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Brokers’ duty when placing Business Interruption Insurance

The claimant alleged that its broker had been negligent when placing business interruption ("BI") cover for it. The claimant had reached a settlement with its insurers after they had indicated that they might exercise their avoidance rights because the claimant was under-insured. Although most of the case turns on the facts of the case (and, in particular, the source of figures supplied to the insurers), Blair J did set out some basic principles of brokers’ duties when placing BI cover:

1) Two particular problems arise with the placement of BI cover: the calculation of "gross profit", allowing for the fact that the insured will not be incurring the costs of purchases or variable costs in the event of a catastrophic event; and the period of indemnity which will be required (the maximum indemnity period can be 12 or 24 months and the insured event may take place near the expiry of the policy).

2) The broker need not calculate the sum insured or choose an indemnity period, but he must provide sufficient explanation to enable the client to do so.

3) The broker is not required to conduct a detailed investigation into a client’s business. However, he should take reasonable steps to ascertain the nature of the client’s business and its insurance needs.

4) It is a general principle that a broker’s duty is not diminished just because his firm may offer an enhanced service at an additional cost.

5) The scope of a broker’s duty to assess a commercial client’s business needs will depend on all the circumstances of the case, including the client’s sophistication (even though the insurance industry, unlike some other parts of the financial services industry, does not have standard procedures for identifying sophisticated clients). It cannot be assumed that an SME will have any understanding of BI insurance.

6) Nor can it be assumed that a broker will not have to repeat advice annually, since personnel at a client may change.

7) Importantly for this case, if a client appears to be well-informed about his business and provides the broker with information, the broker is under no duty to verify that information unless he has a reason to believe it is not accurate.

Here, the judge concluded that the information passed to insurers had come from the client (and the broker had had no reason to doubt it) and that adequate advice had been given by the broker.

One further issue raised in this case was whether Arbory Group Ltd v West Craven Insurance Services [2007] Lloyd’s Rep IR 491 had been correctly decided when it concluded that the object of BI cover is to enable the company to recover and to resume its pre-incident level of profitability at the earliest date and hence an insured can recover foreseeable consequential losses. However, Blair J refused to opine on whether a consequential loss of profits claim could have been made by the claimant in this case.

The judge went on to find that, had the broker been negligent, contributory negligence would have been assessed at 50%, on the basis that incorrect figures had been given by the claimant to the broker (even though the claimant could not be criticised for failing to read in detail the documentation sent to it by the broker).

**COMMENT:** Some writers have found the case of Arbory controversial since it appears to override the rule in Sprung v Royal Insurance (UK) Ltd [1997] CLC 70 (which held that an insured is not entitled to the recovery of damages for the non-payment or late payment of insurance monies). However, the judge in Arbory held that the very purpose of BI insurance is to cover loss of profits and so, for that reason, it is an exception to the rule in Sprung. This case takes the argument no further, though. The issue of damages for non- or late payment of insurance monies was to have been addressed in the Insurance Bill currently going through Parliament (see further below) but the relevant clause was removed from the bill before it was presented to Parliament (although it may possibly be re-introduced in an amended form or by way of separate legislation this autumn).

It is also interesting that the judge held that the claimant’s commercial director who was responsible for placing its insurance would not have been expected to read in detail the documentation sent to it by the broker. Prior caselaw on this point is fact-specific, but, in general, it seems that it is difficult to claim contributory negligence where an insured has no particular insurance expertise. This case continues that trend (a finding of contributory negligence only having been likely because the broker had relied on the figures supplied by the insured itself).

Eurokey Recycling Ltd v Giles Insurance Brokers Ltd [2014] EWHC 2989 (Comm)
Claims cooperation

Duty to comply with Claims cooperation clause where insurer has denied liability/proving quantum

After Eder J held, as a preliminary issue, that the insurance policy in question did cover theft by employees, despite the insured’s non-selection of a “Theft by Employees Section” (and so the insurer couldn’t reject the claim on that basis), the insured proceeded to bring a claim for business interruption losses. This was an unusual BI claim, because such claims are normally based on a single adverse event, such as a fire or flood or major burglary which is immediately known to the insured and which causes major losses of profit clearly reflected in the insured’s accounts. By contrast, here the alleged thefts took place more than 500 times over more than five years (and spanning some five policy years) before discovery in December 2008, and the allegations of loss were founded not on accounts but instead on calculations based on various assumptions. Although the case is fact-specific, some general points of interest arose:

1) Complying with a Claims Cooperation Clause (“CCC”): the policy contained a claims condition that (inter alia), “in the event of a claim being made”, the insured would provide particulars of its claim within 30 days after expiry of the Indemnity period, and deliver accounts and other “documents proofs information explanation and other evidence as may be reasonably required” by the insurer to investigate the claim. It was also provided that “if the terms of this condition have not been complied with, no claims under this Section shall be payable”, and the term was accepted to be a condition precedent.

The insured argued that no claim could be made here until after discovery of the theft in December 2008, and hence there was no obligation to deliver particulars of the claim before that time. That argument was rejected by the judge. It did not matter that the insured did not discover the thefts until 30 days after the indemnity periods had expired under earlier policies. Particulars had not been sent until 17 February 2009 and so the insured had breached this requirement in respect of all thefts prior to 18 January 2008. However, although the judge accepted that insurers could have “pulled the shutters down” in relation to those thefts, he found that they had not done so on the facts.

Eder J also approved textbook commentary to the effect that “full particulars” means “the best particulars the assured can reasonably give”, and (unless the policy states otherwise) further particulars can be supplied later on.

The judge did not decide the “very difficult issue of law which has never properly been considered by an English Court” as to whether an insured must comply with claims conditions if an insurer wrongly rejects a claim (and if that constitutes a repudiation of the insurance policy). Instead, he focused attention on the meaning of what was “reasonably” required.

The judge was prepared to find that the list of various documents required by the insurers had been “reasonably” required “in an abstract sense”. However, he went on to hold that “it does not seem to me that this is necessarily so in circumstances where insurers in effect (wrongly) deny liability in principle or even (wrongly) refuse to admit that “employee theft” was an insured peril, as they did in the present case. I should emphasise that I fully accept that, generally speaking, it may be perfectly “reasonable” for insurers to reserve their position pending receipt of further documents/information and that a requirement by insurers that the insured should deliver such documents/information may be entirely “reasonable” because a review of such documents/information by insurers is necessary in order to decide, for example, whether cover exists or not. In my view, that is a statement of the obvious but it is not this case. I should also make plain that I fully accept as a matter of the general law of contract that a repudiation is a thing “writ in water” and that, unless it is accepted by the innocent party, the latter will generally continue to be bound by the contract and, in particular, continue to be bound to perform that party’s continuing obligations under the contract. That is, indeed, trite law. However, here the focus is one of construction of the contract and, in particular, what information may be “reasonably required” by insurers in the particular circumstances of the present case; and unless and until the defendants were prepared to confirm at the very least that “employee theft” was an insured peril, the requirement to deliver the other
categories of documents ... was, in my judgment, not “reasonable” having regard, in particular, to the time and expense that would have to be incurred by [the insured] in complying with such requirement”.

The judge did, however, find that the insured had breached the claims cooperation clause by failing to provide profit and loss and management accounts from 2005 to 2008, it being common ground that a request for such accounts is routine for commercial claims and hence were “reasonably required”. Although certain issues had been “parked” pending agreement on the question of liability, no additional costs would have had to be incurred in order for the insured to send the accounts.

Furthermore, there had not been unequivocal representation from the insurers that the insured was not required to deliver the accounts (and hence no waiver by estoppel). It did not matter that the insured thought or assumed that they did not have to deliver the accounts – that did not result from any agreement by the insurers. Accordingly, the claim failed because a breach of the CCC.

Eder J also said that it was “difficult” to say the insurer had breached its duty of good faith because it ought to have warned the insured that it was committing a breach of a condition precedent. The judge agreed that the insurer was under no duty positively to warn the insured that it needed to comply with policy terms, and there was also no evidence to support the suggestion that it should be inferred that the insurer’s silence was deliberate.

2) Proving quantum: an insured must establish on a balance of probabilities that a relevant event has been caused by an insured peril. Here, the insured faced difficulty in meeting that burden and proving that thefts had even taken place, and the judge accepted that “there may be different ways of satisfying the legal burden and standard of proof other than by direct evidence”. However, here, although certain thefts (below the policy excess) had been proven, there was no evidence that an assumption made by the insured about the employee’s thieving activities during the relevant period was correct. Indeed, the employee would most likely have tried to keep the number of incidents of theft to a minimum in order to avoid the risk of detection.

**COMMENT:** As mentioned above, this case does not resolve the issue of whether an insured must comply with a policy condition even if the insurer has (wrongfully) rejected a claim. In *Diab v Regent Insurance Co Ltd* [2006] UKPC 29 the Privy Council held that a claims provision remained binding even where insurers had told the insured they would not pay the claim (and the case was followed in *Lexington Insurance Co v Multinacional de Seguros SA* [2008] EWHC 1170 (Comm)), but there is textbook commentary doubting that approach in non-liability or reinsurance cases (see Colinvaux’s Law of Insurance, 9th edn, para 9-018) and Eder J was not strictly bound to follow either *Diab* or *Lexington*. Instead, this case focuses on what an insurer can “reasonably” require from the insured following the rejection of a claim, if the policy contains that wording (and even if the clause does not contain that wording, *Napier v UNUM Ltd* (formerly NEL Permanent Health Insurance Ltd) [1996] 2 Lloyd’s Rep 550 is authority for the view that the courts will imply a reasonableness test into any requirement for the insured to provide information to the insurer about its claim).

However, it might be said that by focusing the inquiry on the policy wording, the judge did implicitly accept that the insured was still bound to comply with a claims provision even though insurers had rejected the claim (even if he did not expressly say that was his conclusion). It is also noteworthy that the judge linked the issue of “reasonableness” in the policy condition to the insurer’s conduct regarding the claim in general: in short, where a claim has not been accepted, an insurer cannot reasonably request information which it will be costly or timely to produce (and query how much time and expense will result in a request not being reasonable).

A fire at the insured’s premises destroyed the vast majority of its stock. The evidence suggested that the fire was started by an intruder. Although a fire alarm at the premises detected the fire, the insured’s burglar alarm had not been set at the time and in fact was no longer being monitored by the provider, SECOM, because its monitoring charge had not been paid by the insured. At the time of the fire, which happened at 01.00 am on a Saturday, the owner of the insured had been asleep in a separate dwelling area on the premises.

The insured’s property insurer repudiated liability on the basis that there had been a breach of two conditions precedent. The policy contained:

a) a condition precedent (GC7) which provided that “the whole of the protections including any Burglar Alarm provided for the safety of the premises shall be in use at all times out of business hours or when the Insured’s premises are left unattended and such protections shall not be withdrawn or varied to the detriment of the interests of Underwriters without their prior consent”; and

b) a further clause (PW1) which provided that “It is a condition precedent to the liability of the Underwriters in respect of loss or damage caused by Theft and/or attempted Theft that the Burglar Alarm shall have been put into full and proper operation whenever the premises…are left unattended…” (emphasis added).

The case therefore turned on the inter-relationship between GC7 and PW1 (it being accepted, in accordance with English law principles that, since they were both conditions precedent, a breach did not have to be shown to have caused the loss). Jay J held as follows:

1) Wording in a quotation sheet which indicated that PW1 was intended to override GC7 did not form any part of the contract of insurance.

2) The correct approach to construction of GC7 is to examine its commercial purpose in light of the other relevant contractual provisions. The judge rejected the approach of some American courts that “each clause must be seen as an island unto itself”. Here, it could not be said that the sole purpose of the burglar alarm was to reduce the risk of theft (and hence a burglar alarm differs from a fire alarm). A burglar alarm protects against the risk of intrusion which might in turn lead to damage to property. Accordingly, it could not be said that PW1 entirely predominated over GC7. Furthermore, the burglar alarm had a “domain of activity” outside of theft and so PW1 was not surplusage.

3) Did PW1 qualify GC7 with the effect that the duties under GC7 could be no more onerous than under PW1? The judge agreed that it did. There was no hard and fast rule that PW1 must be “hermetically sealed and ring-fenced off GC7”. The two must be read together and the commercial purpose behind them considered. Jay J concluded that here GC7 had to be “read down” so that the insured was only required to set the alarm when the premises were unattended (rather than also just when out of business hours) and thus the requirements were no more onerous than they would have been had this been a theft claim (nor did the clauses have to match only for theft claims).

4) Had the premises been “left unattended”? The situation here was said to differ from earlier cases regarding motor insurance, where someone “attending” a vehicle cannot be asleep whilst doing so. The construction of the term was one of fact, degree and circumstance. Here, there was a large and complex building which could not possibly be subject to effective, active surveillance by one person and: “In ordinary parlance, houses or premises become unattended when their occupants leave”. Accordingly, there had been no breach of GC7.

5) Even if GC7 was to be read as a stand-alone provision, it should not be construed in such a way that there was an obligation on the insured to activate the alarm in circumstances where it would have been triggered by the movement of persons who were legitimately on the premises (there being no reference in the clause to “part of” the premises). Nor did it matter what the insured actually used to do in practice: “this cannot be determinative of the claimant’s contractual obligations…those obligations must be ascertained by the application of ordinary principles of construction of insurance documentation”.

Conditions precedent
6) However, the insured’s case failed because the judge held that it had breached the second part of GC7. Regardless of the use of the burglar alarm on one specific occasion, the insured had failed to pay SECOM’s monitoring charge and this had given rise to a real risk that SECOM would cease its monitoring service. The insured had known that the charge was payable in advance, that it had not paid for over six months, and that SECOM would not allow this situation to continue indefinitely. It made no difference that the insured considered that SECOM was in breach of contract for causing or permitting too many false alarms. The insured had been reckless as to the risk of the monitoring service being cut off.

So, with a “degree of reluctance” the judge found in favour of insurers.

COMMENT: The judge’s construction of the two conditions precedent conflicts with some textbook commentary that “each exclusion ‘is meant to be read with the insuring agreement independently of every other exclusion. The exclusions should be read seriatim, not cumulatively … There is no instance in which an exclusion can properly be regarded as inconsistent with another exclusion, since they bear no relationship with one another.’ The meaning must be sought first in context: within the confines of the clause in question” (see Clarke, The Law of Insurance Contracts, 4th edn, para 15-6). However, the judge was clearly swayed by the view that a mismatch between the insured’s obligations in relation to a theft claim as opposed to any other claim arising out of non-working burglar alarm made no commercial sense and could not have been what the parties intended.

Milton Furniture Ltd v Brit Insurance Ltd [2014] EWHC 965 (QB)
Court of Appeal rules that a claimant cannot accept a FOS award and pursue further losses from the courts for the same cause of action

The Financial Ombudsman has the power to award compensation of up to GBP 150,000. Under the FSA's Handbook, a complainant can choose to accept or reject an award and, under section 228(5) of FSMA 2000, “if the complainant notifies the ombudsman that he accepts the determination, it is binding on the respondent and the complainant and is final”. In Andrews v SBJ Benefit Consultants Ltd [2010] EWHC 2875 (Ch), a High Court judge held that, because of the merger doctrine, a claimant cannot accept an award from the Financial Ombudsman and then claim additional losses (above the Ombudsman’s limit) in civil proceedings before the courts. However, in the first instance decision in this case, another High Court judge held that the merger doctrine did not apply and there was nothing to stop a complainant using his award from the Ombudsman to finance his court proceedings to recover a greater amount. Accordingly, there were two conflicting High Court decisions on this issue. The appeal in this case has now unanimously held that court proceedings could not be brought for the same cause of action after a complainant has accepted an award from the Ombudsman.

Although the earlier High Court decisions were based on the merger doctrine, the Court of Appeal reached its conclusion based instead on the principle of res judicata. As explained in the decision: “The requirements of res judicata are different from those of merger. All that is necessary to bring merger into operation is that there should be a judgment on a cause of action. Res judicata may apply either because an issue has already been decided or because a cause of action has already been decided” (the latter kind of res judicata was in issue in this case).

The Court of Appeal held that an award from the Ombudsman can give rise to res judicata, because a complaint to the Ombudsman can be a cause of action (and it makes no difference whether the Ombudsman’s award was for the maximum sum allowed or not). It acknowledged that there could be situations where a complainant may bring court proceedings after accepting an award, provided that the substance of the court proceedings differs from the substance of the complaint to the Ombudsman. Fresh proceedings cannot be permitted, though, where court proceedings are being used to “top up” an award.

Furthermore, where Parliament is silent on an issue, the common law still applies unless it has been excluded. Accordingly, res judicata could apply in this case even though section 228(5) made no reference to it.

Having reached that conclusion on res judicata, there was no need for the Court of Appeal to consider whether merger was also available.

COMMENT: This case has brought some welcome clarity to the issue of whether a complainant’s acceptance of an Ombudsman’s award is truly binding in relation to that complaint. However, it does still remain possible for a complainant to reject an award and pursue recovery for the full amount of his claim from the courts.

Clark v In Focus Asset Management & Tax Solutions Ltd [2014] EWCA Civ 118
Privy Council considers fraudulent devices and the need for dishonest intention

A (genuine) fire at the insured’s premises destroyed all its stock. Insurers repudiated liability on the ground that the insured had submitted false invoices (purportedly showing amounts paid by the insured for stock) in support of its claim (a condition in the policy expressly provided that all benefit under the policy would be forfeited if any false declarations were made, or fraudulent devices were used, in support of a claim). At first instance, the judge found that the insured had not used fraudulent devices. He held, broadly, that invoices had been altered but that there had been no fraudulent purpose (eg because the stock in question had genuinely been bought by the insured). The Court of Appeal allowed the insurers’ appeal from that decision and the Privy Council has now set aside the Court of Appeal’s decision.

The Privy Council noted the statement by Mance LJ in Agapitos v Agnew (The Aegean) [2002] EWCA Civ 247 that “a fraudulent device is used if the insured believes he has suffered the loss claimed but seeks to improve or embellish the facts surrounding the claim by some lie” (the Board’s emphasis). Given that the trial judge had found that there had been no dishonest intent, it was held that he had been entitled to find that fraudulent devices had not been used.

COMMENT: This case might be contrasted with that of Sharon’s Bakery (Europe) Ltd v AXA Insurance UK Plc [2011] EWHC 210 (Comm), where the insured submitted a false invoice in support of its claim. The court held that all benefit under the policy should be forfeited, even though the insured did own the equipment in question (and the equipment was not of dubious provenance or worth less than the insured claimed) and the equipment had been genuinely destroyed. In that case, though, the judge may have been influenced by the fact that the same invoices had been used to obtain a loan which would not otherwise have been extended and that fact should have been disclosed to insurers since it fell within the “moral hazard” principle. Here, the Board was satisfied that there was no fraud at all, since the invoices had been altered only to record genuine purchases by the insured. Nevertheless, this might be seen as a generous decision for the insured, since it is arguable that the false invoices (no matter why they were altered) were “some lie” and thus met the criteria laid down by Mance LJ in Agapitos: “any lie, directly related to the claim to which the fraudulent device relates, which is intended to improve the insured’s prospects of obtaining a settlement or winning the case, and which would, if believed, tend, objectively, prior to any final determination at trial of the parties’ rights, to yield a not insignificant improvement in the insured’s prospects”.

Beacon Insurance Co Ltd v Maharaj Bookstore Ltd [2014] UKPC 21
Court of Appeal strongly supports the fraudulent devices rule

At first instance, Popplewell J found that the insured had a valid claim but that the entire claim was forfeited because the insured had used fraudulent devices (having recklessly misrepresented to insurers that an alarm had been heard by the Master of the ship). In reaching his decision, the judge had expressed some doubts about the materiality test for fraudulent devices, but had said that he felt bound to follow the (what he termed obiter) comments by Mance LJ in Agapitos v Agnew (The Aegeon) (No 1) [2002] EWCA Civ 247 (see further below). The owners appealed and the Court of Appeal has now held as follows:

1) The judge had been entitled to find that the insured had used fraudulent devices. The insurers could reasonably expect that answers to their questions would be based on actual inquiry rather than hypothesis. Nor did it matter that the misrepresentation was likely to be immediately falsified when the insurers spoke to the crew.

2) The correct test for fraudulent devices was that set out by Mance LJ: are the fraudulent devices (a) directly related to the claim and intended to promote it; and (b) if believed, will they yield a not insignificant (or immaterial or insubstantial) improvement in the insured’s prospects (although Clarke LJ preferred the formulation that they are intended to produce “a significant” improvement in the insured’s prospects)? The decision in “The Aegeon” should be followed as a matter of ratio by the Court of Appeal.

3) The Court of Appeal held that there were “several powerful reasons” for this conclusion: “The Aegeon” is authoritative, if not binding; a fraudulent device is a sub-species of a fraudulent claim, founded upon the underlying duty of utmost good faith; and there is a public policy justification for the rule, in order to protect insurers from fraud. As Clarke LJ observed: “The effect of the rule is that if you lie to your insurer in respect of anything significant in the presentation of the claim you will not recover anything from him. Once it is accepted, as it has long been, that an assured who fraudulently exaggerates his claim forfeits the whole of it – so that a fraudulent claimant can lose almost all of his otherwise valid claim (say 95%) – there seems to me no satisfactory reason in principle why the user of a fraudulent device should not lose 100%”.

4) The Court of Appeal also referred to the Law Commissions’ recent review of this issue. It was noted that the final Insurance Bill presented to Parliament in July confirmed that “if the insured makes a fraudulent claim under a contract of insurance...the insurer is not liable to pay that sum”. Although there is no definition of a fraudulent claim in the bill, the notes to the initial draft bill indicated that a fraudulent device would amount to a fraudulent claim.

5) However, the Court of Appeal noted that the Law Commissions did not appear to have considered the possible impact of Article 1 of the First Protocol to the European Convention on Human Rights (“A1P1”), which provides that “every natural or legal person is entitled to the peaceful enjoyment of his possessions” (an argument which was raised for the first time during the appeal).

6) The Court of Appeal went on to reject an argument that forfeiture must be proportionate (either because of an extension to the fraudulent devices rule or because of A1P1). The “bright line rule” that the use of a fraudulent device forfeits the claim is a proportionate means of securing the aim of deterring fraud in relation to insurance claims. It does not matter that forfeiture may be a harsh (or in some cases very harsh) sanction.

Accordingly, the appeal was dismissed.

COMMENT: Insurers will be pleased to note the Court of Appeal’s very strong support for the fraudulent devices rule in this judgment. The rejection by the Court of Appeal of a stronger materiality test (after the Law Commissions also failed to recommend a change to this test) is reassuring. It should be borne in mind, though, that a fraudulent device must still be proven on the facts and the recent Privy Council case of Beacon Insurance v Makaraj Bookstore (above) demonstrates that that can sometimes be a challenge to achieve.

One further general point worth noting from the Court of Appeal’s judgment is its willingness to refer to the notes accompanying the initial draft bill when interpreting the Insurance Bill currently going through Parliament (although there was no need to interpret the bill in this judgment). As we have previously reported, there is much useful guidance contained in the notes, some of which is not reflected in the express wording of the bill, and so this will help to achieve some clarity if and when the bill is enacted.

Versloot Dredging BV v HDI Gerling Industrie Versicherung AG [2014] EWCA Civ 1349
Follow the lead clauses and whether a following underwriter is bound by a settlement which is expressed not to be binding on him

The insured’s vessel was covered by two insurance policies: (1) a policy issued by three Lloyd’s syndicates covering 50% of the interest in the vessel; and (2) a policy issued by the defendant covering 30% of the interest in the vessel (the remaining 20% interest was uninsured). The policy issued by the defendant contained a Follow Clause which read as follows: “Agreed to follow [two of the Lloyd’s syndicates] in claims excluding ex gratia payments” (thus, although the syndicates were not expressly referred to as lead underwriters, this was in effect a follow the lead underwriter clause).

Following damage to the vessel and a claim under both policies, a settlement agreement was entered into between the three syndicates and the insured. The loss was agreed by those parties to be USD 1.5 million and the syndicates agreed to pay their respective shares of an aggregate sum of USD 779,500 (ie just over 50% of the loss). The insured argued that the defendant was bound by this settlement to pay 30% of the agreed loss (ie USD 450,000). However, the defendant argued that it was not obliged to follow this settlement for the following reasons:

1) The Follow Clause authorised only the Lloyd’s syndicates to act on the defendant’s behalf to settle claims and did not bind it to the follow any settlement. That argument was rejected by Teare J. The insured’s interpretation of the clause was said to “ignore, and add to, the simple words of the Follow Clause”. Nor was there any need to introduce a concept of agency into the clause. Although there is uncertainty as to the basis on which a follow clause operates, the issue of what duty the Lloyd’s syndicates owed to the defendant did not fall to be decided in this case.

2) The settlement agreement contained the following clause (Clause 7): “The settlement and release pursuant to the terms of this Agreement participate in the capacity of a Leading Underwriter under the Policy and do not bind any other insurer providing … cover in respect of [the vessel].”

Teare J accepted that the insured had, by virtue of Clause 7, agreed that the settlement agreement would not be binding on the defendant (and this conclusion was unaffected by the absence of a reference to the Follow Clause in Clause 7). However, the defendant had not been a party to the settlement agreement. The judge went on to find that it was unable to rely on the Contracts (Rights of Third Parties) Act 1999 because Clause 7 did not purport to confer a benefit on it. It has been previously held that a contract does not confer a benefit on a third party just because the third party’s position is incidentally improved by the contract – instead, it must be shown that one of the purposes of the contract was to confer that benefit (see Dolphine Maritime & Aviation Services Ltd v Sveriges Angfartygs Assurans [2009] EWHC 716 (Comm)).

Teare J held that the purpose behind Clause 7 was the protection of the syndicates from any possible liability to the defendant (in light of the current uncertainty as to what duty a lead owes to a following underwriter when entering into a settlement with the insured). The judge said that, even if he was wrong in that conclusion, although the syndicates had acknowledged, by the inclusion of Clause 7, that the settlement was not binding on the defendant, that did not prevent the insured from relying on the Follow Clause against the defendant (which was contained in the policy entered into between the insured and the defendant). Clear words would be needed to show that the insured was giving up the benefit of the Follow Clause.
3) The Follow Clause was not triggered by the settlement agreement. The judge rejected an argument that it was an implied term of the Follow Clause that it would not apply to settlements which have been expressly agreed not to be binding on the defendant: “The lead underwriter is, in my judgment, unable to countermand the effect of the Follow Clause if, as I have held, the effect of such clause is to oblige the following underwriter to follow any settlement made by the lead underwriter, whether or not the lead underwriter purported to act as agent from the following underwriter”.

**COMMENT:** This case confirms that, once a “Follow the Lead” clause has been included in a policy, nothing in a later settlement agreement will prevent a following underwriter being bound by that settlement, even if the lead purports to agree that the following underwriter would not be bound. The following underwriter might attempt to circumvent this position by asking to be joined to the agreement, but it would be arguable that there has been no consideration provided from the following underwriter in return for an agreement that the settlement will not bind him (especially where, as here, the leads were settling only their share of the loss).

A separate problem is that a lead underwriter might potentially leave himself exposed to a claim by the following underwriter for a breach of the duty of care which might be owed by the lead to him when reaching the settlement (although it is unclear at present whether leads do indeed owe such a duty to the following market). Accordingly, the lead might, in such a situation, seek to agree directly with the following underwriter that no breach will occur if the settlement with the insured is concluded.

*San Evans Maritime Inc v Aigaion Insurance Co SA [2014] EWHC 163 (Comm)*
Whether a non-reinsured can get a declaration of liability against a reinsurer/whether reinsurer had acted in “businesslike manner”

T&N, an English company which was a major producer and distributor of asbestos in the 20th century, entered into a liability policy with its captive insurer. The liability policy provided that “the Policyholder [ie T&N] shall have full, exclusive and absolute authority, discretion and control, which shall be exercised in a businesslike manner in the spirit of good faith and fair dealing”. On an “Insolvency Event” (which did subsequently take place) this authority, discretion and control, and the requirement to act in a businesslike etc manner, passed to the insurer. The insurer then transferred all its rights and powers under the liability policy to its reinsurers under a reinsurance contract.

The claimant was a trust (set up when T&N started Chapter 11 proceedings in the US) which assumed liability for all asbestos personal injury claims against T&N and which was, in effect, authorised to bring claims against the captive insurer on behalf of a very large number of personal injury claimants in the US. The trust established a mechanism for valuing these asbestos claims and argued that the value which it gave to the claims was considerably lower than a likely settlement or award should litigation be brought in the US tort system. It sought various declarations against the reinsurers to the effect that if the reinsurers used a different method to handle claims, that would cause the reinsured to breach its duty to T&N to act in a businesslike manner. Eder J held as follows:

1) Although the law on granting declaratory relief has “moved on” in the last 20 years, and this relief is discretionary (so not subject to rigid rules), it is not appropriate (save in exceptional circumstances) to grant this relief to a third party where the parties to the relevant contract (here, the reinsurance contract) are not themselves in dispute. To hold otherwise would be to open up potentially “remarkable consequences” which would allow third parties to intervene in the contractual relations of others by way of declaration. Nor did the terms of a power of attorney granted by T&N to the trust make any difference.

2) The judge held that, even if he was wrong on that point, he would not have granted relief in this case anyway. The terms of the reinsurance contract required the reinsurers to exercise “authority, discretion and control” in a businesslike manner and in good faith. Eder J agreed that this was only a “very loose constraint”, excluding only courses of conduct which no similar reinsurer could take. The concept of good faith and fair dealing required reinsurers only to act “honestly and conscionably vis-a-vis the other parties to the contracts” (see Yam Seng Pte Ltd v International Trade Corp Ltd [2013] EWHC 111 (QB)). However, it could not be said that the court cannot intervene at all in the exercise of the reinsurers’ contractual rights.

Here, the judge concluded that the reinsurers were not acting in an unbusinesslike manner by requiring the trust to pursue any claims in the US tort system: “there is no monopoly of what may be ‘business-like’”. The court could not at this stage know how many claims might eventually be brought in the US if the reinsurers’ approach was followed and whether the reinsurers’ strategy would end up costing more in the long run. If it could be shown that it would “inevitably” cost more, the judge conceded that there might be an argument that the reinsurers were being “unbusinesslike”, but that was not the case here. Furthermore, if the reinsurers’ decision to contest claims was ultimately shown to have unreasonably increased claims handling and defence costs, such costs would have to borne by the reinsurers themselves.

3) A further issue in the case concerned the definition of “payment in fact” (the liability policy being a “pay to be paid” policy). Here, certain payments made by T&N to the Trust were set-off against a debt owed to T&N by the Trust and, separately, a “pre-payment” was made by the Trust to T&N pursuant to this debt, in order to enable T&N to satisfy its liability to third party claimants. Eder J held that, in both situations, there had been a payment of fact by T&N and, furthermore, these payments were “in cash” rather than “in kind”: “I would only say that the reference to a payment “as cash” cannot be taken literally as meaning only payment in money bills or other legal tender: cf The Chikuma (1981) 1 Lloyd’s Rep 371, 375-376 in the context of similar words.
in the shipping context”. The set-off and pre-payment achieved the result of payment and counter-payment, as if physical transfers had taken place.

COMMENT: There has been little English caselaw to date on the duties of a reinsurer under a Claims Control Clause. However, in *Gan Insurance Co Ltd v Tai Ping Insurance Co Ltd (No 2)* [2001] EWCA Civ 1047 the Court of Appeal held that there was no implied term that reinsurers’ approval of a settlement should not be withheld unreasonably. The only limitation to be implied into the clause was that the right to withhold approval should be exercised in good faith, after consideration of the facts giving rise to the particular claim (and not by reference to extraneous matters) and should not be exercised arbitrarily.

Should a clause contain an express obligation to act in businesslike manner, though, this case will be a useful indication of what constraints that requirement will place on a reinsurer. This case supports the argument that a party is acting in a businesslike fashion even if its decisions may end up increasing costs in the long run (provided, possibly, that that is not an inevitable outcome of the reinsurers’ strategy) and “best practice” has not been followed. Furthermore, if the reinsurance contract provides that the reinsurer should have “regard to” the interests of the reinsured (or anyone else), he can choose to attach no weight at all to those interests, provided he is not thereby acting irrationally.


### Whether a retrocessionaire bound to follow a settlement on basis the reinsured had not acted in a business-like manner

The claimant in this case was a reinsurer seeking recovery from its retrocessionaire (the defendant). The retrocession contained an unqualified “follow the settlements” clause. It was established in the case of *Insurance Co of Africa v Scor (UK) Reinsurance Co Ltd* [1985] 1 Lloyd’s Rep 312 that such a clause is subject to two provisos: (1) that the claim falls within the scope of the reinsurance contract as a matter of law; and (2) that the reinsured has acted honestly and “taken all proper and businesslike steps in making the settlement”. An earlier decision in this claim (now on appeal to the Court of Appeal) dealt with the standard required to prove the first proviso. This case dealt with the second proviso and the retrocessionaire’s argument that the reinsured had not taken all proper and businesslike steps and hence it was not bound to follow its settlement. The claimant applied for summary judgment on the basis that the retrocessionaire’s defence had no real prospect of success.

The retrocessionaire argued, in essence, that the reinsured had not considered the wording of the direct policy when reaching its settlement with the insured and it ought to have taken legal advice from local lawyers. It argued that it was no defence to argue that the retrocessionaire ought to show that a better settlement would have been achieved had the reinsured taken the steps which the retrocessionaire wanted it to take. The claimant argued that the proviso mentioned above is intended to protect reinsurers against prejudicial settlements and, if the final settlement figure was a good one, it cannot be said that there has been anything improper or unbusinesslike.

Field J held that there was no prospect of success in arguing that the reinsured had failed to act in a businesslike manner, even though it had not fully investigated the issue of aggregation under the local policy. The reinsured had been entitled to conclude that there was nothing further to be gained from such an investigation because the settlement figure was “undoubtedly a good settlement” (and GBP 10-20 million less than the projected final adjustment figure produced by the reinsured’s loss adjusters).

Accordingly, summary judgment was granted and if the retrocessionaire’s appeal to the Court of Appeal fails, it will be bound to follow the reinsured’s settlement.

*Tokio Marine Europe Insurance Ltd v Novae Corporate Underwriting Ltd* [2014] EWHC 2105 (Comm)
Court of Appeal decides whether there was double insurance and whether there was an implied waiver of subrogation

The claimant in this case was a consultant in a company (“R”) within a group carrying out trust business. R (as well as the parent company of the group) entered into indemnity agreements with him, in respect of his provision of any services to R. PI insurance was also taken out by the parent company (R and the claimant being co-insureds), and the excess layer insurers are the defendants to this action. At first instance, Burton J held that the claimant was an insured person under the PI excess policy and that there was no double insurance here (arising from either the indemnity or a separate D&O policy). The judge did, however, hold that the excess insurers had a right of subrogation against the parent company. The Court of Appeal has now allowed the appeal from that decision, holding as follows:

1) The judge had been correct to hold that the claimant was an “insured person” under the terms of the PI excess policy.

2) A clause in the policy stated that: “Insurance provided by this policy applies excess over insurance and indemnification available from any other source” (emphasis added). Burton J had held that this clause did not apply to indemnification from a policyholder or co-insured. The Court of Appeal agreed (and also confirmed that the heading of the clause (“Other insurance”) “cannot be used to cut back on the clear language used in the clause”). Although there is no general rule that indemnities from one co-insured to another should not be included, clear wording had been used here to require that the non-insured indemnification come from some external source (ie a source independent from R or the parent company).

3) The Court of Appeal also agreed that there was no cover for the loss in question under the D&O policy. Nor could it be said that the D&O policy covered defence costs (which would amount to “other insurance”): “Liability policies will not habitually give a free-standing coverage for defence costs even where the liability itself is not insured, and in my view there would need to be very clear provision in the policy to that effect in order for the argument to succeed”. In support of this view, the judge cited the decision in Astrazeneca Insurance Co Ltd v XL Insurance (Bermuda) Ltd [2013] EWCA Civ 1660 where Christopher Clarke LJ observed that, in respect of non-marine liability insurance at least, the right to recover defence costs must, absent clear wording to the contrary, depend on some free-standing entitlement under the policy. That was a claim where no liability could be established but precisely the same principle was said to apply where no liability is covered. Accordingly, this was not a case involving double insurance.

4) However, the Court of Appeal did allow the appeal in relation to subrogation, holding that the insurers had no right of subrogation against R or the parent company. It noted that a right of subrogation can be excluded by a waiver in the policy itself or by the terms of an underlying contract between the insured and a third party. In some contexts, “it may be obvious that subrogation should be denied but the precise reason may be difficult to formulate”. In this case, both routes were pursued by the claimant and parent company:

i) Waiver of subrogation under the policy: a clause in the policy provided that “The insurer shall not exercise its rights of subrogation against any insured person” (emphasis added). The Court of Appeal agreed with the judge that the plain meaning of this clause was that there had been a waiver only in relation to an insured person and that there was no exemption for an insured company. However, it is possible to imply a term into a waiver of subrogation clause (and it was said that Rix LJ in Tyco Fire & Integrated Solutions (UK) Ltd (formerly Wormald Ansul (UK) Ltd) v Rolls Royce Motor Cars Ltd (formerly Hireus Ltd) [2008] EWCA Civ 286 had not intended to suggest that there was any general rule of law that there could not be such an implied term).

Here, construing the policy in its commercial setting, it was held (by a majority of 2:1) that the court should imply a term that the insurers would not seek to be subrogated to the claimant’s rights against the parent company under the indemnity: “I am satisfied that it could not have been the intention of the parties that the insurers should be able to enforce rights of indemnity against a co-insured where the co-insured was indemnifying the very
same risk as the insurers. I believe that implying the term is simply making express what the parties must have intended”. This was because the insurance, and not the indemnity, was intended to be the primary source of protection for the claimant (see further below) and the very purpose of the insurance was to cover the parent company and those it insured against third party claims.

However, Beatson LJ dissented, saying that, although there is no rule of law that only an express exclusion of subrogation in a policy will suffice, this “should be the position in practice in all but an exceptional case”. He also noted that recent caselaw has focused attention on a construction of the underlying contract and said that there was no need to imply a waiver into the policy here because the position in the underlying contract was clear.

ii) Waiver of subrogation because of the terms of the underlying contract (i.e. the indemnity): it was held that a term should be implied into the indemnity that the insurance would be the primary liability, notwithstanding that there was no express term to that effect. This was not just because the parent company had paid the premium for the policy, “it is the fact that [the parent company] is not at fault and that the subrogated right relates to an indemnity which is providing the same protection as the insurance itself”. The claimant would, it was held, have naturally understood that his claim under the indemnity had been exhausted once his liability had been fully met under the policy. Accordingly, there was no right to which the insurers could be subrogated.

5) One further point considered by Elias LJ (although he did not have to decide it, given the conclusion on subrogation), was whether it is possible to oust by agreement the requirement that subrogation arises only after payment by the insurer has been made. Elias J agreed with Burton J that such an ouster is not possible.

COMMENT: Although this case follows the recent trend of looking to the underlying contract between the co-insureds, the majority here was prepared to also go further and suggest an implied term in the policy itself. It seems that a strong rationale for adopting that line here was the fact that (unlike in Tyco), the co-insured in this case had not caused the loss which fell to be covered under the policy, but was otherwise to be faced with a subrogated claim solely because it had provided the indemnity (in other words, in the absence of the indemnity, the insurers would not have been able to subrogate against it at all, since the insurers can have no better rights than the co-insured itself). The same principles influenced the Court of Appeal when deciding that the insurance was intended to be the primary liability here. Again, the key issue was whether the subrogated action was to be against the tortfeasor or not, although it was recognised that each case will turn on the exact nature of the contractual arrangements between the parties. Certainly, a mantra that “insurance is a last resort” will not work in every situation.

Rathbone Brothers Plc v Novae Corporate Underwriting Ltd [2014] EWCA Civ 1464
An Insurance Bill was presented to Parliament in July 2014. The bill is following the special Parliamentary procedure for uncontroversial Law Commission bills and it is therefore possible that it will now be passed before the end of the current parliamentary session (30 March 2015). If Royal Assent is obtained, the Insurance Act 2015 will apply to every insurance policy and reinsurance contract written in England and Wales, Scotland and Northern Ireland and (with certain exceptions set out below) will come into force 18 months after the date it is passed. This will allow time for policy wordings to be amended, where necessary. It should be noted that the bill may be amended further during its passage through Parliament.

Certain clauses included in earlier drafts were omitted from the Insurance Bill. These covered: (a) damages for late payment (earlier drafts had provided for the payment of damages once insurers had had a reasonable amount of time to investigate a claim and could not show reasonable grounds for disputing a claim; and (b) terms designed to reduce the risk of a particular loss. Previous drafts had proposed that, where a term (eg a warranty or a condition precedent) was designed to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular place, a breach would entitle an insurer to refuse claims for losses falling within that category of risk.

The following clauses are still currently included in the bill:

a) Warranties
All “basis of the contract” clauses will be prohibited. A basis of the contract clause in a proposal form has the effect of converting all answers in the proposal form (no matter how trivial) into warranties. In addition, all warranties will become “suspensive conditions”, allowing an insured to remedy a breach and thus come back “on cover” thereafter (and insurers will also still be liable for losses prior to the breach, as is currently the case).

b) Utmost good faith/non-disclosure
These reforms will apply to business insurers only (consumer insurance having been dealt with in the 2012 Act). Insureds will still have a duty to volunteer information and will have to make a fair presentation to insurers (making disclosure in a manner which would be reasonably clear and accessible to a prudent insurer). The knowledge of an insured company will be what is known to its senior management or those responsible for the company’s insurance. Insureds will also be required to carry out a reasonable search for information within the entity, but an insurer will be presumed to know things which are common knowledge, or which an insurer offering insurance of the class in question to be insured in the field of activity in question would be expected to know in the ordinary course of business.

The remedies for a misrepresentation or non-disclosure reflect those now in place for consumer insurance. Broadly, avoidance (without a return of premium) will be available if the insured has acted deliberately or recklessly and in all other cases a scheme of proportionate remedies will apply (designed to reflect the situation as it would have been had full disclosure been made).

c) Good faith
It is proposed that the remedy of avoidance for the breach of the duty of utmost good faith will be abolished (the Law Commissions having previously pointed out that, where an insurer breaches its own duty of good faith, an insured would not want the policy avoided because that would prevent its claiming under the policy). The Law Commissions have instead indicated that insurers may be prevented from exercising a right if it has not been exercised in good faith (although it is perhaps difficult to see how a legitimate right could be exercised in a manner amounting to bad faith in all but the most extreme of circumstances. In any event, there is no provision to this effect included in the bill).

Damages are not proposed as an alternative remedy (and so an argument that late payment by an insurer amounts to a breach of the duty of good faith, thus attracting damages for late payment via an alternative route, would not work).

d) Fraudulent claims
It is proposed that insurers will now have an option of terminating the policy with effect from the date of a fraudulent act, without a return of premium (thus allowing insurers to refuse to pay any genuine claims thereafter, although they would still be liable for legitimate losses before the fraud).
Contracting out of these changes

The Insurance Act (if passed) will represent only a “default regime” for business insurers (although it will not be possible to contract out of the basis of the contract clause prohibition). Where insurers intend to opt out and include a “disadvantageous term”, sufficient steps must be taken to draw that to the insured’s attention before the contract is entered into. A boiler-plate opting-out clause will therefore not suffice: each and every departure from the default position will have to be flagged up. Furthermore, an alternative remedy or position will have to be specified, otherwise there will be a void (and the courts are likely to imply back into the policy the position set out in the Act).

It is also worth noting that the changes to the duty of fair presentation and good faith apply to contracts or variations entered into after 18 months after the Act is passed. However, the changes to warranties and fraudulent claims will apply only to contracts entered into after 18 months after the Act is passed, or variations to those contracts (ie variations to contracts written before the end of the 18 month period will be governed by the previous law).

Third parties (Rights against Insurers) Act 2010

One surprising feature of the published bill was the inclusion of various minor provisions relating to this Act, which received royal assent on 25 March 2010, but which is still awaiting a further statutory instrument to bring it into force. This Act is, broadly, intended to make it easier for third party claimants to bring direct actions against insurers where an insured has become insolvent. The changes included in the Insurance Bill allow the Secretary of State for Justice greater scope to make further regulations and amend the definition of an insured” (and, more specifically the type of insolvency event which the insured must undergo in order to trigger the application of the Act). Although no deadline to bring the 2010 Act into force is set out in the draft Insurance Act, it is worth noting that the powers being passed to the Secretary of State come into force two months after the bill receives royal assent. Accordingly, it might be anticipated that the aim is to bring the 2010 Act into force sometime in 2015.
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