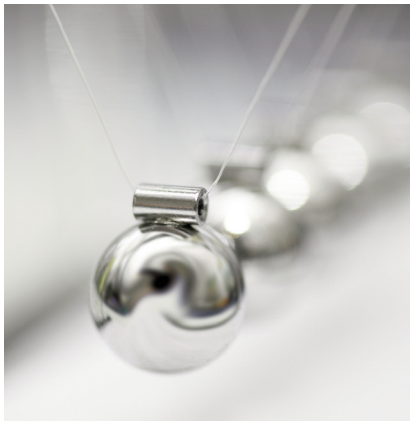

Insurance and Reinsurance Review of 2011

Contents

Broker's Negligence

Ground Gilbey Ltd & Anor v JLT UK Ltd [2011] EWHC 124 (Comm)

Whether broker liable for loss incurred by insured in settling a claim early

The defendant insurance broker acted for the claimants in placing property insurance for Camden Market. A fire broke out at the market in February 2008 after a gas portable heater set fire to clothing on a stall. Various risk improvements had been sent to the insured from 2006 onwards concerning removal of the heaters. In the latest risk improvement, sent in October 2007 to the broker, insurers had pressed for a solution to this fire hazard. However, that risk improvement had not been passed on to the insured at the time. Furthermore, the policy renewal schedule sent out in April 2007 had included a Survey Condition which provided that cover was conditional upon (inter alia) satisfaction of all requested risk improvements within timescales stipulated by the insurers. This was also not passed on to the insured by the brokers.

The claimants argued that, after the fire, their position as regards their insurers was "vulnerable" and hence they reached an early settlement. The brokers countered that neither the risk improvement nor the Survey Condition had provided the insurers with any real defence and the claimants' real intent had been to achieve a quick settlement and to claim the shortfall from their brokers.

It was uncontested between the parties that a broker owes a client a (continuing) duty to take reasonable steps to obtain a policy which clearly meets his client's needs and not to expose his client to an unnecessary risk of legal disputes with his insurer. Blair J held that the broker ought to have advised the claimants about the risk improvement and the Survey Condition and that (given the clear intention to use the heaters to heat the market) the broker ought to have realised that the policy did not meet the claimants' needs. However, the broker raised various defences:

1) The claimants already knew about earlier risk improvements required by insurers and had failed to take any action - therefore, had they been advised of the required October 2007 risk improvement, this would have made no difference. Blair J said that imposition of the risk improvement had a "material and potentially deleterious effect on the insurance cover" (see *HIH Casualty v JLT* [2007]) and advice should have been given to the claimants. The judge did accept, on the facts, that the claimants (had they been informed) would not have immediately removed the heaters. However, they would probably have entered into a dialogue with the insurers to find an alternative and so, following the fire, "the dynamics of the negotiations *[between the claimants and the insurers]* would have been different".

2) The Survey Condition was not a warranty nor a condition precedent and so did not provide insurers with any reasonable defence to the claim under the policy. Blair J rejected the argument that he should form an objective conclusion on this issue. Instead, since a settlement had been concluded with insurers, he said that he should adopt the approach of Colman J in *BP v Aon* (No 2) [2006] and only ask whether the settlement arrived at was "at a figure within the range of what would have been reasonable". Blair J said that the claimants had reached a reasonable settlement. Insurers had raised the Survey Condition as a defence and it was "at least arguable that the Survey Condition did mean that they were not entitled to an indemnity". This was because the insurers had made it clear that they wanted the heaters removed and that this had remained a "live concern" for insurers right up until the fire. Accordingly the claimants had found themselves with "doubtful or uncertain rights". Furthermore, Leading Counsel had endorsed a settlement at just under 70% of the value of the claim. Blair J also rejected an argument that the brokers should have been consulted about the Survey Condition defence before the settlement was concluded.

   The claimants were therefore entitled to the difference between what they had actually recovered from insurers and what they would have recovered had the brokers not been negligent. The judge did accept that, as both the claimants and the insurers had wanted an early cash settlement, they would have had to reach a deal based on the information available to them at the time (and not the information which would have become available had a reinstatement claim been pursued instead).

COMMENT: This case highlights the dangers of brokers failing to pass on all insurers' concerns to their clients. Although the judge accepted that the insured in this case was unlikely to have taken steps which would have prevented the fire had it been alerted to the insurers' (latest) concerns, the mere fact that a discussion might have taken place between the insurers and the insured on the issue was enough for the insured to succeed in its claim against its broker.

Damages

Argo Systems FZE v Liberty Insurance PTE Ltd [2011] EWCA Civ 1572:

Breach of warranty, waiver and affirmation/damages for misrepresentation

A vessel was purchased for scrap and was to be towed as a dead ship from the US Gulf to India. Insurance was purchased for the journey. After the vessel sank, cover was declined and litigation commenced in the US. After the insurer won in the US courts, a new claim was brought against the insurer in England. In the course of the English proceedings, the insurer raised two new defences (in addition to the defences already raised in the US proceedings) - namely, breach of a warranty in the policy that "warranted no release, waivers or "hold harmless" given to tug or towers" and also that it was entitled to avoid because of misrepresentations. At first instance, the judge had held (amongst other things) that there had been a breach of warranty in a marine insurance policy but that the insurer had waived by estoppel its right to rely on the breach. The judge also held that the insurer's claim for damages for misrepresentation was not "bad law" but suggested that the Court of Appeal should decide whether such damages should be available where the right to avoid has been lost (as it had in this case). The insurer appealed both points. The Court of Appeal has now held as follows:

(1) Section 34(3) of the Marine Insurance Act 1906 provides that a breach of warranty may be waived by an insurer. Since an insurer does not need to elect to rely on a breach of warranty, the waiver referred to in section 34(3) refers to waiver by estoppel. Accordingly, the insured must demonstrate that there has been (a) an unequivocal representation, by words or conduct, that the insurer does not, in future, intend to enforce his legal right against the insured (and this is a question of fact) and (b) the insured has relied upon that unequivocal representation in such a way that it would render it inequitable for the insurer to go back on his representation.

    A letter sent by the insurer's lawyers 4 months after the loss to the assured set out the insurer's reasons for declining liability but did not refer to the breach of the warranty in question. The Court of Appeal held that that did not amount to an unequivocal representation, since the letter had contained the important words *"The foregoing is without prejudice to all the remaining terms and conditions of the policy"*. Thus the insurer had reserved the right to raise further defences.

    Nor did it matter that the insurer had not referred to this defence in earlier US proceedings or had waited 7 years between those US proceedings and the English proceedings to refer to the breach of warranty: "Saying nothing and "standing by", ie. doing nothing, are, to my mind, equivocal actions" (as per Aikens LJ).

    Nor did the words of Mustill LJ in the case of *Vitol v Esso Australia* ("The Wise") [1989] (that "explicit reliance on one contention and the absence of reliance on another, which could have been advanced on facts already known, is capable of being a tacit representation that the latter would not be relied upon") apply to the specific facts of this case. In Vitol, there had been a without prejudice agreement between the parties.

(2) Since the insurer was entitled to rely on the breach of warranty, the insurer's claim for damages for misrepresentation was not pursued.

COMMENT: Following the Court of Appeal decision in *HIH Casualty & General v AXA Corporate Solutions* [2003], it has been accepted that only waiver by estoppel (and not waiver by election) can be made by an insurer in the context of a breach of warranty. This has put a heavier burden on insureds since they must demonstrate reliance on the representation. However, this case demonstrates how hard it can be for the insured to overcome even the first hurdle (namely that there has been an unequivocal representation) and how effective a full Reservation of Rights can be.

It is also accepted that an insurer can, in theory, claim damages for misrepresentation by an insured. However, there do not appear to be any reported decisions to date where an insurer has in fact received damages (probably because an insurer will usually choose to avoid the policy instead) and this decision has not, unfortunately, advanced matters any further.

Milton Keynes BC v NIG & Ors [2011] EWHC 2847 (TCC)

Duty to notify and damages for breach of a policy condition

The claimant alleged that a fire at its premises was caused by a Mr Nulty, a self-employed electrical engineer, who was insured by NIG. After a review of the evidence, Edwards-Stuart J concluded that the fire was caused by Mr Nulty's negligence. However, NIG claimed a breach of a notification condition in the liability policy (requiring notification to be made immediately "on the happening of any incident which could result in a claim" under the policy). It was accepted that this was not a condition precedent. The judge considered the following issues:

(1) The effect of "errors" in the declination letter sent by NIG's solicitors (eg it wrongly asserted that the notification condition was a condition precedent). The judge was critical of the NIG personnel's reliance on this letter: "I accept that in matters such as the construction of an insurance policy claims managers would naturally defer to the advice of their solicitors, but both these witnesses were very experienced and could be expected to at least have questioned the basis on which it was proposed to decline cover". However, the errors did not affect NIG's case.

(2) When was Mr Nulty under an obligation to notify NIG? Although no-one had suggested that Mr Nulty was responsible in the week following the fire, Edwards-Stuart J said (as he had found that on a balance of probabilities Mr Nulty was responsible) that Mr Nulty would have appreciated that he might have started the fire (even if he would have wanted to believe that he hadn't). It was held that, in those circumstances, he should have appreciated that an incident had occurred which could result in a claim against him and so he had been under an obligation to notify NIG immediately. Mr Nulty had therefore breached the policy condition.

(3) Had NIG suffered any prejudice as a result of the breach of the notification condition? The judge was doubtful that NIG would have instructed a fire expert to visit the site immediately (indeed, it might have feared that to do so would encourage the claimant to consider a claim against Mr Nulty to have "some merit"). In any event, it was thought that the expert would not have been able to carry out a full site investigation at that time.

    Although the judge thought that NIG's arguments that they had lost the chance to carry out various examinations and interviews were not "very powerful", nevertheless, he considered it "self-evident that a cold trail always puts an investigator at a disadvantage". NIG had been prevented from investigating the claim thoroughly at a much earlier stage and so had lost the chance to prove that there had been another cause of the fire (despite his findings as to Mr Nulty's responsibility, the judge accepted that he could not exclude the possibility that a differently conducted investigation might have persuaded him that he had not been responsible).

(4) NIG's claim for damages should be assessed on the basis of a loss of chance (and the judge did not consider the claim to be too intangible for him to do so). However, a valuation of this loss of chance was "fraught with difficulty". Edwards-Stuart J concluded "largely as a matter of impression" that the prejudice to NIG should be assessed at 15% and this was the amount which could be set off against Mr Nulty's claim for indemnity.

Finally, the judge rejected an argument from the claimant that it was entitled to interest accruing since the date when NIG wrongfully failed to accept its liability to indemnify Mr Nulty. There was no proof that NIG's delays had caused the claimant to delay issuing proceedings.

COMMENT: There have been very few reported cases where an insurer has been able to claim damages as a result of the insured's breach of a "bare" condition (ie not a condition precedent), since it is usually difficult to prove what loss an insurer has suffered as a result, say, of late notification. Indeed, Waller LJ in *Friends Provident v Sirius* [2005] thought that a set-off for damages for a loss of chance was "illusory" because: "by the nature of things it may be difficult if not impossible for the insurer to say whether there were circumstances which would have enabled him to defeat the claim, or what his chances of so doing were". This case is therefore noteworthy as a rare example of damages being awarded for late notification and may encourage insurers to consider running a claim for damages for breach of a notification condition in future cases (not least because the judge did not find any "very powerful" factors to indicate that the insurer had indeed lost any specific investigation opportunity).

Maritsave Ltd v National Farmers Union Mutual Society Ltd [2011] EWHC 1660 (QB)

Breach of warranty and claim for damages

Following a fire at the insured's property, the claimant claimed under its property insurance policy. The insurers alleged the breach of a warranty (which provided that a breach "which contributes to damage" may result in a claim not being paid). On the facts, Supperstone J held that there had been no breach by the insured and hence it was entitled to payment. Of general interest, though, is the fact that the judge agreed that the insured was entitled to damages for breach of the policy. The current rule under English law is that laid down in *Sprung v Royal Insurance* [1999] i.e. that damages cannot be awarded for a delay or failure in payment of insurance monies (instead, the insured is entitled to interest). This is because English law regards payments under an insurance policy as damages for breach of contract (because an insured loss gives rise to a notional breach of contract) and damages cannot be awarded for a failure to pay damages. The rule in *Sprung* has attracted criticism and the Law Commission called for its reform in Issues Paper 6 (Damages for Late Payment) in March 2010. Supperstone J does not, however, discuss these issues in the judgment and it is therefore unclear on what basis his decision was reached.

Disclosure

Consumer Insurance (Disclosure and Representations) Bill: This bill was introduced to the House of Lords on 16 May and it is following the procedure for uncontroversial Law Commission Bills (which will speed up its passage because certain stages can be carried out in committee). The bill only relates to consumer insurance contracts (ie contracts entered into by individuals for purposes unrelated to the individual's trade, business or profession). In its current form, the bill provides for a one-year gap between the date the bill is passed and the date it comes into force.

The main points of the bill are as follows: (1) Consumer insurance contracts will no longer be contracts of utmost good faith and there will be no requirement for the consumer to volunteer information to the insurer. Instead, the consumer must take reasonable care when answering the insurer's questions; (2) If a consumer has taken reasonable care, there can be no avoidance and any claim must be paid; (3) If the consumer makes a careless misrepresentation, the insurer's remedy will be based on what it would have done had the consumer not breached its duty. That may result in the insurer being able to avoid the contract or to impose different terms or to reduce proportionately the payment to the consumer (because a higher premium would have been charged); (4) If the misrepresentation was deliberate or reckless, the insurer can void the contract and keep any premium (unless it would be unfair to the consumer to keep it). (5) "Basis of the contract" clauses will be abolished and it will not be possible to contract out of the terms of the Act (insofar as any contract term purports to put the consumer into a worse position); (6) The bill also provides rules for determining whether a broker (or other agent) is acting as the agent for the consumer or for the insurer.

Fraudulent Claims

Sharon's Bakery (Europe) Ltd v Axa Insurance UK Plc [2011] EWHC 210 (Comm)

Insurers entitled to avoid for moral hazard/fraudulent means or devices

The claimant insured (a bakery) sought an indemnity from the defendant insurers following a fire at its premises. The insurers defended the claim on two grounds:

(1) There had been a non-disclosure of material facts - not relating to the insurance but to a financial leasing transaction. This was said to constitute a "moral hazard" and accordingly the insured was entitled to avoid. The insured accepted that allegations of dishonesty must be disclosed to an insurer when applying for insurance (see *North Star Shipping v Sphere Drake* [2006]). However, it argued that the insured was under no duty to disclose where the insured does not believe himself to have acted dishonestly and no-one has suggested otherwise at the material time (even if the insured is aware that another person might potentially suspect dishonesty). On the facts of the case, though, Blair J concluded that the insured had been aware that a false invoice for equipment had been sent to the financing company for the purpose of obtaining a loan which would not otherwise have been extended. This was a material fact which ought to have been disclosed to insurers: "False documents are inimical to commerce, and in my view, this factual scenario also falls within the "moral hazard" principle". It made no difference here that there had been valuable equipment on the premises which was damaged in the (accidental) fire, or that the financing company had not apparently been concerned about how the insured had acquired its equipment.

(2) Following the fire, the insured submitted the false invoice in support of its claim and this therefore amounted to "fraudulent means or devices" in aid of its claim. This argument was also accepted by the judge. The invoice was provided as evidence of a true sale and purchase agreement which had not taken place and was used to support the insurance claim. Again, it made no difference that the insured claimed to have a perfectly valid set of documentation to show how it had acquired the equipment and the judge had rejected any suggestion that the equipment was of dubious provenance or worth less than the insured claimed. Accordingly, all the benefit under the policy was forfeited.

Aviva Insurance Ltd v Brown [2011] EWHC 361 (QB)

Fraudulent claim and recovery of all amounts paid out under policy

The claimant insurer sought to recover sums which it had paid out under a property insurance policy. A claim for subsidence was made under the policy in 1989 and a further claim was made in 1996. After considerable delay, the insured admitted the claim and repair works were carried out in 2008. The cost of the repairs was over £175,000 and the insurer also paid just over £58,000 in respect of alternative accommodation. The insurer alleged that the claim for alternative accommodation was fraudulent. Much of the case therefore involves a factual dispute but the following is noteworthy:

(1) It was accepted by the insured that there could be an alleged fraudulent claim (or use of fraudulent means or devices) even where (as here) they related to a time before any actual loss in relation to the alternative accommodation was incurred. The judge also accepted, as a general statement, that the withholding of information (when knowing or deliberate) may, in certain circumstances, constitute fraud.

(2) The insurer accepted that the combined test for dishonesty laid down in *Twinsectra v Yardley* [2002] (ie conduct must be dishonest by the ordinary standards of reasonable and honest people and the defendant himself must realise that by those standards his conduct was dishonest) was the relevant test in this case. However, it noted that motive was irrelevant. Eder J agreed that it did not matter that the insured thought that he had been treated badly by the insurer. The issue of what is fraudulent will also depend on the particular facts of a case and it is impermissible to look at conclusions of fact drawn by another judge in another case.

(3) Eder J rejected the argument by the insured that an insurance claim will only fail if there is fraud to a "substantial extent" (the insured having sought to rely on *Orakpo v Barclays* [1995] and *Galloway v Guardian Royal Exchange* [1999]). However, he did accept that the fraudulent element must not be immaterial or insubstantial. In this case, the insured had (amongst other things) represented that a certain alternative property had been "available to rent" and that inevitably led to a conclusion that the owner of that property was someone other than the insured (whereas the insured was in fact the owner of that property). This was held to not be "insubstantial" fraudulent conduct and it did not matter that the insured had not continued to pursue the property as possible alternative accommodation (or that other representations, such as "I am getting chased by the landlord" were held to be not substantial).

(4) Eder J rejected an argument by the insured that *Direct Line v Fox* [2010] was authority for the argument that the insurer could not claim reimbursement of the repair costs but only of the £58,000 paid in respect of alternative accommodation. That case was said to turn on "its own very special facts". Here, the cost of repairs and the alternative accommodation were part of the same claim arising out of subsidence and there was no proper basis for dealing with them separately.

(5) There was some debate as to whether the insurer's claim was for damages or whether it arose out of eg "forfeiture" or "discharge of liability" but in the event, the parties agreed that the distinction was irrelevant to the case.

COMMENT: In this case, the insured had been entitled to claim for alternative accommodation. At one point, the Financial Ombudsman Service had concluded that he was entitled to accommodation "to the same standard" as the insured property. Following difficulties with agreeing this alternative accommodation with the insured, the insurer eventually agreed to pay £6,500 per month for alternative accommodation. These sums were then genuinely paid out to cover the cost of alternative accommodation (and were, it seems, less than it would have cost to rent a fully equivalent property). However, the (not insubstantial) fraudulent conduct by the insured in first seeking to obtain (but not actually succeeding in doing so) payment for alternative accommodation in a property which he owned was enough to invalidate the whole claim. This case, together with Sharon's Bakers v Axa (see above), provides reassurance to insurers that the courts will adopt a strict approach to fraudulent insurance claims, even in circumstances where the insured could have pursued a genuine, honest claim instead.

Gender Discrimination

Association belge des Consommateurs Test-Achats Case C-236/09

ECJ rules that it is incompatible with EU law to take the sex of an insured into account as a risk factor

On 30 September 2010, Advocate General Kokott delivered her opinion that Article 5(2) of Directive 2004/113, which allows Member States to permit differences related to sex in respect of insurance premiums and benefits if sex is a determining risk factor (and that can be substantiated by relevant and accurate actuarial and statistical data) should be declared invalid. As was widely anticipated, the ECJ (grand chamber) subsequently followed that opinion. In a brief judgment, it held that:

(1) Article 6(2) EU provides that the European Union is to respect certain fundamental rights. One of those fundamental rights is the equal treatment of men and women.

(2) The EU legislature provided in Article 5(1) of Directive 2004/113 that differences in premiums and benefits arising from the use of sex as a risk factor must be abolished by 21 December 2007. However, Member States which did not require unisex premiums and benefits at the time when Directive 2004/113 was adopted were given the option of deciding before 21 December 2007 to allow differences in premiums and benefits based on sex as a risk factor (provided that that could be substantiated by relevant and accurate actuarial and statistical data). Although, under Article 5(2), a decision to allow such differences was to be reviewed by the Member State 5 years after 21 December 2007, the Directive was silent as to the length of time during which those differences may continue to be applied. Accordingly, there was a risk that this derogation from the equal treatment of men and women might persist indefinitely.

(3) A provision enabling Member States to maintain, without temporal limitation, an exemption from the rule of unisex premiums and benefits was said to work against the achievement of the objective of equal treatment and hence was invalid.

The ECJ concluded that Article 5(2) will be invalid with effect from 21 December 2012. This is a somewhat shorter time frame than the 3 year transitional period suggested by the Advocate General to allow insurers to adjust to the new legal framework conditions and to adapt their products. However, it does not appear from the judgment that the invalidity will have any retroactive effect. The effect of the ruling, though, is likely to be a levelling up or down of premiums and rates to provide for a unisex rate and possibly even the withdrawal of certain products. Less clear is how matters of indirect gender discrimination will be dealt with - for example, where occupation is used as a risk factor, given that certain jobs traditionally have a higher concentration of either men or women.

Interpretation

Melinda Holdings SA v Hellenic Mutual War Risks Association (Bermuda) Ltd [2011] EWHC 181 (Comm)

Whether claimant entitled to cover under war risk policy/sue and labour clauses

The claimant's vessel was arrested by the Port Suez Court in Egypt in 2008. The defendant insurer accepted that the vessel was a constructive total loss and that prima facie there was an insured cause of loss (capture, seizure, arrest, restraint or detainment) under the war risk policy. However, the insurer sought to rely on two exclusions in the policy:

(1) Exclusion of claims arising out of "ordinary judicial process". In this case, the arrest was a purported executory arrest in respect of a judgment debt owed by two defendants, Fonderance and Seama to the Port Said Court in respect of unpaid court fees. Burton J accepted that there was no connection between Fonderance and Seama and the vessel or the claimant and therefore the arrest of the vessel had not been justified. The Court had not been "acting bona fide as an independent judicial body. There was effectively extortion by the State under a veneer of court process. The Port Suez Court, through its judicial and quasi-judicial powers, was acting piratically: just the risk that is intended to be covered by this insurance".

(2) Breach of the sue and labour clause. Burton J rejected this argument too. Philips LJ in *State of Netherlands v Youell* [1998] made it clear that the Marine Insurance Act 1906 requires breach of the sue and labour duty to be the proximate cause of loss before an insured will forfeit his cover. He said that this also applied to contractual sue and labour clauses which replicate the statutory duty. However, the position is less clear where the contractual clause is in different terms. In this case, the sue and labour clause provided that: "In the event that an Owner commits any breach of this obligation, the Directors may reject any claim by the Owner against the Association arising out of the occurrence or reduce the sum payable by the Association in respect thereof by such amount as they may determine". Colman J in *The Grecia Express* [2002], when considering this type of clause, held that "its construction is at large and does not need to be identical to that of similar words in the statute, unless there is some compelling reason for the meanings to coincide". Burton J said that it was "at least strongly arguable" that the discretion referred to in the clause replaced the proximate cause test. However, he was not required to decide the issue since there had been no breach of the clause.

The sue and labour clause extended the duty to the owners' "agents" and Burton J (although, again, he did not need to decide the point), was unpersuaded by an argument that "agents" did not include lawyers but instead meant only the Master and crew. In any event, the judge held that there could be no criticism of the conduct of the lawyers (or the claimant) in this case.

All Leisure Holidays Ltd v Europaische Reiseversicherung AG & Ors [2011] EWHC 2629 (Comm)

Construction of a Passenger Protection Insurance Policy

The Package Travel Regulations 1992 provide that, where a tour organiser cancels a package before the date of departure, the consumer is entitled to (broadly) either a substitute package from the organiser or a full refund. HICL owned and operated a cruise ship. It took out (on behalf of its customers) a Passenger Protection Insurance Policy with the defendant insurers in order to, in essence, provide security for its obligation to repay any monies paid to it by those customers. After HICL entered into administration, the cruise ship was sold to the claimant. It offered HICL's customers cruises on the same ship (the only difference for the customers being the fact that those cruises were operated by the claimant, rather than HICL). Nevertheless, the claimant required the customers to claim an indemnity under the policy in respect of the monies which they had paid to HICL and to pass the policy proceeds to it (and, in due course, the customers assigned their claims against the insurers to the claimant). The insurers denied liability on three grounds:

(1) There was no "cancellation" of the cruises promised by HICL - the only change was the operator of those cruises. As such, it was argued that there could be no claim under the policy. Teare J held that the word "cancellation" in the policy would, given the context, be reasonably understood by the parties to refer to circumstances where HICL was either unable or unwilling to provide the promised cruise. Although it was true, in a general sense, that the commercial purpose of the policy was to ensure that customers were not "disappointed", having regard to the Regulations, the policy was really providing an indemnity against financial loss and not "disappointment".

(2) Insurers then argued that there had not been any financial loss suffered by the customers, since they had received the cruise which they had paid for. Teare J held that, although that argument "has an attraction", it was only "superficial". HICL had been obliged to return monies paid to it and had been unable to meet its obligation. Accordingly, the customers had lost those payments. Although they were not ultimately out of pocket, their loss was not "cancelled" by the provision of the cruise. This was because: (a) the customers' claims were claims in restitution or debt and hence they had no duty to mitigate; and (b) the customers had bargained with their right to claim under the policy in order to obtain the right to a replacement cruise. That bargaining did not cause the customers to lose their right to claim under the policy. Teare J said that: "I therefore do not consider that the benefits obtained from the agreement between the passengers and the Claimant should be regarded as eliminating the loss which existed immediately prior to that agreement".

(3) Finally, insurers sought to rely on a policy condition requiring customers to prove their loss to the reasonable satisfaction of the insurers. Teare J rejected an argument that this required the submission of a claim form or proof that a loss was not excluded under the policy.

Although the judge agreed with the insurers that the claimant was seeking to use the policy as a means of facilitating its purchase of the cruise ship and retaining the goodwill attached to the cruises, nevertheless, it was entitled to enforce the customers' claims under the policy.

PT Buana Samudra Pratama v Marine Mutual Insurance Association (NZ) Ltd [2011] EWHC 2413 (Comm)

Interpretation of follow the settlements clause/alleged breach of warranty

The claimant sought summary judgment against a following underwriter on a claim under a marine insurance policy. The claimant owned a tug insured under the policy. It ran aground whilst towing a tanker. Several months after the claimant tendered notice of abandonment, the Lead Underwriter agreed to pay its share of the claim. However, the defendant rejected liability because of an alleged breach of warranty. The policy contained the following clause: "It is agreed to follow [the Lead Underwriter] in respect of all decisions, surveys and settlements regarding claims within the terms of the policy, unless these settlements are to be made on an ex gratia or without prejudice basis" (emphasis added). The defendant argued that where there had been a breach of warranty, the claim was not "within the terms of the policy" and so it was not obliged to follow the decision of the Lead Underwriter. The claimant countered that to interpret the clause in this way would be to "drive a coach and horses through the clear commercial purpose of the clause. For it would enable the Defendant, by saying that the claim was outside the terms of the policy, to render the leader's settlement irrelevant and to require litigation with the Defendant before it could be compelled to pay".

Teare J held that the claimant was correct. The clause referred to "all" settlements, as well as "all" decisions and surveys, thus suggesting that the whole process of claims investigation and settlement by the Lead Underwriter was to be followed. That process would necessarily include both issues of liability and of quantum: "In that context the words *regarding claims within the terms of the policy* would, in my judgment, reasonably be understood as encompassing decisions or settlements as to whether claims were within the terms of the policy". Clearer wording would be required to limit the obligation to follow settlements to quantum only. Teare J also rejected an argument that, following a breach of warranty, the defendant was discharged from liability and, as the settlement took place only after that date, the defendant had no longer been obliged to follow the settlement. Teare J said: "In my judgment a decision or settlement regarding claims within the policy, which for the reasons I have given, encompasses decisions or settlements as to whether claims are within the policy, must include decisions or settlements as to whether a claim is to be rejected on the grounds of an alleged breach of warranty occurring before the date of the decision or settlement. Were it otherwise the efficacy of the follow clause would be greatly reduced and its commercial purpose frustrated."

Given this conclusion, Teare J did not have to consider whether there was a real prospect of the defendant establishing a breach of warranty. However, in case the matter goes further, he did give his views on the matter.

The defendant alleged a breach of the warranty that the tug should not undertake towage or salvage under a contract previously arranged by the Assured. Teare J said that he had seen insufficient evidence to enable him to decide whether the tug had, by the time of the grounding, commenced the towage service for the purposes of the warranty. He was also unable to determine whether the claimant was entitled to be held covered pursuant to clause 3 of Institute Time Clauses - Hulls (although the judge did accept that this clause obliges the claimant to give notice of facts amounting to a breach of warranty, irrespective of whether the claimant appreciates those facts amount to a breach of warranty). The defendant did have a real prospect, though, of arguing that the claimant had made two fraudulent misrepresentations. The judge declined to decide at this stage, though, whether, as the misrepresentations were made after the Lead Underwriter had settled the claim, the defendant could not rely on this defence.

Teare J decided not to order summary judgment. The defence based upon the alleged fraudulent misrepresentations must be determined at trial.

Gard Marine & Energy Ltd v Lloyd Tunnicliffe & Ors [2011] EWHC 1658 (Comm)

Construction of an excess or limit clause in a reinsurance policy/whether it scales to reflect assured's interest

The defendant reinsured the claimant's 12.5% line on an energy policy. The "Sum Insured" clause in the reinsurance policy provided as follows: "To pay up to Original Package Policy limits/amounts/sums insured excess of USD 250m (100%) any one occurrence of losses of the original placement". The dispute in this case was what the 100% referred to. Was it (a) the total insured value of the original lost asset (so that if, as here, the insured had a less than 100% interest, the excess point had to be "scaled" to reflect that lower interest) or (b) the insured's interest in the original lost asset.

The parties agreed that the court should approach the question of construction on the assumption that the parties intended to use words which have a special or peculiar meaning in a trade that way (*Myers v Saarl* [1860]). Steel J held that in this case "the evidence is overwhelming that the notation of "(*100%*)" in regard to an excess or limit has a recognised and established meaning in the market writing direct insurance of offshore energy risks and facultative reinsurance. It means that the limit or excess scales to reflect the assured's interest in the relevant assets". The judge also rejected an argument by the reinsurer that the initial reaction to the claim (and the suggestion that the excess point scaled) demonstrated that there was no market practice regarding the use of the 100%: "I accept that the reluctance to treat the point as beyond argument reflected a combination of the impact of a very large claim and the input of legal advice". Nor, on the facts, was an argument of misrepresentation by the broker (on behalf of the reinsured) made out.

Arash Shipping Enterprises Company Limited v Groupama Transport & Anor [2011] EWCA Civ 620

Sanctions Clause and whether notice of cancellation was valid

A marine insurance policy contained an Iran Sanctions Clause which provided (in relevant part) that "Insurers hereon may, on such notice in writing as the Insurer may decide, cancel the Insurer's participation under this Policy in circumstances where the Assured has exposed or may, in the opinion of the Insurer, expose the Insurer to the risk of being or becoming subject to any sanction,.....in any form whatsoever against Iran by.... the European Union..."

A 12-month automatic extension was included in the policy, subject to the assured's claims history. Five months after inception of the policy, Council Regulation (EU) No 961/2010 ("the Regulation") came into force. This, amongst other things, prohibited the provision of (re)insurance to an Iranian entity. It was accepted that the appellant in this case was an Iranian entity.

The key article in the Regulation for the purposes of this case was Article 26(4), which prohibits the extension or renewal of (re)insurance agreements concluded before the entry into force of the Regulation but "it does not prohibit compliance with agreements concluded before that date".

Two months after the Regulation came into force, the insurers served a notice of cancellation (this was withdrawn but subsequently re-served after the appellant had commenced proceedings). The appellant argued that the insurers were not entitled to cancel. At first instance, Burton J held that the notice of cancellation had been valid. The Court of Appeal has now rejected the assured's appeal. Two of the arguments raised by the assured had been as follows:

(1) The wording of the Sanctions Clause required the assured to expose the insurer to the specified risk and this, in turn, required an act or omission by the assured.This argument was rejected by the Court of Appeal. Sanctions are imposed not necessarily because of what the specific entity has done but because of who it is.

(2) The notice of cancellation was not given in good faith and was given unreasonably. The key issue was whether the provision in Article 26(4) allowing compliance with agreements concluded before the Regulation came into force included contractual extensions or renewals. The appellant argued that this was a case of automatic extension and that amounted to an agreement concluded before the Regulation came into force. The Court of Appeal held that this was not a case of automatic extension (the assured's entitlement to the extension depending on its claims history). In any event, both HM Treasury and the European Commission had rejected the appellant's interpretation in relation to automatic extensions: they had formed the view that the Regulation did not provide a carve-out for automatic renewals. There was therefore no scope to argue that insurers had acted unreasonably.

In view of its conclusion on the point, the Court of Appeal held that it was unnecessary to decide whether the insurers had been entitled to serve the notice of cancellation. Although the issue was said to be of general importance to the insurance market, Burnton LJ stated that the court should be cautious before deciding on the effect of legislation, especially where the proceedings were taking place in the absence of submissions from the relevant prosecution authority. Furthermore, the court of final decision on the issue would be the European Court of Justice, and so the decision of the English courts would not be binding on all of the insurers subscribing to the policy. However, Tomlinson LJ expressed the view that Article 26(4) did not exempt an extension which can be said to amount to no more than the compliance by underwriters with an agreement they have made before the operative date: "It is also my present view that the word "agreements" as last used in Article 26(4) means .... a contract of insurance. Insofar as underwriters may be contractually obliged to extend the existing policy, that as it seems to me is compliance with an agreement which is not itself a contract of insurance or an "insurance agreement" but rather a contract to provide a contract of insurance or "insurance agreement".

COMMENT: Insurers are likely to welcome the Court of Appeal's decision that they acted reasonably in cancelling the policy. However, it should be borne in mind that the decision (based on the particular wording of the policy in question) in essence concerned the reasonableness of the insurers' decision and did not reach a binding conclusion on the correctness of the decision itself (although Tomlinson LJ, at least, clearly felt that the cancellation had been correct).

Jurisdiction

Faraday Reinsurance Company Limited v Howden North America Inc [2011 EWHC 2837 (Comm)

Choice of law and jurisdiction issues following notification under an insurance policy

Since 1999, numerous suits have been brought against the insured, a US international engineering group, alleging injuries caused by exposure to asbestos products manufactured by one of its subsidiaries. Certain proceedings are being brought in Pennsylvania, which adopts a different approach to such litigation than the English courts (in particular, the Pennsylvanian courts have (broadly) found that exposure to a hazardous condition is an injury and do not consider the period clause to be a fundamental provision of an insurance policy). In 2011, the insured's agent gave notice to its insurers that it intended to claim under one of its policies.

The insurers then commenced proceedings in England, seeking (inter alia) a declaration that the policy was governed by English law and subject to the jurisdiction of the English courts (there was no express clause to this effect in the policy). The insured applied to set aside service out of the jurisdiction. Beatson J held as follows:

(1) He did not need to decide whether the Rome Convention or the Insurance Contracts Act 1982 applied because he found that the insurers had much the better of the argument that there had been an implied choice of English law (and the two regimes are the same where there is an implied choice).

(2) The fact that the parties had not used an English standard form of policy was not to be regarded as inconsistent with an implied choice of English law: "The mere fact that a policy is placed in the London market may not be sufficient of itself, but the fact that it was broked and issued in London is clearly a material and important factor to be taken into account". Other factors indicating an intention that the relationship was to be governed by English law included the fact that the policy was set out on a London market underwriting slip ("which, although in this case not completed save for the policy number, refers to London market institutions and features such as the "unique market reference" for numbering risks"). Also, the stamp on the slip used London market abbreviations and the policy provided that claims were to be notified to London brokers, in London.

(3) Although the choice of English law does not automatically mean that the English courts have jurisdiction, Beatson J noted "the general principle that a court applies its own law more reliably than does a foreign court assists in identifying the appropriate forum". That was particularly so where insurance is written in London and the case involves major issues of law and construction. The fact that trial could come on quickly here was also relevant. By contrast, the fact that the insured had no manufacturing facilities in the UK and its asbestos liability arose exclusively in the USA was of only limited relevance.

(4) Finally, the judge rejected an argument that the English proceedings were not justified and did not serve a useful purpose. The insurers' interest was not merely "academic or hypothetical" just because the insured had only notified occurrences which "may" give rise to a claim under the policy. Nor could it be said that there was no useful purpose because the Pennsylvania court would ignore a determination by the English court (although the English court would give great respect to the views of that court in due course).

Limitation

William McIlroy (Swindon) Ltd & Ors v Quinn Insurance Ltd [2011] EWCA Civ 825

Whether claim by insured was time-barred/when did the "claim" arise

A third party alleged that the insured had negligently caused a fire which damaged its property. The insured denied liability but notified its public liability insurer. After the third party had written a letter of claim to the insured, the insurer denied liability (on the ground that the insured had breached a policy condition). In due course, a default judgment was entered against the insured and damages were later assessed by the court.

General Condition 16 of the public liability policy provided as follows: "Any dispute between the Insured and the [Insurer] on our liability in respect of a claim...shall be referred within nine months of the dispute arising to an arbitrator...If the dispute has not been referred to arbitration within the aforesaid nine month period, then the claim shall be deemed to have been abandoned and not recoverable thereafter" (emphasis added). It was common ground at first instance that "claim" in General Condition 16 meant the claim by the insured against the insurer (and not a claim by a third party against the insured).

Post Office v Norwich Union [1967] held that until the liability of the insured has been established, and the amount of liability has been ascertained, an insured cannot sue its insurer (for a money claim under the policy). However, the trial judge held that, as an insured can seek a declaration that the insurer is in breach of a policy obligation, in this case a dispute had arisen as soon as the insurer had denied liability. Since that dispute was not referred to arbitration within 9 months, the judge held a claim against the insurer was now time-barred. An appeal was brought and the Court of Appeal has now allowed that appeal.

The Court of Appeal regarded the judge's decision as unfair, since it required the insured to have started arbitration within 9 months of the insurer repudiating liability, even though the insured was denying liability for the fire and its liability to the third party would probably not have been established during the 9-month period. Sir Henry Brooke said that no dispute could have arisen between the insured and the insurer on the insurer's liability unless and until the insured's liability was established. Rix LJ, on the other hand, accepted that it is possible for an insured to sue for a declaration rather than an indemnity but posed the question "have the parties agreed for a 9 month time bar even in a situation where the only dispute which has arisen between the insurer and the insured is the wider dispute about cover under the policy, but where the insured does not as yet have a claim under the policy". He decided that the parties had not agreed that. The clause did not refer to a "potential claim" and he thought that "its talk of "the claim shall have been deemed to have been abandoned"...emphasises to my mind that what the clause is talking about is a claim for an indemnity which an insured is entitled to make against his insurer...In other words, I would regard "claim" in this context as being synonymous with the assertion of a purported cause of action". The insured in this case could not have made a claim under the policy at the time that the insurer repudiated liability. It could only have notified an incident which might give rise to a third party claim.

Reference was made to the case of *Walker v Pennine Insurance* [1980]. There, Roskill LJ had said that "it seems to me that you can, within the present clause, have a claim by the assured for an indemnity against a potential liability, long in advance of any claim against the assured by a third party being agreed or determined either as to liability or quantum or both". Sir Henry Brook said that *Walker* (insofar as it might be taken to impugn the authority of *Post Office*) should not be followed. Rix LJ sought to confine *Walker* to motor policies only and said that "I am satisfied that in the context of a public liability policy...the essence of a claim under the policy is a request for indemnity on the basis of an established cause of action in respect of a third party claim where liability and quantum have been ascertained".

COMMENT: The Court of Appeal was clearly concerned in this case that the authority of the *Post Office* case should not be impugned. However, in the *Post Office* case the insurers had not sought to repudiate liability (they had only argued that the claim under the policy was premature). Given that it is possible for an insured to seek a declaration from the courts that an insurer has wrongfully repudiated liability (and so, for example, require the insurer to meet defence costs even before the insured's liability has been established), it might be argued that the judge at first instance was correct to find that the claim against the insurer had arisen as soon as liability under the policy was repudiated. However, the Court of Appeal was clearly swayed by the argument that it is unfair to require an insured to commence arbitration/litigation against its insurer before it even knows whether it is liable to the third party. Insurers can protect themselves, though, through careful drafting of a dispute resolution clause (for example, by expressly referring to "potential" claims).

Teal Assurance Co Ltd v WR Berkley Insurance (Europe) Ltd & Anor [2011] EWCA Civ 1570

When is the excess point that triggers an excess reinsurance policy reached?

The claimant was the captive insurer of Black & Veatch ("BV") which had a $60 million "tower" of worldwide PI cover (including cover for first party losses incurred in rectifying design defects and not excluding American claims) on top of a US$10 million per claim retention. Above the tower was a "top and drop" layer underwritten by the claimant on different terms, with a £10 million per claim limit and which excluded US claims. The defendants reinsured the top and drop layer.

All of the relevant policies incorporated by reference the Primary Policy. Each of the excess layer policies within the tower and the top and drop layer underwritten by Teal contained wording in common market form ("Clause 1") to the effect that: "Liability to pay under this Policy shall not attach unless and until the Underwriters of the Underlying Policy/ies shall have paid, or have admitted liability or have been held liable to pay, the full amount of their indemnity inclusive of costs and expenses."

The dispute was whether BV/ the claimant could present losses to its (re)insurance programme in whatever order it chose. The claimant's case was that BV could hold back incurred losses on two large Non-American claims until such time as the underlying tower had paid out on the future expected losses on the American claim. At first instance, Smith J found for reinsurers, and said that "the question whether a loss has already been suffered by BV depends in the case of the liability cover provided by the p.i. tower upon whether BV's liability has been established and ascertained in amount" (emphasis added).

The Court of Appeal has now upheld that decision. The first layer insurer was liable whenever claims were established against BV on *Post Office v Norwich Union* [1967] principles. Once its layer has been exhausted, the next policy becomes the underlying policy and the claimant was, therefore, liable (as the first layer was) once the liability of BV (and not its insurer) was established by admission, judgment or award; and so on up the tower.

The Court took the view that Clause 1 had to be read in the context of the various excess layer policies, which included other terms which made clear the manner in which the policies were designed to "drop down" and replace the Primary Policy upon the exhaustion of the underlying policies. Clause 1 thus did no more than determine the inter-relationship of layers of cover, and act as a condition precedent to payment under a layer in question. It was irrelevant to the fundamental question of attachment. Longmore LJ held that this was the more sensible commercial construction and so should be preferred. What the claimant was contending would mean that it could organise the lower levels itself to leave reinsurers to face non-American claims that would have otherwise exhausted the tower, and this was unlikely to have been the parties' intention. It is anticipated that the claimant will appeal to the Supreme Court

COMMENT : There has been a long-running debate in the English courts (which impacts on the question of whether a reinsurance claim is time-barred) as to whether reinsurance covers the reinsured's liability or the primary risk. The view of the House of Lords in *Wasa v Lexington* [2009] was that the reinsurer reinsures the underlying risks accepted by the reinsured. In this case, at first instance, the judge agreed that the reinsurers' liability arises from loss suffered by the original insured. However, he also confirmed that, where there is a reinsurance of a liability insurance policy, the right of the reinsured to indemnity arises only when both the insured's and the reinsured's liability are ascertained and quantified. That therefore leaves open the question whether, for property insurance, in the absence of language to the contrary in the reinsurance contract, the reinsured's liability (and his right to indemnity) attaches as soon as the insured peril occurs. The first instance decision has been upheld by the Court of Appeal and it remains to be seen how the Supreme Court will approach these issues.

Pleural Plaques

Axa General Insurance Ltd & Ors v The Lord Advocate & Ors (Scotland) [2011] UKSC 46

Supreme Court dismisses insurers' challenge to the Scottish Act making pleural plaques actionable for personal injury claims

In this case, insurers challenged the lawfulness of a 2009 Act of the Scottish Parliament which reversed the House of Lords decision in *Rothwell v Chemical & Insulating Co* [2007] that pleural plaques (and certain other conditions) were not actionable for the purposes of personal injury claims. Pleural plaques are asymptomatic, causing no pain or discomfort. Furthermore, they do not progress into or cause any other condition. However, they do indicate that an individual has had significant asbestos exposure in the past and so underline the higher risk that an individual faces of contracting lung cancer, mesothelioma or asbestosis.

The Court of Session held that the Scottish Parliament was not exempt from juridical review but that the insurers' challenge failed. The insurers appealed that decision to the Supreme Court and the insurers have now lost that appeal. The reasoning of the Supreme Court was as follows:

(1) The 2009 Act was not incompatible with the insurers' rights under article 1 of Protocol 1 of the European Convention on Human Rights (which, in substance, is a guarantee of the right to property). Although insurers could show that they were "victims" as a result of the 2009 Act, and the interference with their "possessions" did not result from a legitimate aim, nevertheless, the means chosen by the Scottish Parliament were reasonably proportionate. The Supreme Court Justices differed as to why this was the correct conclusion though. Lord Hope said that one special feature of this case is that insurers were engaged in a commercial venture which is inextricably associated with risk: "Because they were long term policies there was inevitably a risk that circumstances, unseen at the date when they were written, might occur which would increase the burden of liability". However, Lord Brown, Lord Mance and Lord Reed focussed on the particular fact that for about 20 years prior to the decision in Rothwell, pleural plaques were regarded as actionable: "The key to the present appeal is that, when the relevant policies were issued and the relevant employment occurred, there was no certainty whatever how the law might treat claims for pleural plaques if and when they ever emerged" (per Lord Mance).

(2) The Supreme Court also held that Acts of the Scottish Parliament are not subject to judicial review at common law on the grounds of irrationality, unreasonableness or arbitrariness: "it would also be quite wrong for the judges to substitute their views on these issues for the considered judgment of a democratically elected legislature unless authorised to do so, as in the case of the Convention rights, by the constitutional framework laid down by the United Kingdom Parliament" (per Lord Hope).

COMMENT: This decision has echoes of the House of Lords *Wasa v Lexington* case, in that the Supreme Court has again considered the issue of how far (re)insurers (especially long-tail (re)insurers) take on the risk of a change in law after a policy is written. In *Wasa* there had been no identifiable governing law when the policy was written and the changes to the law which did apply were said to have impossible to anticipate. In contrast, the governing law was clear in this case. Although Lord Reed agreed that "at the time when insurers entered into contracts of the type which are affected by this legislation, it could not have been predicted with confidence whether asymptomatic pleural plaques and other analogous conditions would be treated by the law as actionable or not", of crucial significance was the fact that the changes to Scottish law in 2009 in effect caused the legal position to revert to the position as it had been prior to *Rothwell*. As Lord Reed put it: "pleural plaques were regarded as actionable for about 20 years prior to the decision in *Rothwell*. Courts awarded damages for them, and employers and their insurers settled many claims. Insurers treated such claims as one of the risks which they had underwritten. The 2009 Act does not require them to do any more than that. In that sense, it can be regarded as preserving the status quo which existed before a correct understanding of the legal position was established as a result of the *Rothwell* litigation".

Privilege

AXA Seguros SA de CV v Allianz Insurance Plc & Ors [2011] EWHC 268 (Comm)

Litigation privilege in a (re)insurance context

The claimant reinsured sought to recover under its reinsurance contract with the defendant reinsurers following damage caused to parts of the reinsured property (a highway) as a result of a hurricane in Mexico. Prior to the placement of the reinsurance contract, reinsurers had sought the provision of surveys confirming that the highway had been constructed to internationally acceptable standards. When this was not supplied, reinsurers imposed a "Reverse Onus of Proof" clause, requiring the reinsured to prove the condition had been complied with. The hurricane occurred in October 2001. Loss adjusters were immediately appointed by the reinsurers and the reinsured. The loss adjusters subsequently recommended the appointment of engineers to inspect the highway. The engineers were appointed in January 2002 and inspected the highway in February 2002. After the reinsured was ordered, in January 2003, to pay under its insurance policy following an arbitration in Mexico, the reinsurers denied they were liable to indemnify the reinsured because of the alleged breach of a condition precedent in the reinsurance policy. This case involved an application by the claimant to inspect certain reports and other documents produced by the engineers from March 2002 onwards, in respect of which the defendants claimed litigation privilege. Clarke J decided the following points:

(1) When had litigation reasonably been in prospect? This case was said to be close to the border line between circumstances which afford a reasonable prospect of litigation (but not necessarily that litigation is more probable than not), on the one hand, and a (mere) possibility of litigation on the other (the latter scenario not giving rise to litigation privilege). However, in this case, litigation was held to have been in reasonable prospect in January 2002. This was because there was "a reasonable prospect" that the engineers' report would reveal a breach of the condition, with the result that the reinsurers would reject the claim and litigation would inevitably follow. Evidence from the reinsurer's claim manager to that effect, although not conclusive, was also not irrelevant.

(2) However, the engineers had not been instructed to produce reports for the predominant purpose of anticipated litigation. Instead, there had been dual purposes (the other purpose being verification of the original surveyor's quantum calculation - and in that respect, the reinsurers and reinsured shared a common interest). Neither of those two purposes was predominant. Accordingly, the claim for litigation privilege failed.

(3) Clarke J rejected an alternative argument that confidentiality in all the engineers' reports and documents had been lost because certain information and documentation from the engineers had inadvertently been disclosed to the reinsured.

(4) Although not necessary to decide the point, the judge considered whether a claim to privilege could still be maintained in light of the fact that the reinsurers had appointed the engineers as their Part 35 experts. The reinsurers accepted that they would have to waive privilege in due course and the judge said it was "wasteful and inefficient" to spend time arguing a claim for privilege if it was inherently likely that much of the material in dispute would have to be disclosed eventually.

COMMENT: Whilst this case is similar to the Court of Appeal decision in *Dornoch v Westminster* [2009] in fixing the point at which litigation is said to be in reasonable prospect at a fairly early stage in the claims handling process, it is important to note that the dual role performed by the agents prevented a claim for litigation privilege. Loss adjusters and the like will often perform such a dual role for (re)insurers and it will be a question of fact whether this duality prevents a conclusion that any communications from them were produced for the dominant purpose of assisting in the conduct of any future litigation (and hence the (re)insurer will be unable to claim litigation privilege in respect of such communications).