, but the premiums were not increased. An unfunded liability began to build. …
>
> Over the years, the unfunded liability was addressed by reducing benefits, capping the maximum, increasing the waiting time, limiting health and welfare benefits, not offering indexing on all plans, increasing the contribution rate (some rate increases were offset by negotiations at the bargaining table) and reducing administration costs.
>
> Management of the fund was eventually moved to a management company, and Trustees were convinced that trends would stabilize and there would be no need for increased premium payments.
>
> In bargaining in the late 1990s, HSA negotiated $6.1 million for the LTD Trusts to cover the shortfall.
>
> The union learned quickly that $6.1 million was not enough. The unfunded liability grew to $13 million. Through good management the trusts started to address the unfunded liability by changed the investment portfolio and started to get better returns. But then investment returns stalled and premiums paid by members were increased.
>
> Since the mid-1990s, returning the LTD plan to the employer to administer became a union demand at every bargaining round.
>
> In 2006 bargaining … HSA successfully negotiated the return of the LTD plan to the employer. HEABC took it over, with members paying 30% of the premium instead of the previous 100%. Members paid $17 million of a signing bonus into the HSA LTD Trusts to address the liability of the HSA plan, and the premiums paid by members for LTD were reduced by 70 per cent, which meant increased real income for HSA members. However, HEABC refused to take the HSA members already receiving LTD benefits into the new plan. The HSA Trusts were closed to new claimants and no further contributions flowed in. A year later, with positive investment returns, the HSA Trusts were in surplus.
>
> In 2008, the global financial and equity markets collapsed. … In the course of just one year, the HSA LTD Trusts lost $5 million on an asset of $45 million. … The Trusts continued to pay benefits from an asset of declining value, …
>
> The unfunded liability continued to grow, and in February 2012 the Trustees of the HSA LTD Trusts changed the trust rules: members who had enough pensionable service were moved off of LTD benefits to the Municipal Pension Plan effective July 2012, and LTD benefit payments were reduced an average of 23 per cent effective July 2012.

[47] HSA membership rejected the proposal for a dues increase by a margin of 84% to 16%, with 30% of the total HSA membership voting in the Referendum.

[48] At the Board of Trustees' Meeting for Trusts #1, #2 and #3 on September 21, 2012 the Trustees adopted a Resolution to amend Plans #1 and #3, effective as of June 1, 2012. This amendment adopted the proposed reduction in LTD benefits and introduced the mandatory early retirement program. The actuary to the Plans advised the Trustees that as a result of the reductions in LTD benefits, the unfunded liability of the Plans had diminished to approximately $100,000.

The Claims and Claimants

[49] On behalf of the disabled HSA members, the two proposed representative plaintiffs seek to recover the damages suffered as a result of the reduction and termination of LTD benefits under the various Plans.

[50] As noted, Mr. Hensman is a former health care professional and current member of HSA. He began working as a respiratory therapist in 1986 and joined HSA in 1990. In or around 1996 he developed health issues and as a result applied for LTD benefits at that time. He continues to receive those benefits.

[51] Ms. Watt is also a former health care professional. She began working as an X-Ray Technologist in 1994, joining HSA in 1994. She fell ill in October 2003. In 2004 she applied for and began receiving LTD benefits. She continues to do so.

[52] The plaintiffs seek certification of their action as a class proceeding pursuant to the *Class Proceedings Act,* R.S.B.C. 1996, c. 50 [*CPA*]. They advance their claims against the defendant HSA in breach of contract, breach of fiduciary duty and contravention of the *Insurance Act*. They also claim against the defendant Trustees for negligence and breach of fiduciary duty.

[53] The contractual claim against HSA focuses on the allegation that HSA contracted with its members to provide LTD benefits and that the subsequent reductions in LTD benefits amount to a breach of that contract. The plaintiffs refer to the alleged contracts as LTD Agreements #1 and #2 (collectively, the “LTD Agreements”). LTD Agreement #1 relates to benefits provided under Plan #1 and LTD Agreement #2 relates to benefits provided under Plan #2.

[54] In the alternative the plaintiffs assert that HSA breached its fiduciary duty to the disabled HSA members receiving benefits under Plans #1 and #2. The pleadings allege that HSA had a fiduciary duty to the disabled members because it established the trust funds to manage LTD and related benefits to the members, retained control over the trust structure and as a result took on fiduciary duties directly or as a trustee *de son tort*.

[55] Respecting the plaintiffs' claims against the Trustees, the plaintiffs identify the individual defendants as Trustees and the disabled HSA members as beneficiaries. They submit that the Trustees breached fiduciary duties owed to the plaintiffs by failing to ensure the Trusts were sufficiently funded and by actively opposing the referendum seeking increased contribution to the Trusts by way of increased union dues. They also say that the Trustees acted negligently in managing the Trusts.

[56] The defendants raise a number of issues in response to the certification application. Primarily, they say that the plaintiffs' pleadings do not disclose reasonable causes of action, arguing the absence of the requisite evidentiary basis to satisfy certification requirements. The defendants also say that there are no common issues that can be certified and submit that a class proceeding is not the preferable procedure for resolution of the issues.

[57] I turn now to the requirements for certification.

Certification Requirements

[58] Certification of a class proceeding considers the form of the action and whether it should proceed as a class proceeding: *Hollick v. Toronto (City),* 2001 SCC 68 at para. 16; *Pro-Sys Consultants Ltd. v. Microsoft Corporation,* 2013 SCC 57 at para. 99 [*Pro-Sys*]; *Watson v. Bank of America Corp.,* 2014 BCSC 532 at para. 58. Section 4(1) of the *CPA* sets out the requirements for certification:

> **4** (1) The court must certify a proceeding as a class proceeding on an application under section 2 or 3 if all of the following requirements are met:
>
> (a) the pleadings disclose a cause of action;

> (b) there is an identifiable class of 2 or more persons;
>
> (c) the claims of the class members raise common issues, whether or not those common issues predominate over issues affecting only individual members;
>
> (d) a class proceeding would be the preferable procedure for the fair and efficient resolution of the common issues;
>
> (e) there is a representative plaintiff who
>
> (i) would fairly and adequately represent the interests of the class,
>
> (ii) has produced a plan for the proceeding that sets out a workable method of advancing the proceeding on behalf of the class and of notifying class members of the proceeding, and
>
> (iii) does not have, on the common issues, an interest that is in conflict with the interests of other class members.

[59] As explained by Bauman C.J.S.C. (as he then was) in *Watson*:

> [60] Subsection (a) requires that the pleadings disclose a cause of action. This requirement is assessed on the same standard as on a motion to strike pleadings under Rule 9-5(1)(a). Accordingly, the plaintiff satisfies this requirement unless it is plain and obvious that the claim cannot succeed: *Hollick* at para. 25; *Microsoft* at para. 63. For this analysis, the Court must assume that all the pleaded facts are true unless they are patently unreasonable or incapable of proof. Further, a claim must not be struck merely because it is novel or complex: *Hunt v. Carey Canada Inc*., [1990] 2 S.C.R. 959 at 980.
>
> [61] Subsections 4(1)(b)-(e) of the *CPA* require the plaintiff to show "some basis in fact" for each requirement: *Hollick* at para. 25. The plaintiff must show that there is some basis in fact which establishes each of the four requirements, but does not need to establish some basis in fact for the claim itself. Again, the Court is concerned with the appropriateness of a class proceeding, not the strength of the claim. Further, courts are ill-equipped to resolve conflicts in the evidence at certification: *Microsoft* at paras. 100-102.
>
> [62] There is limited utility in attempting to define the "some basis in fact" standard in the abstract; each case must be decided on its own facts. The standard does not require proof on a balance of probabilities, but it requires more than a symbolic scrutiny of the sufficiency of the evidence. Ultimately, the Court must be satisfied "that the conditions for certification have been met to a degree that allow the matter to proceed on a class basis without

> foundering at the merits stage by reason of the requirements of s. 4(1) of the *CPA* not having been met": *Microsoft* at paras. 103-104.

[60] With the *CPA* and these principles in mind I address each of the requirements for certification below.

Section 4(1)(a): Cause of Action Disclosed by the Pleadings

[61] As noted, s. 4(1)(a) of the *CPA* makes class certification contingent upon the proceedings disclosing a cause of action. The courts assess this issue on the same standard applied on a motion to dismiss: *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959 at paras. 32-34.

[62] Rule 3-1(2) of the *Supreme Court Civil Rules*, B.C. Reg. 168/2009, requires that a notice of civil claim set out a concise statement of the material facts giving rise to the claim. Under Rule 9-5(1)(a) pleadings may be struck if they disclose no reasonable claim. No evidence is admissible on an application to strike pleadings: Rule 9-5(2). The basis for striking pleadings in such circumstances is that the case cannot succeed as a matter of law: *Drummond v. Moore,* 2012 BCSC 496 at paras. 16-23.

[63] Pleadings will only be struck if it is plain and obvious, assuming the truth of the facts pleaded, that no reasonable cause of action is disclosed. The Court will not assume to be true allegations incapable of proof: *Young v. Borzoni et al,* 2007 BCCA 16 at paras. 30-32. If there is a reasonable prospect of success, the matter should not be struck but should be allowed to proceed to trial: *R. v. Imperial Tobacco Canada Ltd.*, 2011 SCC 42 at para. 17. On the other hand, if it is plain and obvious that the claims cannot succeed, no reasonable claim is disclosed: *Pro-Sys*, at para. 63.

Do the Plaintiffs' Pleadings Disclose a Cause of Action in Contract?

[64] The plaintiffs' contractual argument hinges on the existence of an agreement between HSA and the plaintiffs relating to their responsibility to provide HSA's disabled members with LTD benefits. The plaintiffs must plead sufficient facts to

meet the threshold found at s. 4(1)(a) of the *CPA*. A bare assertion of a cause of action unsupported by sufficient facts will not meet the requirements under the *CPA*.

[65] That said, if the parties dispute the existence of material facts about the contract, such issues generally cannot be resolved at this stage of the proceeding. In *Spina v. Shoppers Drug Mart Inc.,* 2012 ONSC 5563, Perell J. noted the following in relation to analogous provisions of the Ontario class action legislation and rules of civil procedure:

> [116] Generally speaking, in the context of an alleged breach of contract, Rule 21 is not designed to answer questions of law where materials facts about the contract dispute are in dispute: .... Where the question of law turns on the construction of a contract with unclear or ambiguous terms, a Rule 21 motion, is not an appropriate way to resolve the legal question: ... a court should be loathe to construe a contract in the absence of evidence as to the surrounding circumstances and business context in which the contract was negotiated and signed.
>
> [117] However, conversely, if the factual nexus is not contentious and the construction of the contract is a matter of applying principles of contract interpretation, which are issues of law, then a Rule 21 motion may be an appropriate way to resolve the legal issue or to determine whether the plaintiff has shown a reasonable cause of action.

[66] In this case HSA challenges both the legal and factual existence of a contract, and argues that as a matter of law the plaintiffs' claim in contract cannot succeed. HSA in its written argument submits that it merely assumed responsibility "for setting up a new LTD plan" to be funded by the members and did not take on contractual responsibility for providing LTD benefits to HSA's disabled members. HSA further contends that legally, it could not under the collective agreement make a contract with itself, as it negotiated as agent for the members, not as an adverse party to the members. It says there is no authority for a union and its members to enter into a contract beyond the membership agreement formed when a person joins a union. HSA argues that the contractual framework asserted by the plaintiffs simply does not apply to the relationship between a union and its members.

[67] The assertion that there is no existing authority that a union and its members can enter into a contract beyond the membership agreement does not mean such a claim cannot be advanced. The circumstances giving rise to this application may

well be unique, given unions apparently do not generally provide LTD benefits to their members. However, just because there is no authority addressing the issue, or that no union has entered into such a contract previously, does not mean that this is impossible to do. Indeed, as Macaulay J. recognized in *Collette v. Great Pacific Management et al*, 2001 BCSC 237, the novelty of the cause of action raised on an application for certification ought not militate against the plaintiffs (para. 36) and the law "must be allowed to evolve" (*Spina,* at para. 111).

[68] It is the unique circumstances of a union, the bargaining agent of the members in negotiating collective agreements that gives rise to HSA's objection. As related earlier, HSA assumed responsibility for LTD benefits from the employer in the course of its negotiations. HSA states it did not take over contractual responsibility for the LTD plan, but instead asserts that it settled and established a benefit trust that would provide and administer LTD benefits for HSA members. On the other hand the plaintiffs state that HSA did take over responsibility, in contract, for ensuring that an LTD benefits plan was in place for HSA's disabled members.

[69] In *Berry v. Pulley*, 2002 SCC 40, Justice Iacobucci writing for a unanimous Supreme Court of Canada addressed the nature of a union as follows:

> 3 Since these early cases, the field of labour relations has become increasingly sophisticated and regulated, with the granting of significant statutory powers and duties to trade unions. In light of these developments, unions have come to be recognized as entities which possess a legal personality with respect to their labour relations role. This status not only allows a union member to bring suit against his or her union directly, but also enables the union to enter into contracts of membership with each of its members. [Emphasis added]

[70] The Court in *Berry* considered whether a union member could claim damages in breach of contract against other union members, based on the terms of the union constitution. To resolve that question, the Court addressed more generally the nature of the obligations between union members and the legal status of unions. The Court held that the modern legal context no longer required continuance of the notion that a complex of contracts binds union members to one another; it is no longer necessary to uphold the notion that each union member has a contract with

every other member (para. 4). Instead, the Court said this about the legal status of unions:

> 5 … the recognition of the legal status of trade unions enables the adoption of a more common sense approach, namely, that each union member has a contractual relationship with the union itself. This relationship is based on the constating documents of the union, although it must be read in light of the statutory labour relations regime and governing principles of labour law which regulate unions and their activities. [Emphasis added]

[71] The case at bar raises similar issues: firstly, whether a union is restricted as a legal entity to obligations arising from its function in the field of labour relations, or in other words, given the nature of the contract between a union and its members, which is one of adhesion, what contractual powers can the union or its members exercise? Secondly, if the union can only assume obligations arising from its role as a bargaining agent for its members, is the alleged contract in issue one that arises from the union's role in the field of labour relations?

[72] The *Labour Code* stipulates:

> **Legal entity**
>
> **154** Every trade union and every employers' organization is a legal entity for the purposes of this Code.

[73] The *Labour Code* further provides that a bargaining agent means "a trade union certified by the board as an agent to bargain collectively for an appropriate bargaining unit" in s. 1(1). It also states:

> **1** (1) …
>
> **"collective agreement"** means a written agreement between an employer, or an employers' organization authorized by the employer, and a trade union, providing for rates of pay, hours of work or other conditions of employment, which may include compensation to a dependent contractor for furnishing his or her own tools, vehicles, equipment, machinery, material or any other thing;
>
> **"collective bargaining"** means negotiating in good faith with a view to the conclusion of a collective agreement or its renewal or revision, or to the regulation of relations between an employer and employees;
>
> …

> **"employer"** means a person who employs one or more employees or uses the services of one or more dependent contractors and includes an employers' organization;
>
> …
>
> **"trade union"** means a local or Provincial organization or association of employees, or a local or Provincial branch of a national or international organization or association of employees in British Columbia, that has as one of its purposes the regulation in British Columbia of relations between employers and employees through collective bargaining, and includes an association or council of trade unions, but not an organization or association of employees that is dominated or influenced by an employer;
>
> **"unit"** means an employee or a group of employees, and the expression **"appropriate for collective bargaining"** or **"appropriate bargaining unit"**, with reference to a unit, means a unit determined by the board to be appropriate for collective bargaining, whether it is an employer unit, craft unit, technical unit, plant unit or another unit, and whether or not the employees in it are employed by one or more employers.

[74] As a result a trade union is the representative of the employees for the purposes of collective bargaining with an employer.

[75] In my view, the issue of whether HSA possesses the legal status necessary to enter into the alleged agreements with the plaintiffs turns on the meaning of the following passages in *Berry*:

> 46 As the above cases and statutory provisions suggest, the world of labour relations in Canada has evolved considerably since the decision of this Court in *Orchard*, *supra*. We now have a sophisticated statutory regime under which trade unions are recognized as entities with significant rights and obligations. As part of this gradual evolution the view has emerged that, by conferring these rights and obligations on trade unions, legislatures have intended, absent express legislative provisions to the contrary, to bestow on these entities the legal status to sue and be sued in their own name. As such, unions are legal entities **at least** for the purpose of discharging their function and performing their role in the field of labour relations. It follows from this that, in such a proceeding, a union may be held liable to the extent of its own assets.
>
> 47 Viewed in this modern context, the proposition that a trade union does not have the legal status to enter into **contracts** with its members is implausible. The impediments that prevented Rand J. in *Orchard*, *supra*, from holding that by joining a union, the member contracts directly with the union as a legal entity, have been overcome. In order for trade unions to fulfill their labour relations functions, it is essential for unions to control and regulate their internal affairs. Since the regulation of union membership is a

> fundamental part of the role of trade unions, it is only logical that it should fall within the sphere of activities for which unions have legal status. It follows that unions must have sufficient legal personality to enter into contracts of membership, and that this is an aspect of union affairs for which legislatures have impliedly conferred legal status on unions. In addition, I agree with Lord Morton's statement in *Bonsor*, *supra*, that there are no "vital differences" between an action in tort and an action in breach of contract brought by a member against the union, and to draw a line between the legal status to be sued in tort and the legal status to enter into contracts with its members is arbitrary and illogical.
>
> 48 In light of the above, the time has come to recognize formally that when a member joins a union, a relationship in the nature of a contract arises between the member and the trade union *as a legal entity*. By the act of membership, both the union and the member agree to be bound by the terms of the union constitution, and an action may be brought by a member against the union for its breach; however, since the union itself is the contracting party, the liability of the union is limited to the assets of the union and cannot extend to its members personally. I say that this relationship is in the *nature* of a contract because it is unlike a typical commercial contract. Although the relationship includes at least some of the indicia of a common law contract (for example offer and acceptance), the terms of the contractual relationship between the union and the member will be greatly determined by the statutory regime affecting unions generally as well as the labour law principles that courts have fashioned over the years. With this in mind, for ease of reference I will refer to the membership agreement between the individual member and the union as a contract.
>
> [Emphasis in original -- Italics]
>
> [Emphases added]

[76] In making these statements, the Court noted that the contractual powers of a union differ from those of a commercial entity:

> 49 Having said that there exists an enforceable contract between union members and the union, I believe it is worth elaborating on several factors which make this contract unique. First, it is essentially an adhesion contract as, practically speaking, the applicant has no bargaining power with the union. Moreover, in many situations, union membership is a prerequisite to employment, leaving the individual with little choice but to accept the contract and its terms. Finally, it must be borne in mind that a statutory labour relations scheme is superimposed over the contract between the member and the union, and can create legal obligations. Consequently, the contract must be viewed in this overall statutory context. For example, the statutory right of members to be represented by the union of their choice implies that the contract only exists as long as the members maintain that union as their bargaining agent, and no penalty could be imposed by the contract against members for exercising this statutory right. As it is not necessary to interpret the terms of the membership contract or determine its scope on the facts of this case, I decline from elaborating further on these matters. I simply note

> that the unique character and context of this contract, as well as the nature of the questions in issue, will necessarily inform its construction in any given situation.

[77] The plaintiffs submit that the membership contract does not exhaust a union's ability to enter into agreements with its members. They note that in *Berry* the Court held that "unions are legal entities at least for the purpose of discharging their function and performing their role in the field of labour relations" (para. 46). The plaintiffs say that the words "at least" indicate that the ability of a union to contract with its members is the minimum of its contractual powers and that our highest Court contemplated a union assuming contractual obligations which exceed this baseline.

[78] *Berry* addressed the legal status of unions solely within the context of their capacity to contract in the labour relations field. The Court emphasized this point by stating that the legal recognition accorded to unions does not automatically extend to other unincorporated associations, and further by expressly attributing the unique status of unions in this regard to the "complex labour relations regime governing their existence and operations" (para. 51). Iacobucci J. then enumerated factors specific to the field of labour relations which are addressed by granting *sui generis* legal status to unions:

> 59 However, apart from the fact that there were and are remedies available to the appellants in these particular circumstances, on a more general level, it seems problematic for a court to fill legislative gaps in the labour relations scheme by contorting what is essentially a contractual metaphor into a basis for a breach of contract action. Absent an independent basis for recognizing a breach of contract action between members, the mere argument that there exists a legislative gap is insufficient justification for transforming this contractual metaphor, initially created to provide a foundation for finding group liability, into a concrete basis which allows for personal liability to exist between union members.

[79] Therefore, I must next evaluate whether the parameters of the union's labour relations role include contracts such as those alleged here. That is, can a union contract to provide LTD benefits to its members as a whole? In doing so is it contracting within the parameters established by the Court in *Berry*?

[80] As noted, the Supreme Court of Canada in *Berry* dealt with the contractual relationship between a union and its members in the context of the union's constitution. However, it is not clear that in doing so, the Court restricted the contractual powers of a union only to that factual situation and to such contracts. Had such a result been intended, it could have been stated but was not.

[81] The plaintiffs submit that there is no reason why the agreement of a union to provide benefits to its members would not fall within the scope of the field of labour relations, or the union's role as bargaining agent within that field. They also note that as conceded by HSA, a union has the ability to enter into contracts for matters such as the supply of office materials and presumably contracts of employment. In addition, HSA entered into a policy of insurance with BC Life & Casualty in March 1987 and has entered into the three Trust Agreements at issue in this proceeding. They submit that if HSA is able to enter into all of these agreements, it must also have sufficient legal status to enter into the LTD Agreements.

[82] The plaintiffs further say that there is nothing in the *Labour Code* that limits a union's ability to contract. While HSA argues that s. 27 sets out the entirety of the rights and obligations as regards their membership in HSA, the plaintiffs say that s. 27 merely provides a certified trade union with "exclusive authority to bargain collectively" in certain circumstances. In other words, the plaintiffs take the position that s. 27 does not limit HSA's obligations to its members.

[83] In addition, the plaintiffs submit that there is nothing in HSA's constitution which limits its power to enter into contracts noting, to the contrary, that Article 3(b) provides that one of HSA's "objects and purposes" is to "regulate relations between employees and employers through collective bargaining, and to establish and maintain the best possible standards of pay, benefits, and other working conditions." The plaintiffs submit that entering into the LTD Agreements is consistent with that mandate.

[84] I note that HSA did not advance any authority for the proposition that as a union, it lacked capacity to enter into the alleged LTD Agreements. As noted earlier

that may be a result of the unique facts of this case, as apparently no other similar arrangement by a union to provide LTD benefits to its members exists.

[85] While it is clear that HSA acted in its capacity as a bargaining agent for the members when it negotiated "to assume responsibility for providing the long term disability plan" HSA's characterization of the relationship, that is that the union would be contracting with itself, is not the end of the matter.

[86] In my opinion, while HSA acted as an agent for its members when negotiating with the employer as the members' bargaining agent, when it allegedly assumed responsibility for LTD benefits it potentially entered into a contractual relationship with its members. In other words, the union acted merely as an agent for its members where it negotiated with third parties, but may have assumed a different legal status where HSA itself undertook obligations owed to the members distinct from HSA's own duty to negotiate.

[87] The contractual claims advanced by the plaintiffs appear to accord with HSA's own characterization of the events, that is, that HSA "proposed assuming responsibility for providing the long term disability plan" from the employer, a proposal which the employer accepted during the 1986 collective bargaining. It is clear that the employer's obligation was contractual with regard to the provision of LTD benefits. That is, the previous collective agreement in which the employer provided LTD benefits formed a contract obliging the employer to provide HSA's disabled members with LTD benefits (see *Ali v. Manufacturers Life Insurance Co.,* 2005 BCCA 294 at paras. 7-10). There is little before me to suggest that HSA altered the nature of the employer's responsibility to HSA's disabled members when it allegedly assumed that from the employer.

[88] I conclude that it is not plain and obvious that a union cannot enter into such a contract with its members. I now consider whether the pleadings support the contractual claims advanced by the plaintiffs.

[89] For its part, HSA submits that the plaintiffs have not pleaded sufficient material facts to support their breach of contract claim, specifically citing an alleged absence of the following:

a. details as to how the alleged contracts were formed;

b. sufficient particulars of the documents that gave rise to each of the contracts;

c. sufficient particulars of the terms of the alleged contracts; and

d. material facts as to how later joining members became parties to the contracts.

[90] The plaintiffs argue that sufficient facts have been pleaded and rely primarily on two decisions in support of their contractual argument against HSA: *Lacey v. Weyerhaeuser Company Limited*, 2013 BCCA 252 and *O'Neill v. General Motors of Canada* , 2013 ONSC 4654.

[91] *Lacey* involved the reduction of employer contributions to the cost of medical benefits provided to retired employees. At trial, the Court found that these retirement benefits constituted deferred compensation that the employer was contractually obligated to provide. By unilaterally modifying those benefits, the employer breached its contractual obligations to the employees. The Court of Appeal upheld that finding (paras. 66-67).

[92] In *O'Neill* as in *Lacey*, an employer modified post-retirement benefits of its employees. Significant to the Court's decision to allow the plaintiffs' motion for summary judgment was the finding that the benefits in question were deferred compensation and accordingly formed part of the employees' compensation agreement (paras. 37-41).

[93] HSA submits that *Lacey* and *O'Neill* involved claims for benefits provided by an employer to their employees, not a union to its members. It says that the underlying relationships in those cases therefore differ from the present facts and

urges the Court to distinguish them accordingly. In particular, HSA says that the nature of an employer differs significantly from that of a union, particularly where the latter acts as a bargaining agent. In addition, both *Lacey* and *O'Neill* involve post-retirement benefits for which they submit different principles and considerations apply than those applicable to an LTD plan provided during the course of employment.

[94] This argument presupposes, however, that the union was not capable of contracting to provide LTD benefits to its members and that the assumption of responsibility by HSA from the employer changed the nature of the obligation so assumed; suppositions which are open to challenge as I have indicated above.

[95] HSA further asserts that merely particularizing documents, which "confirm" the terms of the alleged LTD Agreements, does not sufficiently establish that any contracts were actually created.

[96] As discussed, the plaintiffs' pleadings allege two separate contracts between HSA and its members, LTD Agreement #1 entered into on March 1, 1989 and LTD Agreement #2, entered into on March 1, 1999. The contracts pleaded are not in the form of signed agreements but rather are alleged to have come into being "through the terms of the notice and publications to its members, including but not limited to the various collective agreements … HSA entered into a binding agreement with members, including the plaintiffs, to provide, among other things long term disability insurance benefits to its members." The "notices and publications" pleaded are:

a. A brochure dated March 31, 1989 but not issued until in or around October 1995;

b. A brochure issued on or about September 1, 1998; and

c. A brochure issued on or about April 1, 2005 (collectively the "Notices").

[97] The Notices state that they only summarize the terms of the LTD benefit arrangements, that they are subject to the terms of the documents governing the applicable Plans and Trusts. The Notices further state that they are not contracts.

[98] Mr. Hensman does not recall whether he saw the Notices, though he saw and attached a similar one to his affidavit. Ms. Watt believes she either saw the brochures or ones similar to the Notices. It is not disputed that all members received the same materials from HSA.

[99] HSA submits that the basis for the claim is pleaded as a combination of brochures and notices sent to members yet there is a lack of evidence that the plaintiffs saw or relied on them. They note as well the plaintiffs assert the Collective Agreement is part of the contract even though it is an agreement between the employer and the members, not the employees and their bargaining agent.

[100] The plaintiffs take the position that it is the general course of communications issued by HSA to its members that forms the basis for the alleged contract. They submit that it is not necessary to refer to the subjective knowledge of individual HSA members; rather, they assert that the test is objective. In *Lacey,* the employer described the retirement health benefits package at issue to its employees through various employee publications, including handbooks. In construing the terms and the nature of the defendant's obligation, the Court applied an objective analysis emphasizing the manner in which the plan was described and presented to the employees. The employees did not testify at trial in *Lacey,* hence while the evidence showed that communications had been made to the employees, evidence as to whether any particular plaintiff actually received or reviewed those communications was not before the Court. As a result the subjective knowledge or understanding of any individual plaintiff was irrelevant to the analysis in *Lacey*.

[101] It is important to keep in mind that this is a certification application. While the evidence of systemic communication in *Lacey* was better developed than in the case at bar there is still evidence in this case of such systemic communication. For example:

a. the various brochures identified in the pleadings, and in the evidence, appear, on their face, to be intended for communication to HSA members;

b. noting that responsibility for the "Long Term Disability Insurance Plan will be assumed by the union", went on to provide that "There will be a brochure made available on the details of the plan well before the March 1 implementation date."

c. clause 1.04 of the 1989 Plan Document provides in part as follows:

> The HSA shall issue to each Employer, for delivery to each Employee who becomes protected under this Plan, a brochure and/or other document outlining the benefit to which such Employee is entitled hereunder, the circumstances under which the coverage terminates and the rights of the Employee upon termination of her/his coverage. If a brochure and/or other document is issued to, or is held by, any Employee who, for any reason, is not entitled to coverage hereunder, such document shall be of no effect.

[102] The intention of HSA was that every union member would be provided with a copy of the collective agreements and that it was employer's responsibility to provide them with copies. According to HSA such delivery occurred merely for "informational purposes."

[103] Given that the plaintiffs' pleadings refer to the series of communications to the members by HSA, they are consistent with the approach accepted by the Court in *Lacey* as providing the basis for a contract. It cannot be said that they necessarily fail to disclose a cause of action in contract. As in *Lacey,* here the alleged contracts arise from the conduct of the parties and communications between HSA and its members. Similarly, it is alleged that HSA assumed responsibility for LTD benefits from the employer, an obligation which could be construed as a collective obligation rather than an individual obligation. In my view, the pleadings thus disclose a supportable cause of action for breach of contract.

[104] Finally, HSA says that the plaintiffs' claims in contract must fail due to the lack of consideration flowing from the plaintiffs to HSA. In support, HSA notes that the Plans and LTD benefits provided under those plans were entirely employee funded. HSA submits that it did not pay the benefits; the Trustees who administered the Trusts did so, and retained a plan administrator to deal with claims. HSA also denies responsibility for the reductions to the plaintiffs' LTD benefits, noting that the Trustees made the decision to modify these benefits. Accordingly, HSA denies that it entered into a contract with its disabled members, and even if it did so, it did not breach that contract.

[105] The plaintiffs submit that notwithstanding HSA's remission of premiums deducted by the employer to the Trusts, HSA in fact controlled the manner in which the funds were used. Hence the plaintiffs submit that the mere fact that HSA chose to direct the funds to the Trusts does not mean that HSA did not "receive" consideration under the alleged LTD Agreements. Further, the plaintiffs assert that the act or promise comprising the consideration does not have to be to the benefit of the promisor: *Westman v. MacDonald*, [1941] 4 D.L.R. 793 at para. 8 (B.C.S.C.), and *Bank of Montreal v. Unified Homes Ltd*. (1994), 47 A.C.W.S. (3d) 590 at paras. 38-39 (Ont. C.J. (Gen. Div.)).

[106] The case law indicates that the requirement of consideration under a contract is met if the promisee does some act or suffers some detriment which he or she would not have done but for the promise. In this case, the plaintiffs assert they suffered a detriment in the form of a salary reduction for premium payments. Further, when employers offer benefits to employees, these are often viewed as consideration for the employee's labour. In my view, the same may apply to a trade union, which stands to benefit from increased membership, increased dues and enhanced bargaining power in exchange for agreeing to provide benefits to union members. As such benefits may influence an employee's decision to work for a particular employer provision of benefits by the union may affect the employee's decision to work for that employer as a member of a particular union.

[107] In my opinion it cannot be said that it is plain and obvious that the contractual claim will inevitably fail. I conclude there is a basis for the claim and without considering the strength of the claim, I find that it does rise at least to the standard required for certification.

Do the Plaintiffs' Pleadings Disclose a Cause of Action Under the Insurance Act?

[108] The plaintiffs also plead that the LTD Agreements should be construed as contracts of insurance under the *Insurance Act* and that HSA is an insurer under the *Insurance Act*. Accordingly, they submit that ss. 58 and 116 apply to the LTD Agreements:

> **Termination and replacement of group policies**
>
> **58** (1) If a contract of group insurance, or a benefit provision in a contract of group insurance, under which the insurer undertakes to pay insurance money or provide other benefits if a group life insured becomes disabled as a result of bodily injury or disease is terminated, the insurer continues, as though the contract or benefit provision had remained in full force and effect, to be liable to pay insurance money or provide benefits in respect of a group life insured for liability arising from an accident or disease that occurred before the termination of the contract or benefit provision if the disability is reported to the insurer within the 6 month period following the termination or a longer continuous period specified in the contract.
>
> …
>
> **Termination and replacement of group policies**
>
> **116** (1) If a contract of group insurance or a benefit provision in a contract of group insurance is terminated, the insurer continues, as though the contract or benefit provision had remained in full force and effect, to be liable to pay to or in respect of a group person insured under the contract benefits relating to
>
> (a) loss of income because of disability,
>
> (b) death,
>
> (c) dismemberment, or
>
> (d) accidental damage to natural teeth,
>
> arising from an accident or sickness that occurred before the termination of the contract or benefit provision, if the disability, death, dismemberment or accidental damage to natural teeth is reported to the insurer within the 6 month period following the termination or a longer continuous period specified in the contract.

[109] According to the plaintiffs, these provisions obligate HSA to continue to pay LTD benefits to the plaintiffs under the applicable LTD Agreements even following termination of those LTD Agreements. The defendants say that the plaintiffs have not pleaded sufficient material facts for such a claim.

[110] While the legislature amended the *Insurance Act* at various times over the course of the material period, the relevant definitions survive unchanged throughout the various iterations of the legislation (R.S.B.C. 1979, c. 200, R.S.B.C. 1996, c. 226, and R.S.B.C. 2012, c. 1):

> **1** …
>
> **"contract"** means a contract of insurance and includes a policy, certificate, interim receipt, renewal receipt or writing evidencing the contract, whether sealed or not, and a binding oral agreement;
>
> …
>
> **"insurance"** means the undertaking by one person to indemnify another person against loss or liability for loss in respect of a certain risk or peril to which the object of the insurance may be exposed, or to pay a sum of money or other thing of value on the happening of a certain event;
>
> …
>
> **"insurer"** means the person who undertakes, agrees or offers to undertake, a contract;
>
> …
>
> **"premium"** means the single or periodical payment under a contract for the insurance, and includes dues, assessments and other consideration.
>
> …

[111] To find a contract of insurance, the following must be made out:

a. An undertaking of one person;

b. To indemnify another person;

c. For an agreed consideration;

d. From loss or liability in respect of an event; and

e. The happening of which is uncertain.

Barbara Billingsley, *General Principles of Canadian Insurance Law*, 1st ed. (Markham: LexisNexis, 2008), at p. 16.

[112] If the plaintiffs establish the alleged LTD Agreements, HSA may be construed as an insurer if the plaintiffs further show that HSA undertook, agreed to undertake, or offered to undertake, a contract of insurance respecting the plaintiffs. The plaintiffs concede, however, that their claim under the *Insurance Act* will fail if the LTD Agreements cannot be established as alleged.

[113] In my view, an agreement to provide LTD benefits to employees may amount to a contract of insurance. In *Kopet v. Simon Fraser University*, 2013 BCCA 143, the plaintiff was a unionized employee of the defendant university. The applicable collective agreement entitled the plaintiff to various benefits, including LTD benefits. The plaintiff made an unsuccessful claim for LTD benefits and brought an action against both the employer and a third-party insurance company for damages as a result. The trial judge construed the action as having been brought on a contract of insurance, thereby engaging a statutory limitation period with which the plaintiff had not complied. The action was dismissed.

[114] In *Kopet,* the collective bargaining agreement between the employer and the union required the employer to “maintain long term disability insurance and group life insurance for all eligible employees.” The employer arranged for LTD benefits to be provided to union members via an “administrative services only” agreement. Under this plan, a third-party administrator determined entitlement to benefits and remunerated recipients out of funds provided by the employer (paras. 2-3).

[115] On appeal, the plaintiff contended that there was no contract of insurance, and that the trial judge erred in construing a single provision of a comprehensive collective bargaining agreement as such a contract. Primarily, the plaintiff’s argument hinged on the contention that LTD benefits provided through an administrative services agreement do not constitute “insurance.” In support of this

position, the plaintiff cited commentary to the effect that an administrative services only arrangement respecting LTD benefits is instead "part of the employment contract" and thus not governed by insurance law (para. 9). The plaintiff further contended that in this regard an essential characteristic of insurance was lacking as the provision of LTD benefits via an administrative services agreement does not have the effect of transferring risk.

[116] The Court did not accede to the plaintiff's arguments, instead concluding that the trial judge had correctly construed the plaintiff's entitlement to LTD benefits under the Collective Agreement as a contract of insurance. The essential characteristics of such a contract, including consideration and the transfer of risk were apparent on the facts. Consideration stemmed from the employee's provision of labour, skill and knowledge to the employer, with transfer of risk occasioned by the fact that the employer was obligated to fund the benefits payments to employees.

[117] The Court in *Kopet* held that nothing turned on the fact that the LTD benefits were provided through an administrative services only agreement: a plan for insurance is no less a plan for insurance merely because it is underwritten by an employer rather than a third-party insurer. On this point, the Court approvingly cited C*anada (Attorney General) v. Confederation Life Insurance Co*. (1995), 24 O.R. (3d) 717 (Gen. Div.) [*Confederation Life*], stating that an employee's entitlement to LTD benefits may constitute a contract of insurance notwithstanding they are provided pursuant to an administrative services agreement (*Kopet,* at paras. 20-21).

[118] Following *Confederation Life,* the relationship between an employer and a third-party administrator under an administrative services agreement is not itself a contract of insurance, but rather a contract for administrative services. However, this must be distinguished from the relationship between an employer and an employee, which may well give rise to a contract of insurance depending on the circumstances. Notably, the relevant statutory definitions in that case, under the *Insurance Act,*

R.S.O. 1990, c. I.8, are substantially the same as those considered in *Kopet* and at issue on the present facts:

> 1. …
>
> "contract" means a contract of insurance, and includes a policy, certificate, interim receipt, renewal receipt, or writing evidencing the contract, whether sealed or not, and a binding oral agreement; ...
>
> …
>
> "insurance" means the undertaking by one person to indemnify another person against loss or liability for loss in respect of a certain risk or peril to which the object of the insurance may be exposed, or to pay a sum of money or other thing of value upon the happening of a certain event, and includes life insurance; ...
>
> …
>
> "insurer" means the person who undertakes or agrees or offers to undertake a contract; ...
>
> …

[119] The analysis undertaken in *Kopet* suggests that the Court must focus on the wording of the collective agreement in determining whether the obligations or entitlements created by it constitute contracts of insurance. The Court of Appeal noted in that case that the wording of the collective agreement defined the nature of the plaintiff's entitlement by expressly obligating the employer to maintain LTD insurance. The applicable provision of the collective agreement in *Kopet* provided:

> [2] …
>
> 51.04 Long Term Disability and Life Insurance Plans
>
> (a) The University shall maintain long term disability insurance and group life insurance for all eligible employees. The operation of these plans shall be governed solely by the master agreements between the University and the plan carriers.
>
> (b) Continuing employees who work a minimum of thirty-five (35) hours biweekly are eligible for coverage commencing on the first day of employment in a continuing position.
>
> (c) The University shall pay the required premiums for the long term disability insurance and the basic coverage of the group life insurance plan. Eligible employees may elect to contribute to additional benefits coverage under the group life insurance plan as provided for in the plan.

> (d) The long term disability plan will provide a benefit of seventy (70) percent of basic regular annual earnings payable after a waiting period of twenty-six (26) weeks. The basic life insurance will provide coverage equal to one (1) times basic annual earnings rounded to the next higher multiple of one thousand (1000) dollars, if not already a multiple.
>
> [Emphasis added]

[120] The Court of Appeal declined to follow the commentary cited by the plaintiff finding it “not specific to the wording of the collective agreement here or to anywhere where an employer has been required to maintain insurance” (para. 15). Accordingly, the Court found that the employer ”undertook to indemnify the employees for their loss of income in respect of the risk of long-term disability. The plan was then a contract of insurance, and the University was the insurer, consistent with the definitions of "contract", "insurer", and "insurance" in the *Insurance Act*” (para. 21) (emphasis added). The Court of Appeal held that a provision in the collective agreement at issue, substantially similar to Article 34.04(a) of the Master Agreement, gave rise to a contractual liability on the part of the employer to pay LTD benefits.

[121] In my view, the provision of LTD benefits in the employment context, whether in exchange for a cash premium or consideration in the form of labour, and whether provided via a self-funded administrative services agreement or through a third-party insurer, likely constitutes a contract of insurance as contemplated by the *Insurance Act.* In other words, the provision of such benefits constitutes an undertaking to indemnify employees against loss attributable to disability, or alternatively constitutes an undertaking the pay to employees a certain sum (a proportion of their earnings) upon the happening of a certain thing (being rendered disabled).

[122] While the jurisprudence deals almost exclusively with circumstances where LTD benefits are provided to employees by an employer as opposed to a union, HSA itself stated in pleadings and elsewhere that it “assume[d] responsibility” for the LTD plan from the employer. I am of the opinion the jurisprudence dealing with employers is applicable to the extent that it provides guidance as to the nature of the

obligation and responsibility assumed by HSA. The employer's obligation in this regard stemmed from the following article under the collective agreement:

> 34.04 Long Term Disability Insurance
>
> The Employer shall provide a mutually acceptable Long-Term Disability Insurance Plan, for regular full-time and regular part-time employees, providing for two-thirds (2/3rds) salary continuation until age 65 in the event of disability.
>
> The Employer shall pay 100% of the premium.
>
> [Emphasis added]

[123] The collective agreement in this case employs language nearly identical to that used in *Kopet*. In my view *Kopet* applies, and so if HSA assumed the employer's responsibility, it thereby arguably "undertook to indemnify the employees for their loss of income in respect of the risk of long-term disability" as contemplated at para. 21 of *Kopet*.

[124] The remaining question is whether the nature of the responsibility assumed by HSA changed in or after early 1989, when HSA discontinued its relationship with a third-party insurer and instead established a self-funded benefits trust for the purposes of providing its members with LTD benefits. Essentially, HSA adopted an administrative services only model in place of the previous third-party insurer model. HSA informed its members that the "only difference" as a result of these "administrative changes" would be that applications for LTD would be processed by Metropolitan Life, rather than BC Life & Casualty, and that premiums would thereafter go to an "HSA Group Insurance Fund" (emphases added).

[125] In light of this change, can it be said that HSA continued to undertake to indemnify employees for their loss of income in respect of the risk of long-term disability? *Kopet* again provides some guidance, indicating that an insurance plan remains an insurance plan regardless if it is "underwritten by the [employer] as opposed to a third-party insurer" (para. 14).

[126] Thus, the mere adoption of an administrative services only model on its own does not warrant or demonstrate any alteration of HSA's responsibilities or

undertakings. The use of the words “only difference” indicates that it was intended and represented by HSA that its obligations, as assumed from the employer in 1987, would otherwise continue unchanged following the administrative services changeover in 1989. The same is evidenced by the fact that HSA continued to collect what it termed “premiums” which would go into an “insurance fund.”

[127] These factors, along with the fact that the substantive benefits provided by HSA at the time were consistent with those previously provided by the employer, and which clearly provided indemnification against disability, demonstrate that the LTD benefits from March 1989-1999 may well have constituted insurance. It is probable that the same remains true regarding the period of March 1999 through April 2006, although there is less evidence available as to the representations made by HSA in this latter period.

[128] I conclude it cannot be said that it is plain and obvious that the claims against HSA under the *Insurance Act* will inevitably fail. There is some basis in fact to support the plaintiffs’ claims in this regard.

Do the Plaintiffs’ Pleadings Disclose a Cause of Action for Breach of Fiduciary Duty against HSA?

[129] No contractual claim is advanced against the Trustees. However, as an alternative claim the plaintiffs plead a breach of fiduciary duty by both HSA and the Trustees for their failure to properly fund the Trusts to ensure full payment of benefits.

[130] The plaintiffs plead that because the individual defendants are Trustees of the Trusts under which disabled HSA members are beneficiaries, that relationship gives rise to a fiduciary duty. Indeed, the individual defendant Trustees concede that they owe a fiduciary duty to the beneficiaries of the Trusts.

[131] The plaintiffs also plead that HSA owes a fiduciary obligation because HSA created the Trusts and controlled the actions of the Trustees. The plaintiffs plead that HSA’s fiduciary duty arose from their relationship to the Trusts and the disabled

HSA members, that is, an *ad hoc* fiduciary duty or, in the alternative, in their role as a trustee *de son tort*.

[132] This allegation is denied by HSA. Firstly HSA denies it owed a fiduciary duty to the beneficiaries of the Trusts and secondly denies that its control of the Trusts was such that it rendered HSA a trustee *de son tort*.

[133] I turn first to whether HSA owes a fiduciary duty to its disabled members as an *ad hoc* fiduciary, then as a trustee *de son tort*, and finally to whether the Trustees are open to a claim for the alleged breach of their fiduciary duty.

Does HSA Owe an *Ad Hoc* Fiduciary Duty to its Disabled Members?

[134] The relationship between HSA and the plaintiffs is not one of the recognized types of relationships that give rise *per se* to a fiduciary relationship. As a result the plaintiffs rely on an *ad hoc* fiduciary duty, that is, a duty that arises from the particular circumstances of the relationship in question. They do not argue that HSA owes a fiduciary duty to all members, just to the disabled HSA members. The plaintiffs assert that the element that distinguishes the disabled HSA members from HSA members generally is the element of vulnerability.

[135] The issue is not whether there was a fiduciary relationship between the defendants and the plaintiffs, but rather whether the facts pleaded support the possible existence of such a relationship and the breach of the defendants' obligations in the context of that relationship (see *Spina*; *Girardet v. Crease & Company* (1987), 11 B.C.L.R. (2d) 361 at para. 3 (S.C.) and *Lac Minerals Ltd. v. International Corona Resources Ltd.,* [1989] 2 S.C.R. 574, at paras. 30-31, 147). A breach of a fiduciary duty must be "a wrong which is a betrayal of that trust component of the relationship", and a breach of duty by a fiduciary will not in all cases constitute a breach of fiduciary duty: *Varcoe v. Sterling* (1992), 7 O.R. (3d) 204 at para. 72 (S.C. (Gen. Div.)), aff'd (1992) 10 O.R. (3d) 574, and *Spina* at paras. 192-194.

[136] In other words, the question is whether, in unilaterally reducing the LTD benefits, did HSA act in a way that demands the application of the "special protection" afforded by equity (See *Lac Minerals Ltd*., at para. 29).

[137] In *Galambos v. Perez,* 2009 SCC 48, the Supreme Court of Canada considered *ad hoc* fiduciary duties noting that "[t]he existence of the fiduciary obligation is thus primarily a question of fact to be determined by examining specific facts and circumstances" (para. 48). Writing for a unanimous Court, Cromwell J. summarized the Court of Appeal's reasoning as follows:

> 50 The core of the Court of Appeal's reasoning consists of three points, two of which are expressly set out and the third of which is implied. The explicit points are, first, that a "power-dependency" relationship existed between Ms. Perez and Mr. Galambos and second, that in such relationships, fiduciary duties may arise simply on the basis of the reasonable expectations of the weaker party and without any mutual understanding of both parties that one must act in the interests of the other. The third point arises by implication because the court appears to have accepted the proposition, without expressly stating it, that a fiduciary duty may arise even though the fiduciary has no discretionary power to affect the other party's legal or important practical interests.

[138] The Supreme Court held that the Court of Appeal erred in the three respects set out above (para. 51). Cromwell J. reasoned that the findings of the trial judge respecting "power-dependency" should not have been overturned. The existence of such dependency is clearly a question of fact.

[139] The Court further rejected the notion that where a relationship involves power-dependency, fiduciary duties may arise simply on the basis of the reasonable expectations of the weaker party and absent the mutual understanding of the parties that one must act in the interests of the other. On that point Cromwell J. stated:

> [66] In my view, while a mutual understanding may not always be necessary (a point we need not decide here), it is fundamental to *ad hoc* fiduciary duties that there be an undertaking by the fiduciary, which may be either express or implied, that the fiduciary will act in the best interests of the other party. ...
>
> [67] An important focus of fiduciary law is the protection of one party against abuse of power by another in certain types of relationships or in particular circumstances. However, to assert that the protection of the vulnerable is the role of fiduciary law puts the matter too broadly. The law

> seeks to protect the vulnerable in many contexts and through many different doctrines. As La Forest J. noted in *Hodgkinson*, at p. 406: "[W]hereas undue influence focuses on the sufficiency of consent and unconscionability looks at the reasonableness of a given transaction, the fiduciary principle monitors the abuse of a loyalty reposed" ... This brief sentence makes two important points which help sharpen the focus on the role of fiduciary law.
>
> [68] The first is that fiduciary law is more concerned with the position of the parties that *results from* the relationship which gives rise to the fiduciary duty than with the respective positions of the parties *before* they enter into the relationship. ... Thus, while vulnerability in the broad sense resulting from factors external to the relationship is a relevant consideration, a more important one is the extent to which vulnerability arises from the relationship: *Hodgkinson*, at p. 406.
>
> [69] The second is that a critical aspect of a fiduciary relationship is an undertaking of loyalty: the fiduciary undertakes to act in the interests of the other party. This was put succinctly by McLachlin J. (as she then was) in *Norberg*, at p. 273, when she said that "fiduciary relationships ... are always dependent on the fiduciary's undertaking to act in the beneficiary's interests". See also *Hodgkinson*, *per* La Forest J., at pp. 404-7.
>
> [70] Underpinning all of this is the focus of fiduciary law on relationships. ... The particular relationships on which fiduciary law focuses are those in which one party is given a discretionary power to affect the legal or vital practical interests of the other ...
>
> [71] I return to the Court of Appeal's holding that a fiduciary duty may arise in "power-dependency" relationships without any express or implied undertaking by the fiduciary to act in the best interests of the other party. I respectfully disagree with this approach, for two reasons: "power-dependency" relationships are not a special category of fiduciary relationships and the law is, in my view, clear that fiduciary duties will only be imposed on those who have expressly or impliedly undertaken them.
>
> [Emphasis in original]

[140] With respect to the Court of Appeal's holding that fiduciary duties may arise on the basis of the reasonable expectations of one party, Cromwell J. held:

> [76] Thus, what is required in all cases of *ad hoc* fiduciary obligations is that there be an undertaking on the part of the fiduciary to exercise a discretionary power in the interests of that other party. To repeat what was said by McLachlin J. in *Norberg*, "fiduciary relationships ... are always dependent on the fiduciary's undertaking to act in the beneficiary's interests" (p. 273). As Dickson J. put it in *Guerin*, fiduciary duties may arise where "by statute, agreement, or perhaps by unilateral undertaking, one party has an obligation to act for the benefit of another" (p. 384).
>
> [77] The fiduciary's undertaking may be the result of the exercise of statutory powers, the express or implied terms of an agreement or, perhaps, simply an undertaking to act in this way. In cases of *per se* fiduciary relationships, this undertaking will be found in the nature of the category of

> relationship in issue. The critical point is that in both *per se* and *ad hoc* fiduciary relationships, there will be some undertaking on the part of the fiduciary to act with loyalty.
>
> …
>
> [79] This does not mean, however, that an express undertaking is required. Rather, the fiduciary's undertaking may be implied in the particular circumstances of the parties' relationship. Relevant to the enquiry of whether there is such an implied undertaking are considerations such as professional norms, industry or other common practices and whether the alleged fiduciary induced the other party into relying on the fiduciary's loyalty.
>
> [Emphasis added]

[141] McLachlin C.J.C. discussed the requirements of a claim alleging breach of fiduciary duty in *Alberta v. Elder Advocates of Alberta Society,* 2011 SCC 24 [*Elder Advocates*]:

> [27] …
>
> Relationships in which a fiduciary obligation have been imposed seem to possess three general characteristics:
>
> (1) The fiduciary has scope for the exercise of some discretion or power.
>
> (2) The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests.
>
> (3) The beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion or power. ...
>
> …
>
> [29] As useful as the three "hallmarks" ... are in explaining the source fiduciary duties, they are not a complete code for identifying fiduciary duties. It is now clear from the foundational principles ... that the elements outlined in the paragraphs that follow are those which identify the existence of a fiduciary duty in cases not covered by an existing category in which fiduciary duties have been recognized.
>
> [30] First, the evidence must show that the alleged fiduciary gave an undertaking of responsibility to act in the best interests of a beneficiary ... As Cromwell J. wrote in *Galambos*, at para. 75: "what is required in all cases is an undertaking by the fiduciary, express or implied, to act in accordance with the duty of loyalty reposed on him or her."
>
> [31] The existence and character of the undertaking is informed by the norms relating to the particular relationship: *Galambos*, at para. 77. The party asserting the duty must be able to point to a forsaking by the alleged fiduciary of the interests of all others in favour of those of the beneficiary, in relation to the specific legal interest at stake.

> [32] The undertaking may be found in the relationship between the parties, in an imposition of responsibility by statute, or under an express agreement to act as trustee of the beneficiary's interests. …
>
> …
>
> [33] Second, the duty must be owed to a defined person or class of persons who must be vulnerable to the fiduciary in the sense that the fiduciary has a discretionary power over them. Fiduciary duties do not exist at large; they are confined to specific relationships between particular parties. *Per se*, historically recognized, fiduciary relationships exist as a matter of course within the traditional categories of trustee-*cestui qui trust*, executor-beneficiary, solicitor-client, agent-principal, director-corporation and guardian-ward or parent-child. By contrast, *ad hoc* fiduciary relationships must be established on a case-by-case basis.
>
> [34] Finally, to establish a fiduciary duty, the claimant must show that the alleged fiduciary's power may affect the legal or substantial practical interests of the beneficiary: *Frame*, *per* Wilson J., at p. 142.
>
> [35] In the traditional categories of fiduciary relationship, the nature of the relationship itself defines the interest at stake. However, a party seeking to establish an *ad hoc* duty must be able to point to an identifiable legal or vital practical interest that is at stake. The most obvious example is an interest in property, although other interests recognized by law may also be protected.

[142] In the context of unions and their members there is some, albeit qualified, support in the jurisprudence for the existence of a fiduciary duty. For instance, in *Dayco (Canada) Ltd. v. CAW-Canada*, [1993] 2 S.C.R. 230 [*Dayco*], La Forest J. recognized the possibility that the relationship between retirees and their former union might be fiduciary. On this point, he held for the majority that "[i]f a union failed to consider the interests of retirees during collective bargaining, or refused to process a grievance on behalf of those retirees, such conduct might form the basis of a claim for breach of fiduciary duty" (emphasis added) (para. 87). The position of the plaintiffs is analogous to the retirees in *Dayco,* in that both groups were members of a collective bargaining unit, subsequently withdrew from the employment relationship, and sought to assert or protect accrued employment rights (para. 61). However, it should be noted that La Forest J.'s ruling on this point was qualified and equivocal.

[143] The Quebec Court of Appeal applied *Dayco* in *Association provinciale des retraités d'Hydro-Québec v. Hydro-Québec,* 2005 QCCA 304 [*Association provinciale*]. The plaintiffs in that case were retired former employees of the

defendant and entitled to retirement benefits paid out of a pension fund maintained by the defendant. Over time that fund generated a significant surplus which the defendant disbursed largely for the benefit of the defendant and current employees. The plaintiffs accordingly brought a class action claim asserting entitlement to a greater portion of the surplus. The trial court denied certification and the plaintiffs appealed.

[144] Among other things, the plaintiffs in *Association provinciale* claimed a breach of fiduciary duty on the part of the employer. They claimed that the defendant had to take the interests of the retirees into account when negotiating the disbursement of the pension surplus. Citing *Dayco,* the Court of Appeal rejected the notion that former members of a bargaining unit could claim against the employer in this context: "if an obligation to act as a trustee exists with respect to former members of the bargaining unit, logically this duty must be incumbent upon the union and not the ex-employer" (para. 90).

[145] The decision of the New Brunswick Court of Appeal in *C.B.R.T. & G.W. v. Knight* (1988), 95 N.B.R. (2d) 342 (C.A.), LTA ref'd, [1989] S.C.C.A. No. 67 also provides guidance. There, the plaintiffs were casual employees of the Canadian National Railway and members of the defendant union. They brought an action alleging a breach of fiduciary duty by the defendant. The defendant unsuccessfully applied to have the plaintiff's action dismissed on the basis that no fiduciary duty was owed by a union to its members beyond the statutory duty of fair representation. The Court of Appeal rejected that contention, finding that the claims respecting fiduciary obligations "did not arise out of rights created by a collective agreement but are ... independent of a statutory duty of fair representation" (paras. 5, 12).

[146] The New Brunswick Court of Appeal discussed the *ratio* of *Knight* in a subsequent judgment, *Comeau v. Canadian Union of Postal Workers* (1991), 112 N.B.R. (2d) 432 (C.A.). There the Court explained that the statutory duty of fair representation exhausts the obligations owed by a union to its members with regard to the administration of the rights of an employee under a collective agreement.

Thus, no claim for fiduciary duty can be sustained where the dispute falls within the bounds of the collective agreement.

[147] On the other hand, as held in *Comeau,* where the conduct of the union arises beyond the bounds of the collective agreement, a claim for fiduciary duty may be viable. With regard to *Knight,* the duty of fair representation did not apply in that case because the relevant conduct of the union involved negotiating on behalf of employees "outside of the rights created by their collective agreement," a circumstance in which a fiduciary obligation between the union and its members could exist (para. 6).

[148] On the present facts as pleaded, the fiduciary obligation alleged by the plaintiffs flows from the Collective Agreement in that it arose out of collective bargaining with the employer, but cannot be said to reside within the bounds of the Collective Agreement. Indeed, if the obligation in question exists, it does so specifically because responsibility for provision of LTD benefits to HSA members was for a time removed from the collective bargaining context. Further, I note that in *Trustees of the IWA - Forest Industry LTD Plan v. Ainsworth Engineered Canada Limited Partnership,* 2013 BCSC 41, the Court construed a union LTD benefits plan funded through a trust as "separate and distinct" from the collective agreement so that s. 27(1)(c) of the *Labour Code,* which specifically pertains to collective agreements, did not apply to the benefits trust (paras. 35-36).

[149] There is some contrary jurisprudence as well. In *Bjordal v. Labour Relations Board of British Columbia*, 2014 BCSC 1248, the Court noted "there is no current authoritative finding that there is a fiduciary relationship between a union and its members" (para. 42). In numerous other cases, courts in this jurisdiction dismissed or struck claims of breach of fiduciary duties brought against unions by their members.

[150] However, and perhaps without exception, courts founded such decisions on the notion that the essential character of the allegations related to the duty of fair representation under labour relations legislation, thereby depriving the court of

jurisdiction: *Ancheta v. Joe et al*, 2003 BCSC 93 at para. 107; *Klein v. Construction & Specialized Workers Union,* 2013 BCPC 49 at para. 26; *Speckling v. Local 76 of the Communications, Energy and Paperworkers' Union of Canada et al*, 2005 BCSC 349 at para. 68; *Speckling v. Local 76 of the Communications, Energy and Paperworkers' Union of Canada,* 2009 BCCA 258 at para. 56; *Daniels v. British Columbia Government Employees' Union* (1995), 59 A.C.W.S. (3d) 1122 at paras. 14-16 (B.C.S.C.); *Bergman v. Canadian Union of Public Employees, Local 608* (1999), 11 B.C.T.C. 81 at paras. 30, 33 (S.C.); *Joseph v. AUPE*, 2004 ABQB 977 at para. 99.

[151] In light of the above, have the plaintiffs pleaded a claim for breach of fiduciary duty that is not bound to fail? The material facts pleaded in support of this claim in the plaintiff's amended notice of civil claim are:

> 9. HSA owed a fiduciary duty to the Disabled HSA Members, including the Plaintiffs. HSA's fiduciary duty arose out of its relationships to the Trusts and to the Disabled HSA Members including:
>
> (a) as the party establishing or settling each of the Trusts;
>
> (b) as a signatory to each of the Trusts;
>
> (c) as the party responsible for funding each of the Trusts; and
>
> (d) as the party exercising control over the Trusts by its ability to replace trustees of the Trusts and appoint trustees of the Trusts.
>
> 10. HSA owed a duty of loyalty to protect the Disabled HSA Members, including the Plaintiffs. The Disabled HSA Members were vulnerable to an abuse of power by the HSA.
>
> 11. In the alternative, by virtue of its creation of the Trusts and its dealings with the Trusts, HSA was, in effect, a *de facto* trustee of each of the Trusts, and owed the Disabled HSA Members the same duties as a named trustee under the Trusts. In the alternative, by virtue of its actions, including its role in receiving funding for the Trusts, HSA was a trustee de son tort.
>
> 12. HSA breached its fiduciary duty to the Disabled HSA Members including the Plaintiffs by failing to ensure that the Trusts were adequately funded to pay to the Disabled HSA Members the full amounts they were owed under LTD Agreement #1 and LTD Agreement #2.

[152] The plaintiffs submit that the facts pleaded establish that HSA undertook to assume responsibility for the provision of LTD benefits and related benefits to its

members, that there is a clearly defined class vulnerable to HSA's power (the disabled members) and that the disabled beneficiaries' LTD benefits and other benefits, are subject to being adversely affected by HSA's actions. They plead the latter on the basis that HSA determined the manner in which the benefits were to be provided, negotiated responsibility for LTD benefits back to the employer, retained control over the appointment of Trustees, and appointed mainly HSA executives as Trustees. The plaintiffs also point to the operation of the Trusts, the terms of the Trust Agreements, and the modification of the Plans under which benefits were provided.

[153] The first factor in *Elder Advocates* requires that there be an undertaking by the alleged fiduciary to act in the best interests of the alleged beneficiary or beneficiaries. At first blush, the representations made by HSA to its members do not appear to forsake their loyalty to all members of the union other than the plaintiffs. It seems more likely that HSA's conduct evinced an intention to continue to administer the LTD benefits in a manner consistent with the employer's previous administration of the plan. Nevertheless, given the limited analysis appropriate on an application for certification, in my view it is at least arguable that HSA's systemic communications could be construed as an undertaking to act in the disabled members' best interests. Definitive resolution of this question requires interpretation of the significance of HSA's conduct, an undertaking inappropriate on an application for certification.

[154] Further, some aspects of the relationship between HSA and the plaintiffs suggest an implicit undertaking to act with loyalty. Of particular note is the fact that the provision of LTD benefits is at the very least akin to a contract of insurance, which are agreements of "utmost good faith," although this does not itself establish a fiduciary relationship: *Warrington v. Great-West Life Assurance Co*. (1996), 139 D.L.R. (4th) 18 at para. 10 (B.C.C.A.). Prior to becoming disabled the plaintiffs would have understood HSA to be obligated to represent their interests fairly and to not act in a manner which was arbitrary, discriminatory, or in bad faith. While there is little to suggest that HSA undertook to forsake the interests of all others in favour of the plaintiffs, and such an undertaking would perhaps be inconsistent with HSA's

indisputable and ongoing obligations to its non-disabled members, I cannot say that the plaintiffs' position in this regard is doomed to failure. In my view, the first requirement under *Elder Advocates* is satisfied.

[155] The second requirement of the *Elder Advocates* test requires that there be a defined person or class of persons vulnerable to a fiduciary's control. The plaintiffs are HSA members who have become disabled, a defined class. If no contractual relationship is established respecting the plaintiffs' entitlement to disability benefits, HSA, by assuming responsibility for the provision of the benefits will enjoy essentially complete and unfettered power in that regard. Most significantly for the present purposes, HSA would be able to exercise discretion as to whether to fund shortfalls in the Trusts. Further, as contended by the plaintiffs, it may be that HSA exercises *de facto* control over the trusts as well, which would also put matters of duration, amount, and entitlement to benefits within HSA's discretion. I find that the second *Elder Advocates* factor is also met.

[156] The last of the *Elder Advocates* requirements is that the beneficiary or beneficiaries must have a legal or substantial practical interest that stands to be adversely affected by the alleged fiduciary's exercise of discretion or control. The interest at stake is the amount of, and potentially the duration of, LTD benefits. This is clearly an identifiable legal or substantial practical interest.

[157] It is possible that an *ad hoc* fiduciary relationship arises between HSA and the plaintiffs respecting administration of LTD benefits. The plaintiffs plead sufficient facts to support a claim that the plaintiffs have a legal or substantial practical interest which may be adversely affected by the actions of HSA, and that HSA undertook to protect the best interests of the plaintiffs in administering the LTD benefits Plans. The pleadings also allege breaches of those fiduciary obligations. I cannot find that it is plain and obvious that the plaintiffs' claims under this heading will fail.

Is HSA a Trustee *De Son Tort*?

[158] The plaintiffs alternatively plead that HSA acted as a *de facto* trustee *or* trustee *de son tort*. A trustee *de son tort* is a person who is not a trustee and does

not have authority from a trustee yet intermeddles with trust matters or does acts characteristic of the office of trustee. Such a person voluntarily assumes responsibility for the trust, but must also have title or control over trust property: Philip H. Pettit, *Equity and the Law of Trusts*, 11th ed. (Oxford: Oxford University Press, 2009), at p. 152.

[159] The defendants submit that the Trustees were "independent from the union." The plaintiffs however submit that since HSA set up the Trusts, appointed the Trustees, did so mainly from members of the HSA executive, negotiated the deductions from the employer and directed the funds to the Trusts, there is "some basis in fact" to support the allegation that HSA was a trustee *de son tort*.

[160] Specifically, the plaintiffs state that if they establish that HSA has to "some" degree effectively possessed and administered the trust property, then HSA will be considered a trustee *de son tort* and treated as though it was a properly appointed trustee. They refer to *Interstate Investments Ltd. v. Pacific International Securities Inc*., 1995 CanLII 873 at para. 49 (B.C.S.C.), wherein Madam Justice Koenigsberg excerpted with approval from Waters, *Law of Trusts In Canada*, 1984:

> 49. …
>
> A person who was not appointed a trustee, but who takes it upon himself 'to possess and administer trust property for the beneficiaries' will be treated as if he were a trustee. He is known as a trustee de son tort. He becomes a trustee by imposition of law. Though he may subject himself to actions at law, he is not liable because he has taken upon himself the office of trustee, but because he has possessed and administered trust property contrary to the terms of the trust of which he is aware or ought to be aware. In other words, he is treated as if he were a properly appointed trustee from the moment that he starts to possess and administer that property, knowing actually or constructively that it is trust property, and he becomes liable if he acts in a way which would be a breach of trust in a properly appointed trustee. He need not be concerned with making any profit for himself; indeed, he is purporting to act for others, the beneficiaries of the trust.
>
> There is some element of doubt as to what sort of relationship to the trust property the trustee de son tort must have, however. In Re Barney Kekewich J. made a particular point of saying that to be such a trustee a person must have the legal

> interest or the right to call for it. ... In practice, however, it is likely that one who is "possessed" of trust property and is administering it as if he were a trustee, would have had to acquire some title right in the property or else he could not administer it. Provided he had had either title or "dominion and control" at the time of the improper act, he would be a trustee de son tort.
>
> It is more usual in practice for the alleged intermeddling stranger to be an agent of the trustees, as, for instance, a banker, broker or lawyer. Such a person will have duties to fulfill on instructions from the trustees, and, if he acts within the scope of his lawful agency, he is neither an intermeddling stranger nor liable to the beneficiaries in any way because of losses caused by the trustee. But, if he acts outside his legal powers as an agent, he too may become liable as a constructive trustee. ... But, if he joins with the trustee in what he knows to be a dishonest and fraudulent design to injure the trust beneficiaries, he is accountable as a constructive trustee whether or not any trust property ever came to his hands. ... In both cases, either as a trustee de son tort or as a participant in a fraudulent design, he assumes the obligation, jointly and severally with the appointed trustees, to make good the loss which the design has caused.

[161] The necessary degree of control requires that a person “can, if he will, put into his own pocket or pay away as he pleases to someone else” (*Re Barney,* [1892] 2 Ch 265, at p. 276). In other words, as described in *Interstate Investments Ltd.,* a party becomes a trustee *de son tort* where, exerting dominion and control of trust property, and, knowing of the trust, whether constructively or factually, that party acts inconsistently with the terms or existence of the trust (para. 51).

[162] The plaintiffs specifically plead that the alleged LTD Agreement #1 stipulated that HSA members would be charged a premium that would be deducted from their paycheques “and remitted to the ‘HSA Group Insurance Fund.’” The cheques were made out to a specific trust fund or to “HSA LTD Trust,” not to HSA, and the employer directed these cheques to the administrators of the LTD Plan, not to HSA.

[163] The defendants submit that while the plaintiffs’ pleadings allege that HSA had control over the trusts that is not the correct legal test even if sufficient material facts were pleaded. They submit the test is whether HSA had control over the trust property, and say that the plaintiffs have not pleaded that to be the case. The

plaintiffs submit however that they have pleaded that HSA had to some degree effectively possessed and administered the trust property as well.

[164] The pleadings identify HSA as the entity that chose to establish the Trusts, the entity responsible for funding the Trusts, the entity exercising control over the appointment of the Trustees, and ultimately, the entity that controlled the Trusts. The plaintiffs' note that the wording of the relevant trust agreements, along with the evidence on this application substantiate the allegation of HSA control over the trusts. For instance, HSA directed the employer how much to deduct from HSA members and what to do with the funds so deducted. As a result the plaintiffs submit that there is "some basis in fact" to support the allegation that the relationship between HSA and the Trusts was such that HSA was a trustee *de son tort*.

[165] Assuming such a duty exists, the plaintiffs further plead a breach of that duty by HSA. They submit that HSA was in a conflict of interest situation when opposing the resolution designed to avoid a reduction of the LTD benefits; HSA's loyalties were divided between the competing interests of its disabled members in continuing to receive full LTD benefits on one hand, and the interest of its other members in avoiding increased dues payments. They also say that HSA breached its fiduciary duty by failing to ensure that the Trusts were adequately funded so as to pay out the benefits entitlements under the Plans.

[166] HSA submits that it did not do anything dishonest, fraudulent or untoward that affected the Plans or Trusts. Therefore even if it is a trustee *de son tort* as alleged, HSA says it did not breach its duty to the plaintiffs. In my view the law does not necessarily require proof of dishonesty or fraud in order to found liability against a defendant as a trustee *de son tort*. Indeed, in *Interstate Investments Ltd.* the Court expressly found "no evidence of dishonest or fraudulent behaviour on the part of the Defendant," yet noted that liability could nevertheless attach where a party knowingly acts contrary to the terms or existence of a trust (paras. 50-53).

[167] HSA further notes that the Plans and Trusts were entirely employee funded, with the underfunding occurring as a result of the increase in frequency in LTD

benefits claims, as well as a recession economy. These positions raise factual issues requiring resolution by way of trial, and therefore offer little assistance on this certification application.

[168] It is not for this Court, on a certification application, to consider the likelihood of the plaintiff being successful on this issue against HSA. The test asks whether the plaintiffs plead reasonable causes of action and only if it is plain and obvious or beyond doubt that the plaintiffs will not succeed in their claims will they fail to satisfy s. 4(1)(a). I conclude for the reasons given that such has not been shown.

Do the Plaintiffs' Pleadings Disclose a Cause of Action for Breach of Fiduciary Duty or Negligence Against the Trustees?

[169] The Trustees remind the Court that although certification is not the place for a dispute on the merits of the case, or for the resolution of conflicts in the evidence, it is nevertheless intended to be a meaningful screening device. That is, there must be more than a superficial scrutiny of the plaintiffs' case. They submit that in this instance the plaintiffs fail to raise any genuine issues between themselves and the Trustees, noting that in order to satisfy ss. 4(1)(a) and (c) of the *CPA* the plaintiffs must plead a cause of action that is a genuine issue between the parties and that raises common issues between them.

[170] In *Marshall v. United Furniture Warehouse Limited Partnership,* 2013 BCSC 2050, Fisher J. described the "common issues" requirement as follows:

> [143] … while the common issues criterion is not a high legal hurdle, the plaintiffs must adduce some basis in the evidence to show that an issue exists and the court is able to assess it in common. Otherwise, the court's task "would not be to determine a common issue, but rather to identify one. …

[171] The plaintiffs base their claims against the Trustees on the assertion that the Trustees owed the plaintiffs the specific fiduciary obligation to ensure that HSA fulfilled its obligations under the alleged LTD Agreements.

[172] The plaintiffs pleadings respecting the Trustees are repeated for convenience:

> 17. Further, the Trustees of Trust No. 1 owed a fiduciary duty to the Disabled HSA Members whose benefits were paid out of Trust No. 1, including the Plaintiff Hensman. In particular, the Trustees of Trust No. 1 had the ability to exercise control over the affairs of Trust No. 1. Each of the Disabled HSA Members of whose benefits were paid out of Trust No. 1, were particularly vulnerable to the exercise of the power by the Trustees of Trust No. 1. The Trustees of Trust No. 1 were, at all material times, aware of these facts.
>
> 18. In breach of their fiduciary duty to the Disabled HSA Members whose benefits were paid out of Trust No. 1, including the Plaintiff, Hensman, the Trustees of Trust No. 1 failed to ensure that Trust No. 1 was adequately funded to pay to the Disabled HSA Members the full amounts they were owed under LTD Agreement #1.
>
> 19. In the alternative, the Trustees of Trust No. 1 owed a duty of care to the Disabled HSA Members whose benefits were paid out of Trust No. 1 to act reasonably in the administration of Trust No. 1 and to act in accordance with sound business practices, custom, usage and applicable law in the administration of Trust No. 1. The Trustees of Trust No. 1 were negligent, or grossly negligent, and breached their duty of care to the Disabled HSA Members whose benefits were paid out of Trust No. 1 and failed to act in accordance with sound business practice.

[173] The pleadings are similar with respect to Trust #2 and LTD Agreement #2. With respect to Trust #3 the plaintiffs plead:

> 26. As trustees of Trust No. 3, the Trustees of Trust No. 3 owed an undivided duty of loyalty to the Disabled HSA Members whose benefits were paid out of Trust No. 3 and the obligation to act in their best interests.
>
> 27. Further, the Trustees of Trust No. 3 owed a fiduciary duty to the disabled HSA Members of Trust No. 3, including the Plaintiffs. In particular, the Trustees of Trust No. 3 had the ability to exercise control over the affairs of Trust No. 3. Each of the Disabled H[SA] Members whose benefits were paid out of Trust No. 3, were particularly vulnerable to the exercise of the power by the Trustees of Trust No. 3. The Trustees of Trust No. 3 were, at all material times, aware of these facts.
>
> 28. In breach of their fiduciary duty to the Disabled HSA Members whose benefits were paid out of Trust No. 3, including the Plaintiffs, the Trustees of Trust No. 3 failed to ensure that benefits were maintained in so far as they affected Trust No. 3.

[174] The claim of negligence against the Trustees of Trust #1 and Trust #2 alleges that they failed to obtain and consider appropriate actuarial advice in 2006 when they determined the amount required to fully pay out the benefits to disabled HSA members.

[175] The plaintiffs' pleadings do not allege that the Trustees were a party to either LTD Agreement #1 or #2. Indeed the plaintiffs plead that the LTD Agreements do not include either the terms of the Trust documents or the Plans for Trusts #1, #2, or #3. The allegation is that the Trustees' role required it to "facilitate" HSA in carrying out its obligations under the alleged LTD Agreements.

[176] The Trustees submit that "[t]he plaintiffs cannot have it both ways -- they either have a contract with HSA, and only with HSA, or they are beneficiaries of a benefits trust, and their claims are against the Trustees and only against the Trustees."

[177] The Trustees submit that the plaintiffs' claim against the Trustees for breach of fiduciary duty ignores the terms of the Trust Agreements. They state that the Trust documents set out the content and the scope of the Trustees' fiduciary obligations and cannot be inconsistent with them: Waters et al. *Waters' Law of Trusts in Canada*, 4th ed. (Toronto: Thomson Carswell, 2012) at p. 912. In addition they submit the allegations against the Trustees for any failure to perform their obligations are those that the Trustees are answerable to HSA only, not the plaintiffs. The Trustees state that as a result there is no genuine issue between the plaintiffs and the Trustees.

[178] The plaintiffs submit that the fact that they claim against HSA for breach of contract does not preclude an alternative or additional claim against the Trustees for breach of fiduciary duty or in negligence. They say there is nothing inconsistent about the two claims and that they may succeed on both of them. They also state that the fact that HSA established the Trusts to facilitate the provision of benefits does not mean that such a purpose constituted the entire scope of the Trustees' duties. Finally, they argue that even if the claim against the Trustees is inconsistent with the contractual claim against HSA, there is no reason they cannot pursue their claims against the Trustees in the alternative if the contractual claims are unsuccessful.

[179] The Trustees do not dispute that they owed all of the beneficiaries of Trust #1, #2 and #3 a fiduciary obligation. That obligation may include the duty to act proactively in the face of the underfunding that occurred. The Trust Agreements and the Plans themselves specifically allowed the Trustees to reduce LTD disability benefits. The plaintiffs do not suggest the Trustees did not have such a power.

[180] The Trust Agreements authorized establishment of group benefits plans, and granted the Trustees exclusive power and discretion, subject to the terms of the Trust Agreements, to:

a. formulate the Plan;

b. from time to time amend the Plan;

c. determine the nature and extent of benefits to be provided to members;

d. determine the qualifications and conditions necessary for members to receive benefits.

[181] The Trustees submit that because they were empowered to reduce benefits, no claim can be advanced against them for doing so. However, as the plaintiffs note they are not claiming against the Trustees for reducing benefits. The breaches alleged in the pleadings as follows:

> 37A. HSA and the Trust No. 1 Trustees, Trust No. 2 Trustees and Trust No. 3 Trustees failed to take steps to ensure that the Trusts were fully funded such as obtaining additional funds from HSA members and/or open the Trusts for additional contributions.
>
> …
>
> 37E. In July 2012. HSA and/or the Trust No. 1 Trustees. Trust No. 2 Trustees and Trust No. 3 Trustees actively opposed a referendum seeking support to raise HSA union dues from 1.6% to 2% in order to ensure that the Disabled HSA Members' benefits were maintained at their January 2012 levels. That referendum failed.
>
> [Emphases added]

[182] The plaintiffs allege that the Trustees failed to take steps to ensure that the Trusts were adequately funded after 2011, and that the Trustees actively opposed the referendum seeking to address the underfunding of the Trusts through increased union dues. The allegation is that in acting as Trustees, even if in accordance with the Trust Agreements, they acted in breach of their fiduciary duties to the plaintiffs. The fact that the Trust Agreements gave the Trustees power to amend the terms of the LTD benefits Plans begs the question of whether in exercising that power they did so in a manner that breached their fiduciary obligations.

[183] The plaintiffs submit that the nature and scope of the Trustees' duties is an issue to be resolved at trial.

[184] With respect to the allegation that the Trustees opposed the referendum issue, the Trustees submit that the plaintiffs have not advanced any evidence showing that to be the case. The plaintiffs respond that there is no dispute that Trustees appointed from HSA's board of directors administered the trusts and that all of the defendant Trustees were also officers or directors of HSA. The plaintiffs note that the Trustees do not assert that they abstained, opposed or otherwise refused to participate in HSA's decision to oppose the referendum. As a result, the plaintiffs say that it is a reasonable inference that the Trustees did support and participate in that conduct. The plaintiffs state that in any event, given that the evidence on this issue is in the hands of the defendants, they cannot criticize the plaintiffs for not advancing what they do not have in their control.

[185] In my view the pleadings do raise issues between the plaintiffs and the Trustees. In question is the nature and scope of the Trustees' duties and obligations and whether in exercising their powers the Trustees breached their fiduciary obligation. It cannot be said that their claims are bound to fail.

Section 4(1)(b): Identifiable Class of Two or More Persons

[186] As noted earlier, the plaintiffs must show some basis in fact for the existence of an identifiable class of two or more people. That class must be clearly defined.

[187] As held in *Hollick,* there must be a rational connection between the class as defined and the asserted common issues (para. 20). That connection however is required to ensure "that the class is not unnecessarily broad -- that is, that the class could not be defined more narrowly without arbitrarily excluding some people who share the same interest in the resolution of the common issue" (para. 21).

[188] In *Western Canadian Shopping Centres Inc. v. Dutton,* 2001 SCC 46 [*Western Canadian*], McLachlin C.J.C. for the Court held that class definition should state objective criteria by which members of the class can be identified, those criteria bearing a rational relationship to the common issues but not being dependent on the outcome of the litigation. She also explained that class definition is critical in the certification process, as it permits identification of the individuals entitled to notice, relief, and those who are "bound" by the judgment (para. 38).

[189] At the certification hearing in December 2014, the class definition proposed by the plaintiffs encompassed "all those members of the Health Sciences Association of British Columbia ... who became entitled to receive long-term disability benefits between March 1, 1989 and August 3, 2006, and who were receiving such benefits as of June 1, 2012." The plaintiffs now divide this into two subclasses:

> (1) HSA members who became entitled to receive long term disability benefits between March 1, 1989 and February 28, 1999 and who were receiving such benefits as of June 1, 2012 (LTD Agreement #1 Subclass); and
>
> (2) HSA members who became entitled to receive long term disability benefits between March 1, 1999 and August 3, 2006 and who were receiving such benefits as of June 1, 2012 (LTD Agreement #2 Subclass).

[190] However during the course of submissions counsel for HSA objected to the proposed class definition. Primarily HSA objected on grounds that the word "entitled" founded the class definition in "merit" as opposed to objective criteria.

[191] The plaintiffs, while arguing the acceptability of the original definition, accordingly suggest instead referring to members "who started receiving" LTD benefits instead of members "who became entitled to receive" such benefits. They

say this alteration removes any perceived ambiguity on the issue of entitlement. The plaintiffs also submit that the words “who were receiving such benefits as of June” can be replaced with “who were still receiving such benefits as of June” (emphasis added). According to the plaintiffs, that addition ensures that HSA members who started receiving the benefits within the periods described, discontinued those benefits at a later date, and then subsequently began receiving LTD benefits again after the periods described would be properly excluded from the class.

[192] HSA objects to the plaintiffs’ proposed class definition as unworkable because the individuals who fall within either of the proposed class definitions do not or may not have common legal rights or a common factual basis upon which to assert their individual claims. They submit that in defining a class the critical question is not whether you can say that there is a group of individuals, but rather whether the class definition identifies a class that has a rational connection with the common issues and is not overly broad. They refer to *Hollick* at paras 20-21:

> [20] The respondent is of course correct to state that implicit in the "identifiable class" requirement is the requirement that there be some rational relationship between the class and common issues. Little has been said about this requirement because, in the usual case, the relationship is clear from the facts. In a single-incident mass tort case (for example, an airplane crash), the scope of the appropriate class is not usually in dispute. The same is true in product liability actions (where the class is usually composed of those who purchased the product), or securities fraud actions (where the class is usually composed of those who owned the stock). In a case such as this, however, the appropriate scope of the class is not so obvious. It falls to the putative representative to show that the class is defined sufficiently narrowly.
>
> [21] The requirement is not an onerous one. The representative need not show that everyone in the class shares the same interest in the resolution of the asserted common issue. There must be some showing, however, that the class is not unnecessarily broad -- that is, that the class could not be defined more narrowly without arbitrarily excluding some people who share the same interest in the resolution of the common issue. Where the class could be defined more narrowly, the court should either disallow certification or allow certification on condition that the definition of the class be amended: ... *Webb v. K-Mart Canada Ltd*. (1999), 45 O.R. (3d) 389(S.C.J.) (claim for compensation for wrongful dismissal; class definition overbroad because included those who could be proven to have been terminated for just cause); *Mouhteros v. DeVry Canada Inc*. (1998), 41 O.R. (3d) 63 (Gen. Div.) (claim against school for misrepresentations about marketability of students after

> graduation; class definition overinclusive because included students who had found work after graduation).

[193] HSA submits that simply being a beneficiary of one of the Trusts is not sufficient to make someone a class member. They suggest the proposed definitions include individuals without claims because they were, for example, not parties to either of the LTD Agreements or have different claims arising from different factual circumstances such as the contractual terms varying depending on when they became parties to the LTD Agreements. They note as well that the class as defined could include individuals in receipt of LTD benefits for one disability when the benefits were reduced but were in receipt of LTD benefits for a different disability during the relevant time period. They also note that there are numerous subsets of the proposed sub-classes such as members who took early retirement or qualified for the early retirement program.

[194] HSA further says that the class definition must define class membership as members who are parties to the LTD Agreements because that is the basis for the plaintiffs' contractual claims. They state a proper definition must establish a class that can objectively be said to have the same contract claims, noting that the proposed class definitions fail in this regard by relying instead on the status of being a trust beneficiary. In addition, HSA contends that the class definition fails to address the necessary common elements of a contract claim such as offer, acceptance and certainty of terms.

[195] The Trustees largely adopt the objections of HSA. They note as well that to properly address the issue of who was "entitled" to benefits under Trusts #1, #2 and #3 on the basis of the plaintiffs' contractual claim it must be clear what the terms of the alleged LTD Agreement were as regards each specific plaintiff. They submit as well that each member of the class must have qualified for benefits, continued to qualify for them as of June 1, 2012 and continued to qualify for and be in receipt of those benefits as of the day those benefits were reduced by the Trustees. They state that in fact that during the month of June 2012 some of the beneficiaries were

subject to mandatory retirement, leaving only 151 beneficiaries who continued to receive benefits as of June 1, 2012.

[196] HSA and the Trustees also propose an alternative definition, subject to the qualification that in so doing they are not suggesting that there is an identifiable class of two or more people. By proposing this definition, the defendants say they intend to address the problem created by the use of the word "entitled." The proposed definition is:

> HSA members who commenced receipt of long term disability benefits from either Trust No. 1 or Trust No. 2 for a disability between March 1, 1989 and August 3, 2006, and who were in receipt of long term disability benefits for the same disability as of the date long term disability benefits were reduced by the Trustees on September 21, 2012, such reductions retroactive to June 1, 2012.

[197] I agree with the plaintiffs that their proposed rephrasing of the definition to remove the word "entitled" sufficiently addresses any ambiguity created by that word and ensures that the class will be objectively defined.

[198] Regarding the definition proposed by the defendants, I find that the words "in receipt of long term disability benefits <u>for the same disability</u>" (emphasis added) limit the class too narrowly. What must remain constant over time is the identity of the "scheme" or Plan under which a disabled HSA member receives benefits, not the nature of the disability that makes the member eligible to obtain those benefits. In my view, this concept is adequately captured by inclusion of the words "<u>still</u> receiving <u>such</u> benefits" (emphasis added) as recommended by the plaintiffs. That phrasing imports the necessary continuity by requiring not only that the member continue to receive benefits as of June 1, 2012 but also that the benefits be "such" as those the member began to receive in either of the two prescribed periods.

[199] The assertion of the defendants that because the plaintiffs' claims are founded on alleged contracts the plaintiffs must establish a class that can objectively be said to have the same contract claims is problematic.

[200] I note that the plaintiffs allege objectively-assessed agreements arising out of a course of systemic communications on the part of HSA, rather than agreements arrived at as a result of individual negotiations between HSA and each member, relying on *Lacey*. I consider as well that this is a by-product of the fact that the alleged assumption of responsibility for the provision of LTD benefits by HSA arose out of collective bargaining between HSA and an employer on behalf of HSA's membership. That could mean that HSA undertook a single contractual obligation owed to all of its members, rather than individual and potentially unique obligations owed to each member. In any event, the assertion that all members of the class must have the same contract claims is too restrictive. In *Hollick* at para. 21, McLachlin J. stated that there is no need to show that "everyone in the class shares the same interest in the resolution of the asserted common issue."

[201] This is a certification hearing. At this stage in the proceedings the plaintiffs do not have to establish all of the elements of the contractual claim, nor need they show that each class member has exactly the same contractual claim. That is not the purpose of requiring a class definition. The *CPA* merely requires that a class definition permit identification of class members based on objective criteria, and, as noted in *Hollick,* "the requirement ... is not an onerous one" (para. 21). At this point the Court is not attempting to resolve the issues raised by the parties.

[202] In addition, I note that the plaintiffs' claims are advanced in contract and for breach of fiduciary duty by both HSA and the Trustees, as well as in negligence, solely against the Trustees. The defendants' submission regarding the lack of commonality in the contractual claims, assuming for the moment that it has merit, nevertheless overlooks or ignores the additional claims as pleaded.

[203] The argument of the defendants that those disabled HSA members who retired should be excluded is not supportable, given the plaintiffs' claim is that HSA imposed early retirement on certain persons receiving benefits under LTD Agreement #1 and LTD Agreement #2, such imposition itself being alleged to be a breach of contract.

[204] As a result I conclude that the plaintiffs' proposed class definition as amended (the "Class") is appropriate. For convenience, I reproduce it below:

> (1) HSA members who started receiving long term disability benefits between March 1, 1989 and February 28, 1999 and who were still receiving such benefits as of June 1, 2012 (LTD Agreement #1 Subclass); and
>
> (2) HSA members who started receiving long term disability benefits between March 1, 1999 and August 3, 2006 and who were still receiving such benefits as of June 1, 2012 (LTD Agreement #2 Subclass).

Section 4(1)(c): Common Issues

[205] Section 1 of the *CPA* defines common issues as follows:

> **"common issues"** means
>
> (a) common but not necessarily identical issues of fact, or
>
> (b) common but not necessarily identical issues of law that arise from common but not necessarily identical facts;

[206] The Class members' claims must share a substantial common ingredient: *Western Canadian,* at para. 39. However, common issues cannot depend on findings that will require individual trials nor can they be based on assumptions that circumvent the need for individual inquiries. (*Nadolny v. Peel (Region)* (2009) C.P.C. (6th) 252 a paras. 50-52 (Ont. S.C.J.).

[207] The fact that there is "a common cause of action" does not in itself give rise to a common issue. A common issue cannot be dependent upon findings of fact which have to be made with respect to each individual claimant," *Williams v. Mutual Life Assurance Co. of Canada* (2000), 51 O.R. (3d) 54 (S.C.J.), at para. 39.

[208] I now consider whether the claims advanced by the plaintiffs raise common issues as contemplated under s. 4(1)(c) of the *CPA.*

The Claim for Breach of Contract

[209] The first two proposed common issues relate to the breach of contract claim:

> 1. Did HSA enter into a binding agreement with its members to provide various benefits specifically through LTD Agreement #1 and LTD Agreement #2, as alleged in the Amended Notice of Civil Claim?

> 2. If HSA did enter into LTD Agreement #1 and LTD Agreement #2, what were the terms thereof?

[210] These two issues address whether the pleaded contracts between HSA and the proposed Class exist. The plaintiffs submit that resolution of these two issues will apply to all of the members of the defined Class. As previously discussed they rely on *Lacey*, and note the following passage as particularly apt with respect to this issue:

> [12] There is no dispute that the task of the judge was to view the evidence objectively to determine whether retirement medical benefits were part of the contract of employment for each respondent. Nor is there any dispute that, because the communications by MB with its salaried employees were general, if there was an enforceable contractual obligation for MB to provide retirement medical benefits to any plaintiff there was an identical contractual obligation to all of them. [Emphasis added]

[211] While breach of contract as a cause of action appears to apply across the Class in this instance, the defendants argue the proposed common issues are not common to all members of the Class. They note that in this case there is no standard form contract where the interpretation of a term is a common issue that will advance the litigation. Indeed the very existence of the alleged contracts is a common issue. They submit that raises consideration of individual findings of fact in order to establish who is a party to the alleged contracts.

[212] The defendants also submit the pleadings do not plead material facts that establish that the common issues are common to all of the proposed Class members. For example, they assert the terms of the alleged contracts will change over time depending on when they became parties to either LTD Agreement #1 or LTD Agreement #2. Individual findings of fact will be required in order to determine the terms of the alleged contracts given the plaintiffs' assertions respecting how the contract or contracts were formed.

[213] The defendants rely on *Asp v. Boughton Law Corporation,* 2014 BCSC 1124 at para. 59 where Blok J. stated:

> [59] I am unable to accept the plaintiffs' argument. This case does not involve a standard agreement. The plaintiffs' argument that "all proposed

> class members entered into a similar or identical version" of the alleged agreement begs the question: Did they? On the plaintiffs' own pleadings the agreement is said to have been reached through various unparticularised discussions and communications, partly oral, partly in writing and partly by conduct, occurring over a four-year span. The facts suggest that the proposed class members will have had varying involvement in or with these discussions. I agree with the submissions of the defendants that this demonstrates that individual issues will predominate.

[214] Huddart J.A. for the majority in *Harrington v. Dow Corning Corp*., 2000 BCCA 605 stated:

> [24] More important to a determination of common issues is the requirement that they be "common" but not necessarily "identical." In the context of the ***Act***, "common" means that the resolution of the point in question must be applicable to all who are to be bound by it. I agree with the appellants that to be applicable to all parties, the answer to the question must, at least, be capable of extrapolation to each member of the class or subclass on whose behalf the trial of the common issue is certified for trial by a class proceeding. As the appellants note, this requirement will, of necessity, require that the answer be capable of extrapolation to all defendants who will be bound by it. This is the requirement the appellants argue that the case management judge overlooked in determining the common issue: are silicone gel breast implants reasonably fit for their intended purpose? [Emphasis added]

[215] The defendants further submit that because of the manner of distributing materials individual members will have received different materials and information. Ascertaining the contractual terms would require individualized assessments in order to determine the terms of each member's contract with HSA.

[216] If, however, the alleged contracts are established on the basis relied upon by the Court in *Lacey* the need for individual findings to establish who was a party does not arise. Resolution of this issue is a question of fact for trial and is dependent on the contracts claimed being proven. Relatedly, if HSA merely "assumed responsibility" for a collective contractual obligation owed to all HSA members and previously attaching to the employer, the need for individual findings to establish the agreements does not arise. I therefore reject the submissions of the defendants on this issue and find that the proposed common issues respecting the contract claim are appropriate and that their resolution will apply to all Class members.

[217] Proposed issues 3 and 4 are as follows:

> 3. Did HSA breach LTD Agreement #1 through one or more of the following, with respect to HSA members who became disabled between March 1, 1989 and February 28, 1999:
>
> (a) the reduction in long term disability benefits;
>
> (b) the imposition of early retirement and the concurrent discontinuance of long term disability benefits; and / or
>
> (c) the termination of group life insurance and AD&D insurance?
>
> 4. Did HSA breach LTD Agreement #2 through one or more of the following, with respect to HSA members who became disabled between March 1, 1999 and August 3, 2006:
>
> (a) the reduction in long term disability payments under the Index Removal;
>
> (b) the reduction in long term disability benefits; and / or
>
> (c) the imposition of early retirement and the concurrent discontinuance of long term disability benefits?

[218] These issues address the alleged breach by HSA of the LTD Agreements when they unilaterally reduced benefits to the disabled members. The issue mirrors that in *O'Neill*. I am satisfied that resolution of these issues will apply to all Class members falling within each of the two subclasses, and that there is a basis in fact for accepting that the plaintiffs' contractual claims are triable issues.

The *Insurance Act* Claims

[219] The issue of whether the LTD Agreements are contracts of insurance under the *Insurance Act* is raised because of the potential effects of ss. 58 (life insurance) and 116 (disability insurance) of the *Insurance Act*, which the plaintiffs say would preclude HSA from unilaterally reducing or eliminating benefits payable to disabled HSA members, notwithstanding whether the LTD Agreements permit HSA to do so. The proposed *Insurance Act* issues are as follows:

> 5. If the steps identified in paragraph 3, above, did not constitute a breach of LTD Agreement #1, on the basis that the terms thereof permitted HSA to undertake such actions:
>
> (a) is LTD Agreement #1 "group insurance" within the meaning of the *Insurance Act*;

(b) is HSA an "insurer" within the meaning of the *Insurance Act*; and

(c) is HSA thus precluded from taking the steps identified in paragraph 3, above, be sections 58 and / or 116 of the *Insurance Act*?

6. If the steps identified in paragraph 4, above, did not constitute a breach of the LTD Agreement #2, on the basis that the terms thereof permitted HSA to undertake such steps:

(a) is LTD Agreement #2 "group insurance" within the meaning of the *Insurance Act*;

(b) is HSA an "insurer" within the meaning of the *Insurance Act*; and

(c) is HSA thus precluded from taking the steps identified in paragraph 4, above, by sections 116 of the *Insurance Act*?

[220] The defendants make no submissions with respect to issues 5 and 6. If these issues require resolution, their resolution will affect all Class members. I am satisfied that there is a basis in fact for accepting that the plaintiffs' *Insurance Act* claims are triable issues and are sufficiently described.

The Claims for Breach of Fiduciary Duty

[221] Four issues are proposed for certification with respect to the breach of fiduciary duty claim. Plaintiffs' counsel proposes two categories each with two issues:

7. Does HSA owe a fiduciary duty to the Disabled HSA members with respect to the provision of long term disability benefits and other benefits?

8. If HSA owes a fiduciary duty to the Disabled HSA Members, did it breach that duty by failing to ensure that sufficient funds were available to pay each of the Disabled HSA Members the full amount of the benefits to which they were entitled, either through the funding of the Trusts or otherwise?

9. Do the trustees of Trust No. 1, trustees of Trust No. 2 and trustees of Trust No. 3 (collectively, the "Trustees") owe a fiduciary duty to the Disabled HSA members?

10. If the Trustees do owe a fiduciary duty to the Disabled HSA Members, did they breach that duty by failing to ensure that sufficient funds were available in their respective trusts to pay to each of the Disabled HSA Members the full amount of the benefits to which they are entitled?

[222] Issues #7 and #9 relate to whether HSA and the Trustees owed fiduciary duties to HSA's disabled members, issues #8 and #10 to whether such duties were breached by HSA and the Trustees, respectively. The plaintiffs submit that resolution of these common issues will affect all Class members.

[223] HSA's objection to issue **#7** arises out of their assertion that there is no recognized category of fiduciary duty for unions. This has already been addressed, and I am satisfied that it is a suitable common issue for trial, as its resolution would address a significant or substantial component of the plaintiffs' claims. Regarding issue #9, the Trustees admit that they owed a fiduciary duty to the disabled HSA members, hence there is no need to certify this as a common issue.

[224] Respecting issues #8 and #10, the defendants assert that these issues are unsuitable for resolution as common issues due to the individual nature of the inquiries involved. For instance, they note that vulnerability of the beneficiary is one of the "hallmarks" for identifying a fiduciary duty, and will vary from member to member therefore requiring individual assessment. They note as well that the evidence shows that Mr. Hensman was in receipt of information that other potential members did not receive and as a result his level of understanding is likely not shared by other potential members of the class.

[225] However, as argued by the plaintiffs, the disabled HSA members' vulnerability to the exercise of discretion by HSA and the Trustees arose out of the members' status as disabled persons, a circumstance which does not require individual assessment. The Trustees further deny that they owed a duty to ensure that the Trusts were sufficiently funded in relation to liability under the Plans. While they may be correct in taking that position, the existence or nonexistence of the duty cannot be resolved on certification, except to the extent that I cannot say that the plaintiffs' position in this regard is doomed to failure. There is some evidence to support the plaintiffs' claims that the duty exists and was breached, and therefore, I find that it is appropriately described as a common issue, as is issue #8.

The Negligence Claim Against Trustees

[226] The plaintiffs propose the following with respect to the negligence claim against the Trustees:

> 11. Do the trustees of Trust No. 1 and trustees of Trust No. 2 owe one or more of the following duties of care to the Disabled HSA Members, who are the beneficiaries of the Trusts:
>
> (a) to act reasonably in the administration of each trust; and / or
>
> (b) to act in accordance with sound business practices, custom, usage and applicable law in the administration of each trust?
>
> 12. Were the trustees of Trust No. 1 and Trust No. 2 negligent or grossly negligent or, in the alternative, did the trustees of Trust No. 1 and Trust No. 2 fail to act in accordance with sound business practice by failing to properly obtain, and utilize, actuarial advice in determining the amount of funds to be placed in Trust No. 3.

[227] The plaintiffs submit that issue #11 addresses the existence of a duty of care on the part of the Trustees of Trust #1 and Trust #2 as well as the applicable standard of care.

[228] The Trustees concede the existence of the obligation to act prudently in the administration of each Trust and to act in the best interests of all beneficiaries when making decisions. They also admit that they had to fulfill their responsibilities as set out in the terms of the Trust documents and applicable Plans, as well as fulfilling equitable and statutory obligations. They submit that this answers issue #11: they argue that it does not advance this litigation to decide whether the Trustees' obligations fall under the law or negligence or the law of fiduciary duty or both. They further submit that the important question, and the one in issue, is whether that obligation was breached.

[229] However, Perell J.'s decision in *Cavanaugh v. Grenville Christian College*, [2009] O.J. No. 875 (S.C.J.) addresses that objection. He noted that "while negligence and breaches of fiduciary duty may arise from the same facts, doctrinally they are distinct causes of action ... acts of negligence are not necessarily breaches of fiduciary duty and conversely breaches of fiduciary duty are not necessarily acts

of negligence" (para. 30). The Ontario Court of Appeal did not disturb that finding on review: *Cavanaugh v. 226937 Ontario Ltd.*, 2009 ONCA 753 at para. 5. Given the Court's limited role on an application for certification, I cannot at this stage identify the precise boundaries of the duties owed the plaintiffs under the Trustees' fiduciary obligations as opposed to the negligence paradigm. Thus, I cannot say that a breach of the former will necessarily constitute a breach of the latter or vice versa.

[230] The Trustees also submit that issue #11 is not common to the plaintiffs and the Trustees, because they say that the sufficiency of funding of the Trusts was a duty owed to HSA, not the plaintiffs. I am of the view that this question should be resolved at trial, as it requires interpretation and weighing of the evidence. I accept that there is a basis in fact for accepting that this is a triable issue.

[231] With respect to issue #12, the plaintiffs allege that the Trustees were negligent in failing to seek actuarial advice when determining the amount of funds to be placed in Trust #3 in 2006, when the Trustees would have had opportunity to secure additional funds to eliminate the funding deficit. As with issue #11, the Trustees say that this issue is not common to the plaintiffs and Trustees, because the Trustees' duty regarding the adequacy of funding in the Trusts was owed to HSA, and not to the plaintiffs.

[232] The plaintiffs' position with respect to proposed issue #12 is that it addresses the breach of the duty of care taking into account the applicable standard of care and is a common issue in that its resolution will affect all Class members. In light of my conclusions respecting the claim against the Trustees, I find that issue #12 is a suitable and triable common issue.

Remedies

[233] The plaintiffs propose the following issues #13, #14 and #15 with respect to damages and their assessment:

> 13. To the extent that the court concludes that there was a breach of contract (or contracts) on the part of HSA and/or breach of fiduciary duty on the part of HSA and the Trustees and/or negligence on the part of the

> trustees of Trust No. 1 or Trust No. 2, what damages were suffered by the class members as a result thereof?
>
> 14. Should aggravated damages be awarded to the Class members against any of the Defendants? If so, in what amount?
>
> 15. Should punitive damages be awarded to the Class members against any of the Defendants? If so, in what amount?

[234] The plaintiffs submit that these issues go to the availability and calculation of damages if the Court finds one or more of the defendants liable. As such they contend that these are common issues and their resolution will affect all Class members.

[235] The defendants HSA and the Trustees respond only to issue #14, the claim for aggravated damages. Regarding issues #13 and #15, I am satisfied that they are suitable common issues sufficiently pleaded.

[236] Turning to issue #14, aggravated damages compensate plaintiffs, rather than punish defendants. They address non-pecuniary damages arising from such "intangible elements as pain, anguish, grief, humiliation, wounded pride, damaged self-confidence or self-esteem, loss of faith in friends or colleagues, and similar matters that are caused by the conduct of the defendant," *Huff v. Price* (1990), 76 D.L.R. (4th) 138 at para. 50 (B.C.C.A.), LTA ref'd, [1991] S.C.C.A. No. 33.

[237] Given the nature of aggravated damages, HSA asserts that the Court must assess entitlement to such damages on an individual basis, even where the entitlement of the Class to such damages flows from the same event. The defendants refer me to *Ladas v. Apple Inc*., 2014 BCSC 1821 at para. 187, in support of its position that the Court cannot evaluate such damages commonly. As a result, HSA says that the plaintiffs fail to satisfy the burden of providing "some basis in fact" that the proposed common issues are common to the Class.

[238] The plaintiffs argue that aggravated damages are common issues in that their "resolution will affect all class members." The plaintiffs submit that if they prove a breach of the LTD Agreements, that will entitle them to aggravated damages for mental and psychological distress, as a contract for LTD benefits is a contract for

"peace of mind," *Fidler v. Sun Life Assurance Co. of Canada*, 2006 SCC 30 at paras. 41, 51-52.

[239] HSA's argument that the plaintiffs' aggravated damages claim lacks a basis in fact seems to relate to a lack of sufficient particularization. I note, however, that the plaintiffs pleaded that obtaining LTD coverage was to provide peace of mind to the plaintiffs in the event that they became disabled. In my view, the claim is sufficiently particularized in that sense.

[240] The plaintiffs acknowledge that aggravated damages may require individual assessment, but say that this is a common feature of class proceedings which legislators specifically anticipated under ss. 27-28 of the *CPA,* which state:

> **Determination of individual issues**
>
> **27** (1) When the court determines common issues in favour of a class or subclass and determines that there are issues, other than those that may be determined under section 32, that are applicable only to certain individual members of the class or subclass, the court may
>
> (a) determine those individual issues in further hearings presided over by the judge who determined the common issues or by another judge of the court,
>
> (b) appoint one or more persons including, without limitation, one or more independent experts, to conduct an inquiry into those individual issues under the Supreme Court Civil Rules and report back to the court, or
>
> (c) with the consent of the parties, direct that those individual issues be determined in any other manner.
>
> ...
>
> **Individual assessment of liability**
>
> **28** Without limiting section 27, if, after determining common issues in favour of a class or subclass, the court determines that the defendant's liability to individual class members cannot reasonably be determined without proof by those individual class members, section 27 applies to the determination of the defendant's liability to those class members.

[241] However, I agree with the defendants that aggravated damages do not properly constitute a common issue. The impact of a breach of the LTD Agreements

on Class members' "intangible elements" will vary among Class members, thereby requiring individual assessment. Section 27 of the *CPA* sets out procedures for determining individual issues that arise in the context of a class proceeding involving resolution of common issues, but does not contemplate treating individual issues as common issues.

[242] Accordingly, I find that issues #13 and #15 are suitable common issues, but issue #14 is not.

Section 4(1)(d): Preferable Procedure

[243] Assessment of this requirement assumes the existence of an identifiable class with common issues. Section 4(1)(d) requires a finding that "a class proceeding would be the preferable procedure for the fair and efficient resolution of the common issues". Section 4(2) then states:

> **4** (2) In determining whether a class proceeding would be the preferable procedure for the fair and efficient resolution of the common issues, the court must consider all relevant matters including the following:
>
> (a) whether questions of fact or law common to the members of the class predominate over any questions affecting only individual members;
>
> (b) whether a significant number of the members of the class have a valid interest in individually controlling the prosecution of separate actions;
>
> (c) whether the class proceeding would involve claims that are or have been the subject of any other proceedings;
>
> (d) whether other means of resolving the claims are less practical or less efficient;
>
> (e) whether the administration of the class proceeding would create greater difficulties than those likely to be experienced if relief were sought by other means.

[244] The Court must consider the question of preferable procedure in light of the three principal benefits of class actions: judicial economy, access to justice and behaviour modification. However, the plaintiffs need not prove that their proposed class action will actually achieve those goals. I must construe broadly the term

"preferable", evaluating whether the proceeding will be a "fair, efficient, and manageable method of advancing the claim" and whether a class proceeding offers advantages over reasonably alternative means of resolving the claim, such as joinder or test cases: *Hollick,* at paras. 27-28.

[245] The plaintiffs point to evidence indicating that the defendants' actions adversely affected approximately 220 disabled HSA members. Their individual claims, though not insubstantial (for example, $135,000 in Mr. Hensman's situation and $123,000 in Ms. Watt's) are nevertheless modest in the context of complex civil litigation. The plaintiffs therefore assert that individual members will not likely pursue individual claims. A class proceeding is therefore not only the preferable procedure in their estimation, but is the only form of proceeding likely to occur.

[246] In response, HSA disputes the existence of the alleged LTD Agreements, and reiterates its position that resolution of the plaintiffs' claims will require individual determination of various issues, including which disabled HSA members are parties to the alleged contracts, which documents are integrated into the contracts, and whether HSA breached those agreements. HSA also says that the plaintiffs failed to allege how HSA members who were not receiving benefits at the time the contracts were formed became parties to the contracts, and therefore cannot say that proving the existence of the alleged contracts will mean success for all sub-class members.

[247] The objections of HSA rest on the assumption that individual contracts will necessarily have to be established in order for the plaintiffs' claims to succeed. This however is not the approach pleaded by the plaintiffs who, relying on *Lacey,* seek to establish, based on systemic publications by HSA to its members, that objectively assessed contracts exist. The plaintiffs similarly contend that HSA assumed from the employer an obligation owed collectively to the Class members. On either theory, or in relation to the plaintiffs' claims against the defendants for breach of fiduciary duty or negligence, it is my view that the common issues clearly predominate over any questions requiring individual determination. I accordingly conclude that s. 4(2)(a) weighs in favour of the plaintiffs.

[248] Turning to the other s. 4(2) factors, I am not aware of anything that would suggest that a significant number of Class members would have an interest in individually controlling the prosecution of separate actions, nor whether the plaintiffs' claims are the subject of any other proceedings. I accept that there is a basis in fact showing that other means of resolving the claims, particularly given the expense of the litigation and the sums involved, would be less efficient than a class proceeding, so much so that it strikes me as unlikely that these claims would be pursuable on an individual basis. Finally, given my view of the commonality of the issues raised by the plaintiffs' claims, I conclude that the class proceeding eases rather than aggravates the difficulties associated with the litigation, and as a result that the plaintiffs satisfy the "preferable procedure" requirement under s. 4(1)(d) of the *CPA*.

Section 4(1)(e): Representative Plaintiffs

[249] Section 4(1)(e) requires that the party seeking certification show that the proposed representative plaintiffs:

> **4** (1) …
>
> (i) would fairly and adequately represent the interests of the class,
>
> (ii) have produced a plan for the proceeding that sets out a workable method of advancing the proceeding on behalf of the class and of notifying class members of the proceeding, and
>
> (iii) do not have, on the common issues, an interest that is in conflict with the interests of other class members.

[250] The plaintiffs submit that these requirements are met, with Mr. Hensman representing LTD Agreement #1 Subclass and Ms. Watt representing LTD Agreement #2 Subclass.

[251] HSA does not take issue with Ms. Watt and Mr. Hensman being appropriate representative plaintiffs if the Court is satisfied they meet the requirements of the *CPA,* however they only do so in so far as they represent a similarly situated sub-class of members who were receiving benefits from either Trust #1 or Trust #2 as of June 30, 2012. They submit that the Class proposed by the plaintiffs be broken down into further subclasses represented by other representative plaintiffs. These subclasses should, in HSA's view, represent disabled HSA members who fell under the mandatory early retirement program as well as the subclass of individuals who elected to take early retirement.

[252] Since I have concluded that the need for sub-classes of members proposed by the defendant HSA is not appropriate given how the plaintiffs' claims are formulated I do not accede to their submission.

[253] As a result I conclude that the plaintiffs are suitable representative plaintiffs.

Litigation Plan

[254] The defendants made no submissions on the proposed litigation plan noting that a litigation plan can be revisited. On that basis the proposed litigation plan is approved as amended by me and is attached as Schedule A.

Conclusion

[255] I grant the application to certify this action as a class proceeding in accordance with these reasons.

"Punnett J."

SCHEDULE "A"

LITIGATION PLAN

1. NOTICE OF CERTIFICATION

1. If certification is granted, notice shall be given to potential class members in accordance with section 19 of the Class Proceedings Act (the "CPA").

2. Within 15 days of a successful result in the certification application, counsel for the Plaintiffs shall provide counsel for the Defendants with a proposed form of Notice to the class members. In the event that the parties are able to agree on the form of the Notice, it will be provided to the Court for approval pursuant to section 22 of the CPA. In the event that the parties are unable to agree on the form of the Notice, counsel for the Plaintiffs will bring an application to have the Court settle the terms of the Notice pursuant to section 19(6) of the CPA.

3. Following agreement to, or settlement by the Court of, the form of the Notice to Class members, and assuming that the Court makes the orders sought in paragraphs 8 through 11 of Part 1 of the Plaintiffs' Notice of Application, publication of the Notice will be issued in the manner ordered by the Court, namely:

   (i) by letter to those persons whose names and addresses are provided to Church & Company by the Defendant; and

   (ii) by the posting of a copy of the certification notice on Church & Company's website.

4. In accordance with the certification order, class members will be entitled to opt out of the proceeding within 90 days of the last step in item (c) to occur by notice in writing, including by fax and email, to Church & Company at 900 - 1040 West Georgia Street, Vancouver, British Columbia.

5. In accordance with the certification order, class members who reside outside of British Columbia may opt into the proceeding within 90 days of the last step in item (c) to occur, by notice in writing, including by fax and email to Church & Company at 900 - 1040 West Georgia Street, Vancouver, British Columbia.

2. DOCUMENT PRODUCTION

1. Subject to point (b) below, document production will be undertaken in accordance with the provisions of Rule 7-1 of the Supreme Court Civil Rules, with the 35 day time limit for initial production under rule 7-1(1) commencing to run on the date of the entry of the certification order.

b. Rather than waiting for the delivery of the opposing parties' initial list of documents, counsel for each party will deliver a list of the categories of documents that they expect to see produced by the other side and such delivery shall constitute notice for the purposes of Rules 7-1(10) and 7-1(11).

c. It is anticipated that document production will be completed within three months of the entry of the certification order.

3. EXAMINATION FOR DISCOVERY

a. It is anticipated that initial examinations for discovery of the representative Plaintiffs and of the Defendants and their representatives will be completed within six months of the entry of the certification order.

b. An order waiving the 7 hour restriction under Rule 7-12(2) may be sought by the Plaintiffs.

c. Although counsel for the Plaintiffs does not anticipate it being required, to the extent that the Defendants seek examination of class members pursuant to section 17(2) of the CPA, such application would only be made after the examination for discovery of the representative Plaintiffs has been concluded.

4. POSSIBILITY OF MEDIATION

a. Following the completion of discovery procedures, counsel for the Plaintiffs will consider the possibility of mediation.

5. CASE MANAGEMENT

a. Active case management pursuant to section 12 of the CPA, to the extent required, will be used to complete the discovery (documentary and oral) process and to prepare the case for trial, including trial scheduling.

6. DETERMINATION / TRIAL OF COMMON ISSUES

a. To the extent possible, counsel for the Plaintiffs will attempt to determine if one or more of the common issues certified by the Court can be resolved by way of summary trial pursuant to Rule 9-7 of the Supreme Court Civil Rules. To the extent counsel for the Plaintiffs intends to proceed by this method, advance approval of the Court will be sought.

b. If resolution of all of the common issues is not possible by way of summary trial, a case management conference will be held at least 28 days before the trial date and the parties will file a trial certificate within 28 days of trial.

c. An aggregate award is likely to be sought for the punitive damages.

d. Following the outcome of the common issues trial, counsel for the Plaintiffs will prepare a proposed notice to class members of the outcome for approval by the Court. The notice will be published in the manner directed by the Court and in accordance with the provisions of section 20 of the CPA.

e. To the extent that the Plaintiffs are successful on one or more of the common issues, it is anticipated that further proceedings may be required in respect of individual damage assessments. Court assistance and direction will be sought in that regard.

7. MEDIATION OF INDIVIDUAL ISSUES

a. It is expected that the damages of individual class members will be relatively simple for the parties to compute. Mediation will likely be sought in that regard.

8. DETERMINATION OF INDIVIDUAL ISSUES

a. To the extent that mediation is not successful in respect of individual damage assessments, it is proposed that the Defendants will produce a statement of the benefits received by each class member, both before and after the effective date of the Resolutions.

b. A determination of the individual damage assessments will likely be sought by way of summary trial, or as ordered by the Court.