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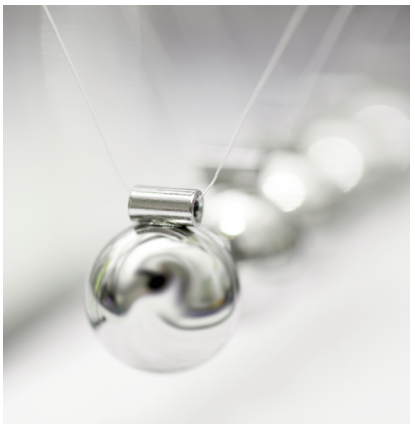

Insurance and Reinsurance
Review of 2010

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Aggregation

IRB Brasil Resseguros SA v CX Reinsurance CO Ltd [2010] EWHC 974 (Comm)

Whether arbitrators correctly applied law in a reinsurance dispute

The reinsured was one of a number of insurers who settled various US liability insurance claims. It then sought to recover from its reinsurer, who had participated in an excess of loss reinsurance programme protecting the reinsured's casualty book of business. After the reinsurer refused to pay, the dispute went to arbitration and the arbitrators found in favour of the reinsured. The reinsurer then sought to challenge the award on the ground that there had been an error of approach in law by the arbitrators. Three particular issues were raised:

"Both provisos had to be proven on the balance of probabilities"

1) The reinsurance policy contained a "double proviso" "follow settlements" clause - i.e. all loss settlements by the reinsured would bind the reinsurers provided such settlements were within the conditions of the original policies as well as within the terms of the reinsurance. Gross J in *Equitas v R&Q* [2009] concluded that both provisos had to be proven on the balance of probabilities. Burton J decided that although the arbitrators had referred in some parts of the award to arguability rather than a balance of probability, they were expressing themselves to be satisfied on the balance of probabilities that the arguable claims which were settled fell within the terms of the insurance and reinsurance policies. Thus they had applied the law correctly;

2) In relation to an issue regarding allocation, Burton J held that the failure of the arbitrators to refer expressly to the case of *Municipal Mutual v CSEA* [1998] did not mean that they had adopted an approach which was inconsistent with that case; and

3) The "each and every loss" clause in the reinsurance policy referred to a loss or series of losses arising out of one event. In the award, the arbitrators did "commit what might be termed a "howler"" by referring to whether "the loss each year stemmed from a single cause". As Lord Mustill held in *Axa Re v Field* [1996], "cause" and "event" are "not at all the same". Nevertheless, Burton J said that he was clear that the arbitrators had in fact meant to say "event" instead of "cause".

Asbestos

Employers' Liability Insurance "Trigger" Litigation [2008] EWHC 2692 (QB) – ON APPEAL TO THE SUPREME COURT

Whether cover for mesothelioma claims under EL policies triggered by exposure or onset of disease

This is the appeal from an earlier decision of Burton J. The underlying issue is whether the correct employers' liability policy to respond to mesothelioma claims is the one in place when the asbestos dust was first inhaled or the one in place at the onset of the disease (in many cases, the onset of disease takes place up to 35 years after inhalation). The particular policy wordings in question differ slightly but, broadly, they provided cover for "injury sustained" or "disease contracted" during the policy period.

At first instance, Burton J found that there was no injury at the date of inhalation. However, taking into account the factual matrix of the case, he concluded that the policies had to be construed as meaning that injury was sustained when it was caused (ie at the date of inhalation). Equally, he construed that disease was contracted when it was caused. The Court of Appeal has now found as follows:

"Mesothelioma is not an "injury" (and injury is not "sustained") until its onset"

1) Mesothelioma is not an "injury" (and injury is not "sustained") until its onset. The Court of Appeal reached this conclusion, on the basis that they were bound by the earlier Court of Appeal decision of *Bolton MBC v MMI* [2006] (concerning mesothelioma in relation to a public liability policy). However, although Rix LJ did not say that *Bolton* was wrongly decided, he did indicate that, had he not been bound by precedent, he would have preferred the view that, once mesothelioma develops, it is the risk of mesothelioma created by the exposure which is the injury. Burnton LJ, however, found *Bolton* convincing;

   However, both Rix LJ and Burnton LJ (Smith LJ dissenting) rejected the judge's decision that something had gone wrong with the language and that this finding would be in conflict with the commercial purpose of EL insurance. Accordingly, injury was <u>not</u> sustained at the date of inhalation and the appellants (with this policy wording) won on this point;

2) However, all 3 Lords Justices agreed (Burnton LJ with hesitation) that "disease contracted" referred to the time of the disease's causal origins (ie the date of exposure) (Rix LJ opining that the commercial purpose of the policy should prevail on this issue and Burton LJ opining that little, if any, assistance was to be gained by referring to the commercial purpose of the policy). Accordingly, the appellants (with this policy wording) lost on this point; and

3) One further argument was that the wordings only applied to employees in the course of their employment and did not apply to ex-employees. At first instance the judge held that this point favoured a construction that cover was intended to be the date of causation in all cases. Smith LJ agreed with the judge, Rix LJ agreed that the wordings did not apply to ex-employees but felt that that did not point to a causation trigger, and Burnton LJ held that (certain) wordings did apply to ex-employees.

Permission to appeal to the Supreme Court on all the above issues has been granted.

COMMENT: From a practical viewpoint, it is arguable that linking cover to the date of onset (for injury sustained wording) is unsatisfactory. Whereas the date of causation can be fixed with relative certainty, victims will often only learn that they are suffering from mesothelioma once they have started to experience symptoms. Onset will usually be "around 5 years" before manifestation but (retrospectively) determining the exact date of onset will be almost impossible in most cases. As a result of this, Burton J suggested the adoption of a prima facie rule of 5 years before manifestation, but this issue was not argued on appeal. More importantly, though, where an employer has become insolvent or is no longer in business, there will be no policy in place at the time of onset of mesothelioma. It might be expected that the Supreme Court and/or government will not favour an approach which leaves victims without any redress against an employer/insurer.

Avoidance

Joseph Fielding Properties (Blackpool) Limited v Aviva Insurance Limited [2010] EWHC 2192 (QB)

Fraudulent claims, non-disclosure, moral hazard and the Rehabilitation of Offenders Act 1974

An insurer denied liability to indemnify the insured following a fire at its commercial premises on the basis that the insured had (1) made an earlier fraudulent claim (during the currency of the policy); (2) failed to disclose at inception that it had made a fraudulent claim to a prior insurer; and (3) failed to disclose at inception that it had made misrepresentations to other insurers in the past. Much of the case therefore turns on the particular facts and the insurer was able to prove its allegations. Here are the main points of the case:

1) The policy contained a condition which gave the insurer the option of avoiding the policy from either inception or the date of the claim (or of avoiding the claim alone) in the event of a fraudulent or intentionally exaggerated claim. The judge, Waksman QC, rejected an argument by the insured that the condition did not apply where the insured could have made a lesser claim in a non-fraudulent manner. Even if the condition did not apply, and the insured had to rely on fraud at common law instead, it was sufficient that the fraud here was substantial and the size of the genuine claim was irrelevant. The judge also rejected that a proportionality requirement should be introduced (and any observations to the contrary by Staughton LJ in *Orakpo v Barclays* [1995] were a minority (and *obiter*) view).

   The policy condition also meant that the insurer did not need to prove reliance and that it could also avoid the policy and recoup monies paid out on a first (honest) fire claim (even though the insurer conceded that this would not have been the position at common law). It is worth noting, though, that the judge highlighted that Mance LJ's observations in *Axa v Gottlieb* [2005] that a fraudulent claim should not have any retrospective effect on earlier honest claims were only *obiter*.

2) As for the non-disclosure argument, Waksman QC said that materiality must be considered "in the round" and that "it is the full picture which has to be assessed". He rejected an argument that if an initial false statement would have been immaterial to a prior insurer, then it should be removed from the picture altogether.

   Furthermore, if there was a moral hazard in insuring this insured, that was "unlikely to be something which can be cured by the imposition of a further condition on the policy".

> ""Materiality must be considered "in the round""

3) The insured also argued that the insurer could not rely on false statements about a previous conviction in light of the Rehabilitation of Offenders Act 1974. That Act provides that questions seeking information about a person's previous convictions shall be treated as not applying to spent convictions (section 4(2)) and "any obligation imposed on any person by any rule of law or by the provisions of any agreement...to disclose any matters .....shall not extend to requiring him to disclose a spent conviction" (section 4(3)).

The judge held that section 4(2) did not apply because no express question about previous convictions had been asked (notwithstanding that the insured was under a general duty to disclose). As for section 4(3), the judge agreed that the obligation on the insured to make disclosure to the insurer of all material facts was a duty imposed by a rule of law or agreement. However, the judge said that the section should not be "so broadly interpreted" and the restriction on the duty of disclosure which it imposes "applies where its direct object is the spent conviction". So the insured was under no duty to disclose the fact of a previous (spent) conviction (even if it was otherwise material).

However, in this case, the insurer's argument about non-disclosure related to the false statement to a prior insurer that the insured's director had no convictions at a time when that conviction was not spent. What section 4(3) could not outlaw "is the duty to disclose the making of false statements if material to the present insurance. A string of lies to previous insurers, for example, should be disclosed". Even if the insured was under no duty to disclose what the false statement was about to the current insurer (because the conviction was spent), it was likely that that insurer would have refused to write the risk.

Accordingly, the insurer was under no liability to pay the insured.

Sugar Hut Group & Ors v Great Lakes Reinsurance & Ors [2010] EWHC 2636 (Comm)

Insurers relying on defences of non-disclosure, breach of warranties and breach of condition precedent

Clyde & Co for defendants

The defendants insured four nightclubs. A fire at one of the nightclubs caused substantial damage and the claimants sought an indemnity from insurers. Insurers denied liability on the following grounds:

1) Material non-disclosure. The proposal form asked "how long have you traded in this name", to which the response was "2007". A further question asked "have you ever traded in any other names", to which the reply was "yes". Some two months prior to completion of the proposal form 3 companies in the insured group went into administration due to financial difficulties and new companies were then formed to take over their businesses and were substituted as insureds. Insurers argued that had they known about the background to this they would have had grave concerns. It was alleged that a former shareholder of the 3 "old" companies had been siphoning money from the business. Burton J accepted that a prudent underwriter would have wanted to know whether there was a risk that the financial viability of the business going forward was endangered. The judge said that there was no criticism of the underwriter due to the fact that he did not have any Underwriting Guidelines;

> "No evidence that the underwriter had been so keen to accept the risk that he would "not have batted an eyelid""

The insured argued that, however careful and experienced an underwriter is, if he has avoided for non-disclosure he will be "bound to say" that information not disclosed to him was material. Accordingly, the judge looked at the surrounding circumstances of the case. He found no evidence that the underwriter had been so keen to accept the risk that he would "not have batted an eyelid" had the undisclosed facts been disclosed to him; and

Nor did the judge find that there had been a waiver of disclosure. The insured had sought to argue that as the insured was invited to disclose "*any other facts not covered by the questions in this form* ", given that the only information sought about trading history was covered by express questions, no other information was required. Burton J dismissed that argument: "the Claimants cannot rely on factors not being *"covered by the questions"* if the reality is that they were not covered by the answers".

2) Breach of warranties. The insurers argued the breach of two warranties:

a) a Frying and Cooking Equipment warranty (requiring (inter alia) that ducting be kept free from combustible materials and checked "at least once every 6 months"). Burton J rejected the argument by the insured that the duct should be checked every 6 months starting from the date of inception of the policy. Instead, (as a matter of business efficacy) the check should be every 6 months since the last check. There had therefore been a breach. The judge held that the part referring to 6-monthly inspections could be regarded as a suspensive condition. Unlike the position for ordinary warranties, where the breach of a suspensive condition is repaired, the insurer will be back on risk. However, in this case the inspection was not just late - it had not taken place by the time of the fire and hence cover was in any event suspended as at the date of the fire. There was also a breach of the combustible materials part of the warranty and Burton J rejected an argument that this should be treated as "*de minimis*". There was no caselaw to support the argument that the *de minimis* concept applied to breaches of insurance warranties. Also, this was a warranty as to a state of affairs; and

b) a Burglar Alarm warranty (requiring a NACOSS Central Monitoring Station Alarm be installed and operational). Again, the judge found this to be a "true" warranty which, on the facts, had been breached. The slip contained a term that cover was subject to a satisfactory survey and the carrying out of necessary risk improvements. The judge held that these obligations survived into the policy and/or that contrary to any general presumption, the policy did not supersede the obligations in the slip. Compliance with a risk improvement notice was a suspensory condition. Since the fire took place before the work was carried out, there was no cover in place at the date of the fire.

Brokers' Duties

Nicholas G Jones v Environcom Ltd [2010] EWHC 759 (Comm)

Duty of broker to explain to the insured the duty of disclosure

Following a fire, the insured sought to claim under its commercial combined insurance policy (covering property and business interruption risks). The insurers declined the claim on the basis that it had elected to avoid the policy due to material non-disclosure. The insurers and the insured settled their dispute but the insured alleged that the brokers had been negligent in failing to adequately advise it as to its duty of disclosure.

It was undisputed that the broker must advise his client of the duty to disclose all material circumstances and of the consequences of failing to do so. He must indicate the sort of matters which ought to be disclosed as being material and must take reasonable care to elicit matters which ought to be disclosed, but which the client might not think it necessary to mention (see the *FSA Insurance Conduct of Business Handbook*). It was also common ground between the parties that where a change in personnel led to a new person being responsible for insurance matters in the client's organisation, the broker must ensure that an appropriate understanding of questions of materiality is held by that person.

> "The broker must satisfy himself that the position is in fact understood by his client "

The judge concluded that in this case the broker had breached its duty because the documentation forwarded to the insured contained an inadequate explanation of the duty of disclosure. Steel J held "I am not persuaded that it is sufficient simply to rely upon written standard form explanations and warnings annexed to proposals or policy documents.... The broker must satisfy himself that the position is in fact understood by his client and this will usually require a specific oral or written exchange on the topic, both at the time of the original placement and at renewal (particularly if a new person has become that client's representative)".

The judge went on to find that the broker had not been under a duty to inquire about a particular tool used in the insured's fridge recycling process. However, the broker should have advised that all previous fires (whether significant or not) ought to have been disclosed and he rejected the broker's argument that "it must have been perfectly obvious to a competent business man like Mr. Hamilton who was responsible for obtaining insurance cover against the risks of fire that the fact of fires was a material matter requiring disclosure". The broker should have elicited the information from the insured.

Nevertheless, the judge concluded that, had the information been disclosed, the insured would have been unable to obtain cover from either the particular insurer in question or from any other group of underwriters (and if cover would have been obtained it would have been on the pre-condition that the particular tool in question was not used and so no fire would have taken place).

Causation

Orient-Express Hotels Limited v Assicurazoni Generali S.p.A (UK Branch) [2010] EWHC 1186 (Comm)

Hurricane Katrina case involving two concurrent independent causes and applicability of the "but for" test

The insured claimed that an arbitration tribunal had erred in law in finding that its claim did not fall to be covered under a combined property damage and business interruption policy of insurance. The insured owns a hotel in New Orleans. The hotel was damaged by Hurricanes Katrina and Rita and had to close for two months in 2005. The difficulty in this case was that, during that period, a curfew was imposed on the City. Accordingly, even if the hotel had been undamaged, it could not have received visitors. The tribunal held that the insured can only recover in respect of loss which it can be shown would not have arisen had the damage to the hotel not occurred – i.e. which satisfies the "but for" test of causation. The insured could not satisfy this test. It argued, though, that the tribunal had erred in law. Although the "but for" test is the normal rule for determining causation, the insured claimed that the test was inappropriate and unfair in this case. It is also an accepted principle that where there are two proximate causes of a loss an insured can recover on the basis that it is sufficient that one of the causes was a peril insured, provided that the other cause is not excluded – see *Miss Jay Jay* [1987]. However, to date, that principle has only been applied where there are concurrent *interdependent* causes, and not concurrent *independent* causes.

Hamblen J saw "considerable force" in much of the insured's argument. However, he was unable to conclude that the tribunal had erred in law. It was clear that the policy intended a "but for" test: "This is made clear in the Trends Clause which is predicated on calculating the recoverable losses on the basis of what would have happened "had the Damage not occurred" or "but for the Damage"". (The Trends Clause in question read as follows: "In respect of definitions under [ ] above for Gross Revenue and Standard Revenue, adjustments shall be made as may be necessary to provide for the trend of the Business and for variations in or special circumstances affecting the Business either before or after the Damage or which would have affected the Business had the Damage not occurred so that the figures thus adjusted shall represent as nearly as may be reasonably practicable the results which but for the Damage would have been obtained during the relative period after the Damage").

> “It was clear that the policy intended a "but for" test”

Furthermore, whether "fairness and reasonableness" require that the "but for" test should not be applied is very much a matter for the tribunal of fact, rather than for a court on an appeal limited to questions of law. In any event, the judge was not satisfied that the "but for" test was unfair or unreasonable. If such a test was not adopted, he could not see that another test would have been fairer.

The judge also held that on the true construction of the policy, the same event(s) which cause the damage to the insured property which give rise to the business interruption loss are also capable of being or giving rise to 'special circumstances' for the purposes of allowing an adjustment of the same business interruption loss within the scope of the Trends Clause.

Chubb Fire Ltd v Vicar of Spalding [2010] EWCA Civ 981

Duty to warn and the doctrine of a "new intervening act"

Vandals discharged a fire extinguisher in a church. The operation to clean up the fine dust which was released cost about £240,000. Insurers paid and, exercising their right of subrogation, brought a claim against the suppliers of the extinguisher. As a contractual claim would have been time-barred, they claimed in tort, alleging that the suppliers had negligently failed to warn the church that any discharge of the extinguisher was likely to cause a mess. At first instance, the judge found that the suppliers were liable and the suppliers appealed.

The Court of Appeal rejected the submission that the judge should, on the facts, have found that a warning about the messiness of the extinguisher was given to the church. However, it was also held that the judge had erred in finding that, if the warning had been given, the church would not have installed the extinguisher. On the available evidence, the judge should have concluded that the church would have taken further advice and would, ultimately, have installed the extinguisher in any event.

In light of that finding, the appeal was allowed. Nevertheless, Aikens LJ went on to consider the argument that the action of the vandals should be regarded as a "new intervening act", such that the suppliers were not liable (even if the extinguisher would not have been installed in any event).

He found that the judge had failed to properly apply the correct legal principles (in particular because the suppliers did not owe a duty to protect the church against vandals). The four issues set out in *Clerk & Lindsell on Torts* had to be addressed: (1) Did the third party's intervening conduct render the original wrongdoing "merely a part of the history of events"?; (2) was the third party's conduct either deliberate or wholly unreasonable?; (3) was the intervention foreseeable?; and (4) does the defendant owe the claimant any responsibility for the conduct of the third party?

> "The attack took place 7 years after the failure to warn"

Aikens LJ concluded that the suppliers were not liable for the damage caused by the vandals. The attack took place 7 years after the failure to warn and although malicious discharge was foreseeable in 1999, no one thought then that there was any degree of likelihood that the exact combination of events which did occur (eg that the vandals would enter the church in the short space of time when it was unattended and would go into the room where the extinguisher was stored before returning to the body of the church to discharge it) would in fact do so. The particular combination was, at most, a mere possibility.

However, Longmore LJ and Arden LJ refused to comment on the new intervening act argument, since it was not determinative of the appeal.

Conditions

Widefree Ltd v Brit Insurance Ltd [2009] EWHC 3671 (QB)

Whether condition precedent had been breached

The claimants (jewellery shop owners) believed that a theft had taken place at their premises. Only one of the five CCTV cameras in the shop contained any relevant footage of the incident. Acting on police advice (and in accordance with normal procedure), the relevant footage was downloaded onto a DVD and the rest of the footage was automatically wiped. They notified a claim to their insurers and loss adjusters were appointed. The insurance policy contained a condition precedent that the insured should give to the insurer such information as the insurers might reasonably require and as might be in the insured's power to give. The claimants had been unable to meet the insurers' request that they provide them with footage from all five cameras and the insurers argued that this was a breach of the CP. They argued that the claimants should have asked them if they wanted to see the footage before it was deleted.

"The insured's obligation to provide the footage only arose after the insurers' request"

It was held that there had not been a breach of the CP. The insured's obligation to provide the footage only arose after the insurers' request and in this case the request had been made only after the footage had already been deleted. The claimants did not have to guess what the insurers might want to see. Furthermore, the insurers knew or should have known that images recorded by CCTV cameras were regularly wiped. It was proper for the insured to download only footage which the police advised him would be relevant to proving the theft and loss.

Loyaltrend Ltd and another v Creechurch Dedicated Ltd and Ors [2010] EWHC 425 (Comm)

Date of material damage in subsidence claim

The insured was a company trading as a fashion clothing retailer. By the late summer of 2003, cracks had started to appear to the front of one of its shops. The factual evidence was that the situation had deteriorated significantly by November 2003, with significantly more cracks appearing. The situation was said to have become much worse towards the end of 2004 (the insured talking of a "step change" in October 2004, with water regularly leaking into the property from that time and it no longer being possible to "patch up" damage). By March 2005, the insured had written to the landlord's agents demanding a suspension of rent, referring to loss of profits at the shop. It was found by the judge that notice to its insurers had not been given until August 2005.

The insured was insured by three different insurers from 11 December 2002 to 11 December 2006. When its claim for damage and business interruption arising from the subsidence was rejected, it pursued proceedings against only one of the insurers - Brit Insurance- which had written the policy covering the period 11 December 2003 to 11 December 2004.

Mackie J held that the claim against Brit failed because the insured had breached a condition precedent in the policy requiring notice to be given within 30 days of "the happening of any damage in consequence of which a claim is or may be made under this Policy". That is an objective test (see L*aker Vent v Templeton* [2009]). In this case, although the judge accepted that there was a "step change" in October 2004 (in the sense of the witnesses' sudden perception of a change in what was a gradual process), that did not detract from the seriousness of what was already apparent in December 2003, which the insured should have notified to insurers. Accordingly, the insured was in breach of the CP and the claim failed on that basis.

"It would be surprising if Brit, who insured only the middle of three years was liable for the entirety of the loss sustained"

The judge also went on to state that, if he was wrong on the CP issue, "it would be surprising if Brit, who insured only the middle of three years over which the relevant events occurred, was liable for the entirety of the loss sustained". Although the picture of when material damage occurred was confused, the position was materially worse in autumn 2004. He stated that "it is inaccurate to express the progressive deterioration caused by subsidence in terms of a series of sudden changes. The appearance of "step change" is the result of inspection and testing necessarily occurring only at intervals". The trigger for business interruption loss was not the subsidence but the material damage to the shop and on the evidence available the judge could only conclude that there must have been some material damage during Brit's year but less than in the other two relevant years. Although subsidence was continuing throughout Brit's year of cover, most of the material damage was in 2005.

William McIlroy Swindon Ltd v Quinn Insurance Ltd [2010] EWHC 2448 (TCC)

When did a dispute arise between an insured and insurer/whether an insurer must highlight onerous terms

General Condition 16 of a liability policy provided that any dispute between the insured and the insurer on the insurer's liability in respect of a claim must be referred to arbitration within 9 months of the dispute arising (failing which, the claim shall be deemed to have been abandoned). The insurer denied liability on the grounds that the insured had breached certain policy conditions. The insured was subsequently found liable to a third party (and shortly afterwards went into voluntary liquidation, resulting in a claim against the insurer under the Third Parties (Rights against Insurers) Act 1930.

The main issue in the case was when the dispute between the insured and the insurer arose (and hence whether the 9 month deadline to commence arbitration had expired). The claimants argued that a dispute could not have arisen until the insured's liability to the third party had been established. Edwards-Stuart J held as follows:

"Seeking a declaration that the insurer is in breach of contract before liability has been ascertained"

1) Reference to a "claim" in General Condition 16 was to a claim by the insured under the policy (and not a claim by a third party). *Post Office v Norwich Union* [1967] establishes that until the liability of the insured has been established, and the amount of that liability has been ascertained, an insured cannot sue its insurer for a particular sum of money. However, that does not always prevent an insured from seeking a declaration that the insurer is in breach of contract before liability has been ascertained. That is because the insurer will often be in breach of a policy obligation - for example, the policy might require the insurer to consider whether or not to conduct the defence of a third party claim. In this case, as soon as the insurer notified the insured that it was refusing indemnity, a dispute had arisen and that dispute should have been referred to arbitration within 9 months.

2) General Condition 16 had been incorporated as a term of the policy. "Cases on the incorporation of terms....must be approached with some care in the context of an insurance policy". It is well-known that commercial insurance policies contain many detailed requirements: "Whether or not he has read them, any reasonable businessman can be expected to know that his policy will contain many such detailed provisions". Nor was General Condition 16 unduly onerous. Although it is clearly much shorter than the statutory 6 year limitation period, "9 months is a reasonably generous time within which to explore the merits of any dispute that has arisen". Nor was the judge persuaded that an insurer should draw an insured's attention to every term in a commercial insurance policy which might prove onerous (apart from the duty to notify a claim within a particular period). To impose such a duty "could lead to endless disputes about whether such notification had been adequate. It would simply provide kindling for claims".

3) The judge doubted whether he had jurisdiction to extend time to begin arbitral proceedings under section 12 of the Arbitration Act 1996, since it appeared that the policy was governed by Irish law and that the seat of any potential arbitration under General Condition 16 would be Ireland. He nevertheless expressed his view that (had he had jurisdiction) he would not have extended time. In the absence of unusual circumstances, the conduct of the party resisting the application under section 12 must have been such as to have in some way caused or contributed to the failure of the applicant to comply with the time bar. In this case, there was no obligation on the insurer to advise that time was about to expire.

4) Paragraph 7.3.5 of the Insurance Conduct of Business Rules ("ICOB") (now ICOBS paragraph 8.1.1) referred to guidance to help an insured make a claim under the policy. The judge said that he did not believe this paragraph applied where an insurer has rejected the claim (rightly or wrongly). Even if that was wrong, the paragraph did not require the insurer to alert the insured to the existence of a time bar (such as the one in General Condition 16): "That time bar applies to the time for referring any dispute to arbitration once a dispute has arisen in relation to the insurer's liability in respect of a claim: it is not a period within which the insured must make his claim".

COMMENT: In *Post Office*, the insurers had not sought to deny liability. Instead, they argued that the claim for indemnity under the policy was premature. However, this case confirms that where an insurer repudiates liability, the insured can bring a claim for a declaration against its insurer even before it has been ordered to pay anything to a third party (and thus seek to obtain (if the policy allows it) indemnity for any defence costs incurred in defending the third party claim). Hence the limitation period in such circumstances begins to run from the date when the insured has been notified that the insurer will not pay the claim.

Clare Horwood & Ors v Land of Leather Ltd [2010] EWHC 546 (Comm)

Breach of condition giving control of claims to insurer/scope of implied duty of good faith during the policy

The claimants alleged that they suffered personal injury from the use of sofas purchased from (inter alia) Land of Leather ("LoL"). LoL was insured in respect of product liability by Zurich. After LoL went into administration, the claimants sought to claim against Zurich pursuant to the Third Parties (Rights Against Insurers) Act 1930. Zurich claimed that it was not liable to indemnify LoL and so was not liable to the claimants. Zurich claimed that LoL was in breach of a condition ("Condition 3") which gave it the right (inter alia) to control settlements and prohibited settlements by the insured without the consent of Zurich. LoL had entered into a settlement with the sofa manufacturer, whereby the manufacturer compensated it for damage to reputation and unsold stock. However, a further agreement was entered into a few months later, under which (the judge found) LoL had agreed that it would not pursue any right of indemnity from the manufacturer in respect of any liability for personal injury which LoL owed to the claimants. Teare J went on to consider whether, as a result of that agreement, insurers could rely on two defences:

1) Breach of Condition 3. The judge rejected the argument that the prohibition on settling claims applied only to claims against the insured and not to claims which the insured itself could bring against third parties. Furthermore, the condition was given the status of a condition precedent to liability in the policy. Accordingly, Zurich was not liable to indemnify LoL.

2) Breach of an implied term. Zurich argued that if the agreement with the manufacturer had not extended to the release of the personal injury claims (or, if it did, but the agreement was unenforceable), LoL was still in breach of an implied term of the policy to act reasonably and in good faith with due regard to Zurich's interests and rights of subrogation. In view of the judge's conclusion that Zurich did not have to indemnify LoL, he did not need to reach a decision on this issue but he stated what his decision would have been had it been necessary.

It was argued on behalf of LoL that the implied duty did not extend to the situation where a settlement was not actually concluded and so the insurer was not prejudiced. That argument was rejected by Teare J. The implied term arises because the insurer has a contingent right to be subrogated to the rights of the insured when he indemnifies the insured. If the insured acts without regard to that contingent right, he may harm the value of that right to the insurer. Obviously a settlement may deprive the insurer of that right, "But in principle harm may be caused to the insurer's rights of subrogation where the claim against the third party is not lost or reduced in value by settlement. For example, the documents necessary to establish such claim may be destroyed". However, on the facts of the case, if there was no settlement by LoL, there was no breach of the implied term even on this formulation of the implied term (although if the settlement had been concluded but was unenforceable, the judge said that that would have been a breach of the implied term, but that it could not have caused any loss).

"But in principle harm may be caused to the insurer's rights of subrogation where the claim against the third party is not lost or reduced in value"

Double Insurance

The National Farmers Union Mutual Insurance v HSBC Insurance (UK) Limited [2010] EWHC 773 (Comm)

Whether double insurance arose in this case

Double insurance arises when the same party is insured with two (or more) insurers in respect of the same interest on the same subject-matter against the same risks. The general rule is that (subject to the terms of each policy), the insured can recover in full from either insurer and the paying insurer is entitled to a contribution from the other insurer.

In this case, following exchange of contracts on a property, the risk of damage to the property passed to the buyers (under common law). The buyers therefore took out a policy with NFU, which insured them against damage by fire. The policy provided that if there was insurance covering the same damage, the insurer would only pay its share (ie its rateable proportion). Following a fire at the property 17 days after exchange of contracts, NFU paid out and the issue then became whether there was any "other insurance", and so whether it could claim a contribution from the other insurers.

The sellers were insured by HSBC at the time of the fire against damage to the building, and the policy contained an extension covering anyone buying the property (until completion of the sale or the end of the policy, whichever was sooner) but provided that the insurer would not pay "if the buildings are insured under any other insurance".

The judge (Gavin Kealey QC) held that the only policy covering the buyers in respect of the fire was the NFU policy: "the grant of buildings cover by HSBC to buyers...was directly qualified by the proviso [i.e. *that there is no other insurance in place*]: the one cannot properly be separated from the other". Accordingly, this was not a case of double insurance (the buyers were never covered under the HSBC policy) and NFU was not entitled to a contribution from HSBC. In reaching this conclusion, the judge had regard to the primary purpose of the policy extension: it was intended to provide valuable protection to HSBC's own original insured (the sellers), in the event that the buyers were otherwise uninsured (and so the cover would enable or encourage the buyers to complete the property purchase following damage to the property post-exchange but pre-completion).

It was also held that general Claims Condition 2 in the HSBC policy (which provided "we will not pay any claim if any loss...covered under this policy is also covered...under any other insurance except in respect of any excess beyond the amount which would have been covered under such other insurance") was overridden by the special clause in the HSBC policy referred to above, to the extent of any conflict between the two terms.

The judge also commented (obiter) on the case of *Austin v Zurich* [1944]. It is an established principle that where there is double insurance, if both policies (which would otherwise cover the loss) purport to exclude indemnity altogether in the event of other insurance, the two exclusions cancel each other out and liability is therefore shared between the insurers (see *Weddell v Road Transport & General* [1932]). In *Austin v Zurich*, one policy ("A") provided that in the event of other insurance, the insurer would only pay its rateable proportion. The other policy ("B") provided that it would only pay in excess of any sums recovered from the other insurance. The judge concluded that each insurer was liable for 50% of the loss (the two "escape" clauses cancelling each other out). Kealey QC said that in his view it would have been more correct to say that policy A was liable to the full extent of its limits and that policy B only provided excess cover.

COMMENT: It might be difficult in practice to distinguish between a condition in a policy which provides that it will cover a loss but will not pay out in the event of double insurance and a condition which provides that there will be no cover at all if another policy covers the same risk and subject matter. Care should therefore be taken to ensure that the exact nature of the condition is spelt out when drafting the insurance policy.

Exclusions

Axa Corporate Solutions SA v National Westminster Bank Plc

Clyde & Co for winning claimant

In 2005, NatWest was sued in the USA by victims of Hamas suicide bombings in Israel who allege that a British charity, Interpal, is a fundraiser for Hamas and that it collected donations through NatWest bank accounts. NatWest notified its insurer of potential claims under its public liability and products liability ("PPL") combined policy for the policy years when the relevant suicide bombings occurred. Of issue in this case was whether the policy in question contained an express term excluding liability for terrorism (the insurer sought a declaration that it did).

> "It is a common feature of the London market that parties contemplate a fuller wording to follow the slip"

Much of the case therefore turns on the particular factual events surrounding the renewal for the policy. Hamblen J (having agreed that it made no difference if NatWest, or its parent company RBS Group, were ignorant of the fact that the insurer had told RBS/NatWest's broker that it would only renew on terms which included a terrorism exclusion) accepted that a terrorism exclusion had been included in the PPL policy.

The exclusion was agreed in the following terms: "Terrorism exclusion (wording to be agreed)". Hamblen J rejected the argument that this did not amount to an effective agreement to a terrorism exclusion in the absence of any wording being agreed. He said that the further wording was not an essential term of the contract: "The fact that the parties then contemplated a fuller expression of the same exclusion in a wording subsequently to be agreed could not and does not undermine the fact that the exclusion was cast in terms which are capable of both interpretation and application. It is a common feature of the London market that parties contemplate a fuller wording to follow the slip or short-form statement of their agreed terms".

The insured also sought to argue that the exclusion should be construed as referring only to an act of terrorism affecting premises owned or occupied by it. The judge said that it would not be appropriate for him to seek to construe the term agreed in the abstract. If the insured wished to have the term construed by the courts, it should make a separate application to the court.

Goldsmith Williams v Travelers Insurance Company Ltd [2010] EWHC 26 (QB)

Meaning of "condone" in a dishonesty exclusion in a PI policy

The claimant brought a claim under the Third Parties (Rights Against Insurers) Act 1930 after the insured was made the subject of a winding up order. The insured was a company trading as solicitors. It had two directors, Mr Atikpakpa and Ms Usman. Mr Atikpakpa had made a false mortgage application and stolen the funds advanced by the lender. The claimant (who had been instructed by the lender in relation to the transaction and had indemnified the lender for its loss) obtained judgment against the insured and brought a claim against the insured's professional liability insurers. The insurers argued that they were entitled to repudiate liability because of the policy's dishonesty exclusion, which read (in relevant part) as follows: [The insurers] "shall not be liable...in respect of..Fraud or dishonesty...any claim....arising from dishonesty or a fraudulent act or omission committed or condoned by such insured, except that....no such dishonesty, act or omission will be imputed to a body corporate unless it was committed or condoned by....all directors of that body corporate".

Williams J applied the test for dishonesty set out in *Twinsectra v Yardley* [2002] (ie that the defendant's conduct is dishonest by the ordinary standards of reasonable and honest people and that he himself realised that by those standards his conduct was dishonest). It was agreed that the word "condoned" in the exclusion meant that a non-dishonest director knows of the dishonesty of his co-director yet overlooks it. The judge found, on the facts, that Ms Usman had knowingly provided false information on the mortgage application form and condoned the false application by her co-director. However, there was no suggestion that she had benefited directly from the *theft* by her co-director or condoned it: "It is one thing to obtain loans by making fraudulent statements, it is quite another to steal the loans".

> "There could have been no theft without the application"

Nevertheless, the judge held that the insurer was entitled to repudiate liability. It was wrong to suggest that the theft of the money did not arise from the mortgage application - there could have been no theft without the application. He referred to the recent case of *Zurich Professional v Karim* [2006], in which the judge found that if an insured condones a course of conduct which is dishonest or fraudulent and that course of conduct leads to or permits the specific acts or omissions upon which the claim is founded, the insurer will be entitled to repudiate liability (although the wording of the dishonesty exclusion in *Karim* differed from the exclusion in this case, that was held to be no reason to adopt a different approach).

Fraud

Mr Farid Yeganeh v Zurich Plc [2010] EWHC 1185 (QB)

Allegations of fraud against an insured - importance of motive

This case illustrates the difficulties which insurers can face in proving allegations of fraud (and, in particular, arson) by a policyholder. The legal issues were not in dispute in this case and it was accepted by both sides that as soon as there is any fraud in the claims process, the whole insurance claim is fraudulent (see *Axa General v Gottlieb* [2005]). Whilst the standard of proof for fraud is the balance of probabilities, the more serious the allegation, the stronger the evidence needed to establish it. On the other hand, it is unlikely that there will be any documentary evidence of an insurance fraud and so the court may have to draw appropriate inferences from circumstantial evidence.

The property insurer alleged that the defendant had deliberately burnt down his property. The defendant admitted making untruthful claims to his local council in order to evade Council Tax and the judge said that there were doubts about the honesty of the defendant and the truthfulness and accuracy of his evidence. However, despite this, the judge found that there was no direct evidence of arson and there was no evidence to contradict his denials of guilt and about where he was on the night of the fire. The judge said that, if there had have been sound evidence of motive, he might have concluded that there had been arson because the likelihood of the only other possibility (that a heater was accidentally switched back on when it was tilted) was "so remote". However, the judge found that the list of reasons advanced by the defendant as to why he would not wish to burn down his house was "powerful". In particular, it was hard to see how arson followed by reinstatement of the house would advance any planning ambitions which the defendant had. This lack of a motive was therefore fatal to the insurer's claim of arson: "Arson is a very serious crime in quite a different league, in terms of execution as well as gravity, from making dishonest claims for payment or to save money".

> "If there had have been sound evidence of motive, he might have concluded that there had been arson"

However, the judge did accept that the defendant had made a dishonest claim for the contents of the property. In this respect, the defendant's dishonesty regarding Council Tax went to more than just his credibility as a witness - "It points to a tendency consistent with the fraud alleged" by the insurer..."This was not the first time he had made a dishonest claim for limited financial advantage". As a result of this fraud, the entire claim by the insured failed.

Shaul Yechiel v Kerry London Ltd [2010] EWHC 215 (Comm)

Factual evidence of insurance fraud

Various items of jewellery belonging to the insured were stolen when the insured was in France. The policy in question provided cover for those items only when they were in a deposit box or, for a period of up to 14 days only, in the insured's personal custody. At the time of the theft, the jewellery had been in the insured's custody for more than 14 days. The insured accepted that there was therefore no cover for the theft, but claimed that his insurance brokers had failed to inform the insurers that the jewellery would be out of the deposit box for more than 14 days. The issue in this case was whether the insured had sent a letter to his brokers (by fax and by post) informing them that he was going to breach the 14 day limit. The case therefore turns on its particular facts but it is noteworthy for the factors which the judge took into account when deciding whom to believe.

"Taken cumulatively these factors were compelling"

Although each factor was not in itself conclusive, taken cumulatively these factors were compelling. They included the following: the insured had been inefficient at dealing with the insurers' requests in the past; it was not his practice to deal with his brokers by letter (instead he would phone them); if he had faxed the letter, the judge could not see why he would also have posted it; the insured did not call the brokers for confirmation of receipt even though he was seeking an extension of the 14 day time limit and knew that he would need to pay an additional premium/deal with insurers' further questions. The judge therefore concluded that the letter had not been sent.

Mark Noble v Martin Raymond Owens [2010] EWCA Civ 224

Whether retrial or fresh action should be ordered where claimant may have exaggerated damages due from insurers

The respondent was injured in a traffic accident. Liability was admitted and Field J assessed the level of damages at over £3m. A few months later, the defendant's insurers received confidential information that the respondent had in effect exaggerated his injuries and surveillance of him for several months appeared to the insurers to support that view and that the respondent had deliberately misled the court. The insurers applied for permission to appeal the award and for a retrial to take place. The respondent argued that judgment in his favour should not be set aside and instead the insurers should commence a fresh action to set aside the original judgment.

The Court of Appeal found that there was conflicting authority on this issue. In *Ladd v Marshall* [1954] Denning LJ held that a retrial should be held where, broadly, (1) the fresh evidence could not have been obtained with reasonable diligence for the original trial, (2) the evidence would have had an important influence on the case and (3) the evidence must be apparently credible. However, in the House of Lords case of *Jonesco v Beard* [1930], it was suggested that the proper course where deceit is alleged is to leave the aggrieved party to commence a new action (unless the Court of Appeal determines the issue itself or the evidence is incontrovertible).

Smith LJ said that the authorities are in conflict where the new evidence (as here) only suggests fraud and is contested by the other side. She concluded that, generally, "where fresh evidence is adduced to the Court of Appeal tending to show that the judge at first instance was deliberately misled, the court will only allow the appeal and order a retrial where the fraud is either admitted or the evidence of it is incontrovertible. In any other case, the issue of fraud must be determined before the judgment of the court below can be set aside". It was unnecessary to commence a fresh action, though, and the Court of Appeal allowed the appeal to the extent that the issue of fraud should be referred for trial by a High Court judge.

Piracy

Masefield AG v Amlin Corporate Member Ltd [2010] EWHC 280 (Comm)

Whether act of piracy amounted to actual or constructive total loss

According to section 57(1) of the Marine Insurance Act 1906 ("the Act") provides that there is an actual total loss where "the subject-matter insured is destroyed, or so damaged as to cease to be a thing of the kind insured, or where the assured is irretrievably deprived thereof" (there is no need to give notice of abandonment). Section 60(1) of the Act provides that "there is a constructive total loss where the subject-matter insured is reasonably abandoned on account of its actual total loss appearing to be unavoidable, or because it could not be preserved from actual total loss without an expenditure which would exceed its value when the expenditure had been incurred". The policy in this case also contained a Constructive Total Loss clause which provided that no claim for a CTL would be recoverable unless the insured cargo was "reasonably abandoned either on account of its actual loss appearing to be unavoidable or because the cost of recovering...the subject-matter...would exceed its value on arrival".

In this case, Somali pirates had seized a tanker and the claimant cargo owner served a notice of abandonment on the defendant cargo insurer. The notice was declined. 10 days later the shipowners paid the pirates a ransom and the vessel was released. The claimant argued that although there had always been the possibility that the shipowner would successfully ransom the ship, that possibility should be ignored for the purposes of sections 57 and 60 of the Act. Steel J dealt with the following issues:

> “”An insured is not irretrievably deprived of property "if it is legally and physically possible to recover it”"

1) Actual total loss. The issue was whether the claimant was "irretrievably deprived" of the cargo before the ransom was paid. The judge held that an insured is not irretrievably deprived of property "if it is legally and physically possible to recover it (and even if such recovery can only be achieved by disproportionate effort and expense)". The facts in this case were that (by contemporaneous correspondence and information in the public domain) the claimant was fully aware that the cargoes were likely to be recovered and that other vessels seized by Somali pirates had been promptly released following negotiations (and in fact the vessel and cargo were recovered shortly afterwards);

2) Constructive total loss. It could not be said that the subject matter had been abandoned or that an actual total loss appeared unavoidable: "What is required is not a notice of abandonment....but the abandonment of any hope of recovery". In this case, the shipowners and cargo owners had every intention of recovering their property and were fully hopeful of doing so; and

3) Was payment of the ransom contrary to public policy? The judge was not persuaded that it was. Payment of a ransom is not illegal as a matter of English law and although it was true that paying a ransom encouraged repetition (especially where there is insurance cover), it is the only option for ensuring that the crews of such vessels are taken out of harm's way. As there was no clear and urgent reason for categorising the activity as contrary to public policy, the courts should not become involved (this view was strengthened by the fact that kidnap and ransom cover is a long-standing feature of the insurance market and such policies should not be considered unenforceable).

Privilege

Akzo Nobel Chemicals and Akros Chemicals v European Commission (2010/C 301/02)

ECJ (Grand Chamber) dismisses appeal over legal professional privilege and in-house lawyers (in relation to EU competition investigations)

In April 2010, Advocate General Kokott issued an opinion approving the 2007 decision of the Court of First Instance of the ECJ that communications with in-house lawyers did not qualify for legal professional privilege in the context of EU competition investigations. As was widely predicted, the ECJ Grand Chamber has now followed that opinion and rejected an appeal against the Court of First Instance's judgment. The reasoning of the Grand Chamber was as follows:

1) Following the decision in *AM&S Europe v Commission* [1982], legal professional privilege (in relation to EU competition investigations) does not cover exchanges within a company with in-house lawyers because such lawyers are not "independent": "An in-house lawyer, despite his enrolment with a Bar or Law Society and the professional ethical obligations to which he is, as a result, subject, does not enjoy the same degree of independence from his employer as a lawyer working in an external law firm does in relation to his client. Consequently, an in-house lawyer is less able to deal effectively with any conflicts between his professional obligations and the aims of his client". It was said that, as an employee, an in-house lawyer cannot ignore commercial strategies pursued by his employer and so cannot exercise professional independence.

> "An in-house lawyer does not enjoy a level of professional independence equal to that of external lawyers"

2) This approach does not violate the general EU law principle of equal treatment because "an in-house lawyer does not enjoy a level of professional independence equal to that of external lawyers".

3) There is no predominant trend across all the Member States towards affording legal professional privilege to communications with in-house lawyers. A larger number of Member States still exclude in-house lawyers from the scope of legal professional privilege or do not allow them to be admitted to a Bar or Law Society.

4) Even if consultation with in-house lawyers was covered by the right to obtain legal advice (which the ECJ did not believe was the case), in-house lawyers are not always able to represent their employer before all the national courts.

5) The conclusion of the ECJ does not undermine the principle of legal certainty and nor does it violate the principle of national procedural autonomy.

COMMENT: This decision, though expected following Advocate General Kokott's opinion, will be disappointing for in-house lawyers, not least because the decision might be deployed in argument in other areas of EU law, beyond competition law. Nevertheless, it should be recalled that this position was first established almost 30 years ago in *AM&S* and there has been no impact since then from that decision on the general English law position regarding in-house lawyers and privilege. The case of *Alfred Compton v Customs & Excise Commissioners* (No.2) [1972] confirmed that under English law, in-house lawyers do qualify for legal professional privilege (provided that advice is given in a legal context). Alfred Compton has been continually applied by the English courts, even after *AM&S* and, more recently, *Akzo Nobel* and there is no reason to anticipate that this position will change following the Grand Chamber's decision.

Quinn Direct Insurance Limited v The Law Society of England and Wales [2010] EWCA Civ 805

Request for disclosure of documents to solicitors' insurer following Law Society intervention

"O" and "I" were joint partners of a firm of solicitors. Following the intervention of the Law Society in their practice, the solicitors' insurer refused to indemnify "O" on the ground of his alleged dishonesty. The insurer then sought disclosure of all documents of the firm in the Law Society's possession "to consider whether under the policy the [insurer] is obliged to indemnify or obliged not to indemnify ["I"]". No allegation of dishonesty had been made against "I" at that stage. The Law Society agreed to provide certain documentation (where specific claims had been made by clients and there were no privilege or confidentiality objections) but refused a blanket request for access. At first instance, Smith J refused the insurer's application (see Weekly Update 42/09) and the insurer appealed.

The Court of Appeal has dismissed the appeal. There was no implied term in the regulatory scheme (which requires solicitors to be insured) that the insurers are entitled to disclosure. This conclusion was based on several grounds, including: 1) an insured solicitor is not bound or entitled to disclose to his insurers privileged documents without a client's consent; and 2) the objective of the insurer in seeking the information and documents is not the advancement of any public purpose or regulatory responsibility but the private purpose of seeking evidence to justify a refusal of an indemnity to "I" in respect of clients' claims made against him.

Third party judgments

Omega Proteins Ltd v Aspen Insurance UK Ltd [2010] EWHC 2280 (Comm)

Whether judgment between insured and third party is binding on liability insurers

Clyde & Co for claimant

The insured was ordered to pay a third party damages after it failed to comply with a new law banning the supply of animal material containing the vertebral column of cattle aged over 24 months. The judgment found that the insured had breached express and implied contractual terms. The insured was placed in liquidation and so the third party brought a direct claim against the insured's liability insurers under the Third Parties (Rights Against Insurers) Act 1930. Insurers sought to rely on a policy exclusion which provided that the insurers would not indemnify the insured against any liability arising under a contract "unless such liability would have attached in the absence of such contract". Clarke J held as follows:

1) The exclusion clause in question requires the court to consider what liability there would have been had there been no contract between the insured and the third party (and not what liability there would have been taking into account the existence of the contract (the existence of a contract sometimes helping to establish the necessary proximity between the parties to found a tortious duty of care)).

2) The judgment against the insured was not determinative of whether or not the loss is covered under the policy. It is open for both insurers and the insured to dispute whether the insured was in fact liable and, if so, on what basis: "Unless B and C have by contract agreed something different, a judgment given in proceedings between A and B is neither binding on, nor enforceable by, C in subsequent proceedings between B and C".

"It is only the primary facts which are fixed by the judgment against the insured"

Insurers had sought to rely on the observations of Tomlinson J in *London Borough of Redbridge v Municipal Mutual Insurance* [2001], where he held that it would not normally be possible to "look beyond or outside the four corners of the determination itself for the basis of the liability to which the insured has become subject". Clarke J said that as a first instance decision, these comments were not binding on him and, even if they were, Tomlinson J had only referred to what would "normally" be the position. In any event, he did not agree with Tomlinson J's conclusion and even if Tomlinson J was correct, it is only the primary facts which are fixed by the judgment against the insured.

In reinsurance, it is an implied term of the reinsurance contract which is governed by English law that the decision of a foreign court as to the liability of the reinsured to its original insured will be treated as binding (save for certain exceptions), even if the English court might have reached a different conclusion (see *Commercial Union v NRG* [1998]). Clarke J held that no such implied term arose in this case which did not involve worldwide reinsurance cover and, in any event, did not involve the decision of a foreign court.

3) In this case, the insured would have been liable even in the absence of the contract pursuant to which it supplied the material. It had failed to take reasonable care to ensure that the product which it supplied was safe and could be lawfully supplied. As part of its duty of care, it should also have kept itself informed of changes in the law (which were reasonably discoverable). Accordingly, it had been negligent.

4) As for the burden of proof, the judge held that since the policy term in issue was an exclusion clause with an exception (ie every liability which arises under any contract is excluded unless it would have attached anyway) and so it was for the insurer to show that the liability in question arose under a contract and also that the exception was inapplicable. The judge therefore rejected the argument that, once the insurer proves that the loss arose under a contract, it was then for the insured to show that the exception to the exclusion applies. However, it should be noted that this decision was confined to the particular clause in question in this case. The insurers were unable to discharge their burden of proof on the facts. Accordingly, the third party was entitled to be indemnified under the terms of the policy.

COMMENT: In this case, Clarke J was determining a question ("would the insured still have been liable in the absence of the contract?") which could not have been determined in the original action against the insured because that question was not in issue. However, Clarke J also commented that it was open to parties to re-argue questions which had already been decided in the original action. For example, an insured who had been held to be fraudulent in the original action might argue, in a subsequent action between the insured and his insurers, that he was in fact negligent (and therefore covered under his policy). Thus the original action establishes the primary facts (eg that a representation was made and what it included), but in a further action, the judge could look again at whether the representation was fraudulent or negligent (whatever was decided in the original action). In practice this approach will often entail the re-examination of witnesses and other evidence and could therefore be a potentially costly and time-consuming exercise for both the insured and its insurers.

Underwriting

Persimmon Homes Ltd v Great Lakes Reinsurance (UK) Plc [2010] EWHC 1705 (Comm)

Whether ATE insurers entitled to avoid policy/allegations of negligent underwriting

An After the Event ("ATE") insurance policy was issued to the insured, who was bringing a claim against Persimmon. Persimmon won the action and the insured was ordered to pay Persimmon's costs. The insured was then wound up and so Persimmon brought a claim against the ATE insurers pursuant to the Third Parties (Rights against Insurers) Act 1930. The judge had found that the insured's employee had acted dishonestly in giving evidence against Persimmon. The ATE insurers purported to avoid their policy on a number of grounds, including misrepresentation of the risk.

Persimmon initially sought to advance the argument that, in the context of ATE insurance, the insurer must show that the material misrepresentation and/or non-disclosure would have affected the opinion of the solicitor acting for the insured in the underlying litigation and not of the "prudent underwriter". However, this argument was abandoned when the experts agreed that the misrepresentations and non-disclosure in this case were material. Steel J also rejected an argument that the insurers in this case had been aware of the misrepresentations and non-disclosure and had failed to react. A further argument was raised that there had been negligent underwriting in this case.

"Amber lights" set out in the insurers' own underwriting manual included: 1) a case with merits at 50%; 2) a case primarily dependent on oral testimony; and 3) a case with the hallmarks of a *"David v Goliath*". Persimmon argued that all these factors were present in this case. However, the judge noted that 1) although counsel had given an assessment of a 50% prospect of success in respect of their conditional fee agreement, of greater significance was the assessment of the merits by both counsel and solicitors in the region of 60% or more; 2) whilst the claim was mainly dependent on the resolution of a dispute between the witnesses, the dominant issue was the outcome of a meeting in respect of which the insured had an apparently contemporaneous note; and 3) although there was an element of inequality of arms, that would seem to be true of any claim for which a claimant was in need of a CFA in order to prosecute it. Steel J concluded that "Although many underwriters might (and indeed did) reject the risk, I am unable to accept the proposition that underwriters would certainly have rejected it as too risky". In particular, the willingness of counsel to act on the basis of a CFA had given the underwriter confidence to write the cover.

Kris Motor Spares Limited v Fox Williams LLP [2010] EWHC 1008 (QB)

Recoverability of ATE premiums - whether it is reasonable to insure at a late stage of proceedings

A dispute arose between a firm of solicitors and its clients. The solicitors were self-insured during the proceedings but shortly before the trial of a preliminary issue, took out an ATE (After the Event) insurance policy. The premium was expensive - £95,550 to obtain cover of £130,000 (a rate on line of 73.5%). After the solicitors won at trial, the master held that costs (including the ATE premium) should be paid by the clients. The clients appealed and said that the premium was objectionable for two reasons:

1) The policy had been taken out too late in the proceedings. Simon J rejected that argument. There is no principle that the premium on a late incepting policy is irrecoverable as an unreasonable cost - each case will depend on its particular facts. In this case, it had been reasonable for the solicitors to take the view that it would be imprudent to continue to self-insure, particularly in light of the fact that the clients had instructed Leading Counsel (thus possibly reducing the solicitors' chances of success).

"There is no principle that the premium on a late incepting policy is irrecoverable as an unreasonable cost"

2) The amount of the premium was unreasonable and contrary to the general principle against increasing the costs of litigation. The judge said that this was a less easy question to decide. ATE insurers do not compete for claimants, instead they compete for solicitors to recommend their product. Thus the only restraining force on the premium charged is how much a costs judge will allow on an assessment and the costs judges, in turn, have no criteria to enable them to decide whether any given premium is reasonable. The judge therefore concluded that "where the issue is raised as to the size of the premium there is an evidential burden on the paying party to advance at least some material in support of the contention that the premium is unreasonable". No expert evidence was adduced in this case, though, and so it could not be said that the master's conclusion on the level of the premium was wrong.

However, the judge did add that he recognised that the recoverability of ATE premiums under a costs order is currently the subject of vigorous debate (see, for example, the recent Jackson Report) and this judgment should not be seen as discouraging challenges to ATE premiums on the basis of unreasonableness. However, such challenges must be resolved on the basis of evidence and analysis.

Sanctions against Iran

On 9 June 2010 the United Nations Security Council (UNSC) passed Resolution 1929 (2010) imposing further UN sanctions on Iranian entities. A day later the UK responded by including within its own sanctions regime individuals and entities targeted by the UN. On 1 July 2010 the US enacted the Comprehensive Iran Sanctions, Accountability, and Divestment Act of 2010 (CISADA), which was followed on 26 July 2010 by the EU Foreign Affairs Council Decision, which together impose the toughest sanctions regime yet on Iran, with ramifications for the energy, insurance, transport and financial sectors. More recently on 16 August 2010 the US Treasury Department issued the Iranian Financial Sanctions Regulations to implement subsections 104(c) and 104(d) of CISADA and on 25 October 2010, the European Council adopted a wide-ranging package of sanctions on Iran, with prohibitions affecting the energy, insurance, transport and financial sectors which came into force on 27 October 2010.

"The latest EU sanctions prohibit the provision of insurance or reinsurance"

The latest EU sanctions prohibit the provision of insurance or reinsurance to the Government of Iran, an Iranian person, entity or body and, to any natural person or legal person acting on behalf of or at direction of an Iranian person. Importantly, HM Treasury takes the view that this prohibition will also apply to reinsurance provided by a UK reinsurer where the underlying insured is an Iranian company, regardless of where the insurer is based.

Certain exceptions to this ban are allowed for the provision of: (i) health and travel insurance to individuals acting in their private capacity; (ii) any compulsory or third party insurance to Iranian persons or entities based in the EU; (iii) insurance or reinsurance to Iranian individuals acting in their private capacity (except if they are in the list of designated persons or entities); (iv) insurance or reinsurance to the owner of a vessel, aircraft or vehicle chartered by the Iranian Government or an Iranian person or entity.

Participation in any activities intended to circumvent this prohibition, knowingly or intentionally, is also prohibited. Insurance and reinsurance contracts concluded before 27 October 2010 are not prohibited but the sanctions prohibit their extension or renewal. In response to a query, HM Treasury has expressed the view that the prohibition does not apply to Iranian risks ceded after 27 October 2010 under existing treaty reinsurance.

Third Parties (Rights against Insurers) Act 2010

The Third Parties (Rights against Insurers) Act 2010 received royal assent in March 2010. The new Act is not yet in force and no date has been set yet for it to come into force. We set out below, though, some of the main changes introduced by the Act.

"The Act removes the need for multiple sets of proceedings"

The 1930 Act of the same name allowed a third party claimant, in certain circumstances, to claim directly against an insurer where the insured has become insolvent. Under the 1930 Act, though, a third party couldn't issue proceedings against an insurer without first establishing the existence and amount of the insured's liability. That often necessitated expensive and time-consuming legal proceedings. The Act removes the need for multiple sets of proceedings by allowing the third party (if it wishes to do so) to issue proceedings directly against the insurer and resolving all issues (including the insured's liability) within those proceedings.

The Act also improves the third party's rights to information about the insurance policy, allowing the third party to obtain information at an early stage about the rights transferred to him or her in order to enable an informed decision to be taken about whether or not to commence or continue litigation.

The Act updates the law to reflect changes in insolvency law since the 1930s. This includes providing for rights to be transferred to a third party where an insured is facing financial difficulties and enters into certain alternatives to insolvency such as voluntary procedures between the insured and the insured's creditors.

It is also confirmed (the issue previously being in doubt) that the Act applies to voluntarily-incurred liabilities such as liabilities covered by legal expenses insurance.

An insurer's defences against an insured continue to operate against the third party so that the third party cannot be in any better position as against the insurer than the insured would have been. However some of the more technical defences on which insurers were previously entitled to rely on have been abolished. For example, it will no longer be possible for an insurer to decline liability on the grounds that the insured failed to notify him, provided that the third party has notified the insurer in accordance with the terms of the policy.

Jackson Report on Civil Litigation Costs

On 14 January 2010, Lord Justice Jackson produced the final report into his review of civil litigation costs. The report runs to over 500 pages and contains a broad range of proposals for reform. We summarise below some of the most important aspects of the report for insurers:

Liability Insurers: The report recommends that the recoverable costs in personal injury cases in the fast track (which deals with claims worth more than £5,000 but less than £25,000) should be fixed. The report also recognises the need to control the cost of expert evidence if an overall cap is introduced. Lord Justice Jackson remains of the opinion that BTE (i.e. legal expenses) insurance is beneficial to small businesses and he recommends that both insurers and the Department for Business, Innovation and Skills should make serious efforts to draw the various forms of BTE insurance (and its costs) to the attention of SMEs.

In relation to Conditional Fee Arrangements, the report recommends that success fees and ATE insurance premiums should no longer be recoverable under costs orders from losing parties. Instead, a return to "old style" CFAs (ie the type of CFAs in place prior to April 2000, whereby success fees and ATE premiums would be deducted from the client's damages (subject to a voluntary cap of 25% of the damages received)) is recommended.

Personal Injury Insurers: The report concludes that the payment of referral fees for personal injury claims should be banned. It also concludes that the introduction of one-way costs shifting (whereby the defendant pays the claimant's costs if the claimant wins, but the claimant does not pay the defendant's costs if the claimant loses) will materially reduce the costs of personal injuries litigation. However, the report also recommends two-way costs shifting if it reasonable and just to do so in a particular case.

Third Party Funders: The report recognises that third party funding promotes access to justice and (unlike CFAs) does not impose additional burdens on opposing parties. It also tends to weed out weak claims, because funders will not take on the risk of such cases. It is likely to become even more important if success fees under CFAs become irrecoverable. Although the report does not recommend the abolition of the law of maintenance and champerty, it does propose that if funders comply with a voluntary code drafted by the Civil Justice Council (or some other form of regulation), funding agreements should not be overturned on the ground that they breach that law. It is also suggested that if the third party funding market expands significantly, the FSA might eventually regulate it.

However, the report also recommends that third party funders should be exposed to liability for adverse costs in respect of litigation which they fund (subject to the discretion of the judge).

Further information

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