2016 REVIEW

INSURANCE AND REINSURANCE DISPUTES
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Our Insurance Annual Review brings together various bulletins and briefings that we have produced over the last twelve months. We hope that this will be a useful single source of reference to our clients with an involvement or interest in relevant developments in the insurance and reinsurance market.

2016 will undoubtedly be remembered as a year of significant and fundamental developments for the UK insurance market with both the Insurance Act 2015 coming into force and the UK’s vote to leave the EU. We look at the potential impact of both of these key developments in a number of the articles in this Annual Review but it will only be over the coming months and years that the true impact of both will be seen. We have been assisting clients from across the market as they face the challenges that the shifting landscape brings.

As the Insurance Act 2015 is the most significant reform of UK insurance law in over a century, there is a risk of overlooking two other significant legislative changes which occurred this year: the Third Parties (Rights Against Insurers) Act 2010 finally came into force and the Enterprise Act 2016 received royal assent giving policyholders, for the first time, the right to claim damages for late payment of insurance claims. We look at the practical implications of both of these in this Annual Review.

The courts dealt with some familiar issues in insurance disputes this year including the construction of terms, aggregation, subrogation rights and fraud. The trend for relatively few reinsurance disputes making their way into the courts continued. More generally, the courts have continued to grapple with questions such as the scope of privilege, the application of CPR Part 36 and how to approach procedural failings post-Denton. Aside from these relatively routine issues, the courts have also been looking at the novel issues around use of predictive coding for e-disclosure. In Pyrro Investments Limited & Anr v MWB Property Limited and Others [2016], the High Court expressly approved use of predictive coding for a large disclosure exercise. As noted in Master Matthews’s decision, predictive coding has to date been used relatively infrequently in English litigation. However, Herbert Smith Freehills is among a small number of firms that have already employed the technology in large-scale disclosure exercises in England.

On the regulatory side, Brexit has been (and will continue to be) a key focus in the market as the practical impact of the UK’s vote to leave is worked out. Brexit brings with it the prospect of restricted access to talent and European markets but also the opportunity for progressive regulatory reform. There are also implications from a contractual perspective. Whilst the core principles of English contract and insurance contract law will not be affected, there may be other implications for particular aspects of parties’ contractual relationships, including how certain terms may be interpreted, whether any termination rights may be triggered and questions relating to jurisdiction and enforcement of judgments. Our articles explore both these implications as well as the regulatory impact of Brexit.

We hope that you find our Annual Review of use. Should you need further hard copies (soft copies are available on the Herbert Smith Freehills website) then please contact me or any member of the insurance and reinsurance disputes team.

It is a fascinating time to be practising insurance law but we recognise that we are only able to do that with your continued support. Thank you from the whole team here for that support. We look forward to assisting you during the turbulent times ahead.

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INSURANCE ACT 2015 COMES INTO FORCE

The Insurance Act 2015 (the “Act”) came into force on 12 August 2016. This is the most significant reform of UK insurance law in over 100 years. The Act applies to all new insurance and reinsurance policies that are entered into (including renewals) and to any variations agreed to existing policies from 12 August 2016 (unless agreed otherwise by the parties).

SUMMARY OF THE KEY CHANGES

Disclosure

<table>
<thead>
<tr>
<th>PRE-ACT</th>
<th>INSURANCE ACT 2015</th>
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<tbody>
<tr>
<td><strong>What is the duty?</strong></td>
<td>Duty on the insured to disclose to the insurer all material circumstances before the contract is concluded</td>
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<tr>
<td><strong>Duty of fair presentation</strong></td>
<td>The insured must:</td>
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<td></td>
<td>• disclose every material circumstance which the insured knows or ought to know, or</td>
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<td>• failing that, give the insurers sufficient information to put a prudent insurer on notice to make further enquiries</td>
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<td>• present in a reasonably clear manner and accessible to prudent insurer</td>
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<td><strong>What is material?</strong></td>
<td>A fact is material if it would have influenced the judgment of a prudent insurer in fixing the premium or determining whether to take the risk</td>
</tr>
<tr>
<td><strong>Whose knowledge is relevant?</strong></td>
<td>Knowledge of those who represent the directing mind and will of the company, and who control what it does</td>
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<td></td>
<td>Insured is deemed to know every circumstance, which in the ordinary course of business, ought to be known by him</td>
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<tr>
<td><strong>Disclose every material circumstance...</strong></td>
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<td></td>
<td>• which the insured knows</td>
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<td></td>
<td>• knowledge of “senior management”</td>
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<td></td>
<td>• knowledge of individuals responsible for insurance</td>
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<td></td>
<td>• not knowledge of agents acquired in different capacity</td>
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<td></td>
<td>• which the insured ought to know</td>
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<td>• what should reasonably have been revealed by a reasonable search</td>
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<td>• includes information held by the broker</td>
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<td></td>
<td>• includes information held by persons covered by insurance</td>
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<td><strong>What if duty is breached?</strong></td>
<td>Insurer must show the non-disclosure actually induced the making of the contract on the relevant terms</td>
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<tr>
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<td>If the insurer can show inducement, it is entitled to avoid the policy, ie, treat the contract as if it never existed</td>
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<td><strong>Proportionate remedies</strong></td>
<td>For deliberate/reckless breaches:</td>
</tr>
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<td></td>
<td>• avoidance (no return of premium)</td>
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<td>For other types of breach:</td>
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<td>• if the insurer would not have entered into the contract: avoidance (but must return premium)</td>
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<td>• if the insurer would have entered into the contract but on different terms: contract may be treated as if it included those terms from the outset</td>
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<tr>
<td></td>
<td>• if the insurer would have entered into the contract but would have charged a higher premium: the amount paid on claim may be “reduced proportionately”</td>
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# INSURANCE ACT 2015 COMES INTO FORCE

## Policy Terms

<table>
<thead>
<tr>
<th>Warranty</th>
<th>Condition Precedent</th>
<th>Bare Condition</th>
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<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>A pre-contractual promise by the insured that a given fact is true or that a given fact will remain true, or that the insured will refrain from behaving in a particular way</td>
<td>A contingency upon which the validity of the policy or claim may depend</td>
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<tr>
<td><strong>Can be created by “basis of contract” clauses although such clauses will be abolished by the Act</strong></td>
<td><strong>Breach means:</strong></td>
<td><strong>Breach means:</strong></td>
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<tr>
<td><strong>Remedy for breach:</strong></td>
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<tr>
<td>Pre-Act</td>
<td>Breach automatically brings the insurance cover to an end</td>
<td>Insurer doesn’t come on risk (if condition precedent is precedent to validity of the policy or attachment of the risk), or</td>
</tr>
<tr>
<td></td>
<td>Insurer off risk from the date of breach</td>
<td>insured is prevented from making a claim (if condition precedent is precedent to insurer’s liability)</td>
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</tr>
<tr>
<td>Insurers act</td>
<td>Warranties operate as suspensive conditions. Insurer has no liability whilst insured is in breach for:</td>
<td><strong>Breach means:</strong></td>
</tr>
<tr>
<td></td>
<td>1. any loss occurring, and 2. any loss which is attributable to something happening during the “suspended” period</td>
<td>1. insurer doesn’t come on risk (if condition precedent is precedent to validity of the policy or attachment of the risk), or 2. insured is prevented from making a claim (if condition precedent is precedent to insurer’s liability)</td>
</tr>
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</table>

The Act also brings in a new provision which provides that if compliance with any policy term would tend to reduce the risk of loss of a particular kind or at a particular time/location (and it is not a term defining the risk as a whole), the insurer cannot rely on a breach of that term if the insured can show that the non-compliance could not have increased the risk of loss.
Fraudulent claims

The Act replaces the current co-existing remedies of forfeiture (under common law) and avoidance (under the 1906 Act) with a statutory regime for fraudulent claims.

The Act provides that the insurer:
- will not be liable to pay fraudulent claims;
- can elect to terminate the contract and refuse to pay claims relating to losses suffered after the fraud; but importantly,
- will remain liable for all legitimate losses suffered before the fraud.

For group insurance contracts, the Act provides that where a beneficiary makes a fraudulent claim under a group insurance policy, the insurer:
- has no liability to pay the fraudulent claim;
- has the option to terminate its liability to pay out in respect of losses suffered after the fraudulent act, but only as regards the fraudulent claimant; and
- remains liable for legitimate losses suffered by the fraudulent claimant before the fraudulent act.

The fraudulent claimant and the insurer are treated as though they had entered into a separate insurance contract between them, meaning that innocent group members are not unfairly prejudiced.

Contracting out

The Act allows parties to non-consumer insurance contracts to contract out of the default regime (with the exception of the prohibition on “basis of the contract” clauses) as long as any “disadvantageous term” (which puts an insured in a worse position than that under the default regime) meets the “transparency requirements”:
- the insurer must take sufficient steps to draw the disadvantageous term to the insured’s attention before the contract is entered into or the variation agreed; and
- the disadvantageous term must be clear and unambiguous as to its effect.

In determining whether the transparency requirements have been met, the characteristics of the insured and the circumstances of the transaction should be taken into account.

PRACTICAL IMPLICATIONS

We have been working with clients to assist them in preparing for the new Act. Some of the issues we have been considering include:
- what drafting changes may be necessary to policy wordings as a result of the Act;
- the impact of the Act on the disclosure process for policyholders;
- whether parties may be able to agree certain elements of the new duty of fair presentation, for example, the scope of the reasonable search and/or those individuals whose knowledge is relevant (particularly in the context of composite policies, for example);
- how any such agreements reached on the scope of the duty of fair presentation can be reflected in policy documentation;
- how to preserve the status quo if there are provisions in existing policies that are more favourable than the Act (eg innocent non-disclosure clauses);
- how the underwriting process will be affected by the Act; and
- whether clients want to contract out of some aspects of the Act.
INSURANCE ACT 2015: SHIFTING THE BALANCE

In this article we explain how organisations can take advantage of major changes to UK insurance law brought about by the Insurance Act 2015.

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For the past 18 months, insurance lawyers, brokers and industry leaders have been urging insurance buyers to get ready for the imminent arrival of the biggest change to hit UK insurance law in over 100 years. Now that the change is here, corporate counsel need to ensure that their organisations are ready.

On 12 August 2016, the Insurance Act 2015 (“2015 Act”) came into force, bringing with it significant changes to pre-contractual disclosure for insurance policies and a range of other changes that shift the balance in favour of insureds. Even if an organisation has not been paying close attention to these developments, there is still time to take steps to take advantage of the beneficial changes under the new regime and minimise the chance of claims disputes.

This article outlines the key features of the new regime for corporate policyholders.

The article:
- provides a short background to the 2015 Act;
- briefly explains the new duty of fair presentation of the risk;
- covers practical aspects of pre-placement disclosure in light of the new regime under the 2015 Act;
- outlines some other key changes brought about by the 2015 Act, including to the law on warranties and basis clauses;
- examines negotiations for renewals and variations, including upgrading existing policies ahead of the renewal date and making sure not to lose advantageous existing provisions in any renewals; and
- introduces the Enterprise Act 2016 and the new remedy of damages for the late payment of claims by insurers.

BACKGROUND

The 2015 Act received Royal Assent on 12 February 2015, as the culmination of a nine-year consultation period started by the English and Scottish Law Commissions (“the Commissions”) in 2006. The 2015 Act aims to address a perceived imbalance in the law in favour of insurers, which is said to have put the English market at a competitive disadvantage.

Consultation papers released by the Commissions in 2007, 2011 and 2012 are likely to remain useful references, especially during the 2015 Act’s infancy.

In particular, the 2015 Act has updated the statutory framework for insurance contracts in the following areas:
- Disclosure and misrepresentation in business and other non-consumer insurance contracts.
- Insurance warranties.
- Insurers’ remedies for fraudulent acts.

The 2015 Act applies to insurance and reinsurance contracts governed by the laws of England and Wales, Scotland or Northern Ireland, wherever they are underwritten, entered into on or after 12 August 2016. The 2015 Act also applies to variations that were made to existing insurance contracts on or after that date.

In effect, the 2015 Act provides a new default regime governing non-consumer insurance contracts, although it is possible to contract out of the 2015 Act, subject to specified requirements (see “Contracting out” below).

DUTY OF FAIR PRESENTATION

As its centrepiece, the 2015 Act has brought about significant changes to the law of pre-placement disclosure by policyholders. It sets out a prescriptive regime which requires insured organisations to review carefully their policy placement and disclosure procedures and to think especially about what they disclose and how they disclose it.

Under the old common law position as codified by the Marine Insurance Act 1906 (“1906 Act”), the insured’s duty was to disclose to the insurer all material circumstances before the contract was concluded. This duty still exists in the 2015 Act as part of the duty to provide a fair presentation of the risk, which encompasses:
- the insured’s duty of disclosure;
- a requirement to make the disclosure in a manner which would be reasonably clear and accessible to a prudent insurer; and
the existing duty not to make mis-representations (which is unchanged).

**DEEMED KNOWLEDGE AND REASONABLE SEARCHES**

Under the Insurance Act 2015:

- The insured is deemed to know every circumstance which in the ordinary course of business it ought to know.
- What an organisation ought to know includes what should reasonably have been revealed by a reasonable search of the information available to it.
- A reasonable search will be deemed to include information held by the broker and information held by other persons covered by the insurance, but does not include knowledge of agents acquired in a different capacity.

The new duty applies to disclosure before the policy starts as well as to variations of non-consumer insurance contracts (in the case of variations, “risk” means “changes in the risk relevant to the proposed variation”).

Additionally, the duty of fair presentation brings with it a suite of new, more flexible proportionate remedies which are broadly more favourable to insured parties. These remedies are a significant development (see “Remedies for insurers” below).

The new regime aims to improve understanding and compliance, and to avoid passive underwriting of risk by insurers and problematic “data dumping” by policyholders; that is, bombarding the insurers with swathes of material whether or not it is relevant. Above all, it rewards parties that proactively engage with their insurance arrangements. Practitioners need to understand the new requirements both from a risk perspective and in order to take advantage of the benefits of the 2015 Act.

**FAIR PRESENTATION IN PRACTICE**

Some key practical questions for corporate counsel in relation to fair presentation of the risk are:

- What must be disclosed?
- Whose knowledge counts within a corporate entity?
- How should the risk be presented?

**Disclosure**

In order to satisfy its disclosure obligations under the 2015 Act, an insured must do one of the following.

- Disclose every material circumstance that the insured knows or ought to know.
- Give the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.

A policyholder should not rely on the latter option as the primary route to satisfying the disclosure obligation; it should really be seen only as a safety net.

The meaning of “material circumstance” has not changed; it means a circumstance or representation which would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms. There is, however, now some guidance on matters which may be material circumstances (section 7(4), 2015 Act).

**Knowledge**

When considering what material circumstances the insured knows or ought to know, a major issue is likely to be whose knowledge counts. Under the 2015 Act, there is additional guidance to help answer this question. “Knowledge” will include the actual knowledge of senior management and of the individuals in an organisation that are responsible for the insured’s insurance.

The 2015 Act defines senior management as anyone who plays a significant role in the making of decisions about how the insured organisation’s activities are to be managed or organised.

Senior management will include the board but may extend beyond this. Organisations should:

- establish a defined list of positions or persons who fall into this category and provide the list to insurers with an explanation of how it was derived; and
- consider seeking insurers’ agreement that these are the relevant positions and individuals.

An individual responsible for the insurance is an individual who participates on behalf of the insured organisation in the process of procuring the insurance. This includes risk managers, or employees who assist in the collection of data or negotiate the terms of the insurance. This will also include brokers, which should be asked about how they will demonstrate their knowledge to satisfy the organisation’s insurers.

The concept of a reasonable search is a new requirement in the 2015 Act (see box “Deemed knowledge and reasonable searches”). What amounts to a reasonable search is not specified, which creates some uncertainty but also presents an opportunity to an informed policyholder to: engage with insurers; specify what steps it has taken; and seek insurers’ agreement to those steps.

A reasonable search will include information held by brokers as well as information held by persons covered by insurance. This is
In creating an audit trail, practical things to consider include:

- the best way of gathering information; for example, by email questionnaires, meetings with relevant individuals or site visits;
- the method of documenting questions and responses;
- the system for keeping a record of those contacted and chased; and
- creating a library of key information on, for example, locations and financial information.

### Presentation

The duty to provide a fair presentation of the risk requires the insured to disclose information in a manner which would be reasonably clear and accessible to a prudent insurer.

Every material representation of facts must be substantially correct and every representation of expectation or belief must be in good faith.

One of the aims of these new requirements is to discourage data dumping. The explanatory notes to the 2015 Act make it clear that an overly brief or cryptic presentation would not be a fair presentation.

Insureds should consider with their broker whether they need to change or develop how they currently present information; in particular, to ensure that the information is structured, indexed and signposted to make it clear and accessible. Ultimately, a presentation of the risk should be readily navigable, for example with an index, and should fully respond to insurers’ questions (see box “Tips to ensure fair presentation”).

The new provisions will be particularly important for the insurance of complex risks, for example, a global property policy covering multiple sites or portfolios.

Another important part of the role of corporate counsel will be to educate those in the organisation about what they will need to provide in order to comply with the duty of fair presentation. This extends beyond the mere content of the risk presentation to the way it is organised and accessed. With some advance planning and perhaps some early discussions with both brokers and insurers, counsel can ensure that their organisation is ready to comply with its duty of fair presentation of the risk before the next renewal.

### Remedies for insurers

The fair presentation regime may seem onerous for policyholders, but it comes with significant benefits. Firstly, it delivers greater certainty to those policyholders that are well-organised and engaged with their insurance arrangements. Secondly, where

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**EXAMPLE OF REASONABLE SEARCH CHECKLIST FOR LIABILITY POLICIES**

The information below may form part of a reasonable search for a liability policy. It will be essential to scope the reasonable search well in advance and to allow sufficient time to locate and gather the relevant data.

- Business sector and activities.
- Who to contact to identify potential claims and circumstances.
- Changes to business structure.
- Changes to organisational structure.
- Business resilience and data recovery.
- The organisation’s response to any regulatory changes.
- Greater liability than normal or expected, possibly because of industry-specific contract terms of trade.
- Restricted rights of subrogation associated with claims or losses because of the business sector or specific products.
- Previous claims history or experience, especially in relation to historical, emerging or other unexpected risks.
- Previous policy cancellation, refusal of insurance or special restrictions or conditions applied to insurance contracts.
- Details of the trading profitability and financial status of the business, including insolvency or liquidation concerns.
- The status, reputation, length of service, qualifications and experience of board members, as well as details of any criminal convictions.
policyholders breach the duty of fair presentation, the 2015 Act allows for more commercially flexible remedies which are expected to be largely beneficial for insureds.

Under the 1906 Act, insurers had a strict remedy of avoidance of the policy for a breach of the duty of good faith, for example, for material non-disclosure. This was the case even for relatively minor breaches and where they would have covered the risk anyway. It was recognised that, in most instances, this was a draconian remedy which did not adequately distinguish between innocent and deliberate or reckless breaches.

The 2015 Act provides for a range of proportionate remedies (see box “A worked example of a proportionate remedy”). Unless the breach is deliberate or reckless, in which case the remedy of avoidance would still be available to an insurer, the onus is on the insurer to show what it would have done had it received a fair presentation of the risk. The following options will be available:

- The insurer will still be entitled to avoid the policy if it can show that had it received a fair presentation of the risk, it would not have entered into the contract.
- If the insurer would have entered into the contract but on different terms, the contract is treated as if those terms apply.
- If the insurer would have entered into the contract but only at a higher premium, the insurer may reduce proportionately the amount to be paid on a claim.

These beneficial changes might even persuade businesses to seek to upgrade their existing arrangements (see “Upgrades” below).

A WORKED EXAMPLE OF A PROPORTIONATE REMEDY

In breach of the duty of fair presentation, an insured fails to disclose the presence of highly flammable materials at site A, one of three sites being insured. The non-disclosure is not deliberate or reckless. There is then a fire at one of the sites and the insured claims £10 million in respect of the damage.

If the insurer can show that it would have entered into the contract but with an exclusion for fire caused by the flammable material at site A:

- The policy is treated as if it included the exclusion from the outset.
- The claim would be excluded if the fire was at site A but if the fire occurred at a different site, the claim would be covered.

If the insurer can show that it would have charged a £100,000 premium instead of £50,000, the claim monies will be reduced proportionately so that the insured is entitled to recover only 50% of any claim, in this case, only £5 million of the claim.

OTHER KEY CHANGES

Other key changes in the 2015 Act might have an impact on cover for businesses.

Warranties

Under the 1906 Act, a breach of warranty discharges the insurer’s liability under the contract in its entirety, even if the breach is only trivial or does not in any way relate to the insured’s loss (Section 33(3), 1906 Act) (see box “What is a warranty?”). Under the 2015 Act, a breach of warranty no longer automatically takes the insurer off risk. The 2015 Act makes warranties “suspensive conditions”; that is, the insurer’s liability will be suspended while the insured is in breach of a warranty but can be restored if the breach is subsequently remedied. However, this term will only assist if:

- the warranty is capable of remedy, as not all of them are; and
- the business is aware of the breach of warranty and corrects it.

The fact that warranties are suspensive means that the insurer will come back on risk once the breach is rectified. There are two key steps here for corporate counsel: make sure that those responsible for risk management and those working in the business are aware of the warranties in the policy; and audit any breach and rectification so as to take advantage of the change in law.

TIPS TO ENSURE FAIR PRESENTATION

**DO:**
- Organise an underwriting presentation.
- Make it readily navigable with indices, headings and signposts, which as a fall-back, at least put insurers on notice to ask further questions.
- Respond fully to questions raised by insurers.

**DO NOT:**
- Provide insurers with CDs of information that is not organised.
- Simply refer insurers to the organisation’s website.
- Be too brief or cryptic.
INSURANCE ACT 2015: SHIFTING THE BALANCE

Under the 2015 Act, warranties are potentially more advantageous for policyholders than conditions precedent because a breach of warranty may be capable of remedy, in which case the insurer will be back on risk. Policyholders should therefore be aware of insurers seeking to use a sweep-up clause to convert all of the insured’s obligations to conditions precedent to liability.

WHAT IS A WARRANTY?
A warranty is a term of an insurance contract by which an insured:
- Undertakes to do or not do a particular thing.
- Undertakes that some condition will be fulfilled.
- Affirms or denies the existence of a state of facts.

Basis clauses
The 2015 Act also abolishes “basis of the contract” clauses, which operate to turn the insured’s pre-contractual representations, including answers to questions on a proposal form, into warranties.

A basis clause is a declaration in a proposal form or policy that the insured warrants the accuracy of all the answers given or that the answers form the basis of the contract. This has the legal effect of converting the representations into warranties so that the insurer is discharged from liability for claims if any of the representations are incorrect, even if the misrepresentation was unintended and did not induce the insurer to enter into the policy.

In practical terms, under the old law, this meant that if there was a basis clause and the insured answered a question in a proposal form incorrectly, even if this was an innocent mistake, the insured would find itself without insurance cover as the insurer never came on risk.

Risk mitigation terms
Previously, the remedy for breach of a term was dictated by the nature of the term, irrespective of its connection to the loss. As a result, a policyholder’s claim could be denied as a result of a breach which had no connection to the loss.

Section 11 of the 2015 Act (section 11) delivers an important new protection for policyholders in this regard, which should mean that breaches totally unrelated to a loss do not affect cover. It provides that if there is a breach of a term which is intended to reduce the risk of loss of a particular kind or at a particular time or location (that is, a risk mitigation term), insurers will not have a remedy if the insured can show that its breach could not have increased the risk of the loss that actually occurred. Section 11 does not apply to terms that go to the risk as a whole.

Some potential difficulties are likely to arise in practice, not least: determining which terms fall within the scope of section 11; and showing that the breach could not have increased the risk of the loss. The Commissions have given some examples of clauses that they suggest go to the risk as a whole, including a provision in a motor policy that the vehicle will not be used for commercial use.

It is difficult to be prescriptive about what this means for policyholders but clauses should be reviewed to:
- determine if they could be drafted so as to increase the prospects that the protection under section 11 will apply; and
- confirm expressly that section 11 applies.

Fraudulent claims
The 2015 Act provides a new statutory regime for fraudulent claims which clarifies the existing law. The 2015 Act provides that the insurer:
- is not liable to pay fraudulent claims;
- can elect to terminate the contract and refuse to pay claims relating to losses suffered after the fraudulent act; and
- remains liable for legitimate losses suffered by the insured before the fraudulent act.

The Commissions considered the previous law to be confused and contradictory, particularly as to whether the insurer would be liable to pay other genuine claims in the event of a fraud. The 2015 Act has clarified the position from the pre-existing case law.

RENEWALS AND VARIATIONS
The changes introduced by the 2015 Act affect the commercial dynamic between the policyholder and the insurer as regards policy renewals and the practical implications of negotiations with insurers. Three broad issues arise:
- If the 2015 Act provides a more helpful regime than present arrangements, it may be possible to negotiate an upgrade of current policies with insurers to take advantage of some of the beneficial provisions in the 2015 Act; in particular, the changes to remedies and warranties.
- If terms in current policies are more advantageous than the provisions under the 2015 Act, policyholders might want to keep these terms in any renewals.
- In certain circumstances, a new policy may make modifications to the regime under the 2015 Act, and so contract out of the legislation.
Upgrades

It is possible for insureds to negotiate to upgrade existing policies by agreement with their insurers if they wish, for example, to take advantage of the more favourable remedies under the 2015 Act in relation to breaches of warranty rather than wait for renewal under the 2015 Act.

Other helpful provisions are: the prohibitions on basis clauses; the provision on terms not relevant to the actual loss; and remedies for non-disclosure and misrepresentation.

The Association of Insurance and Risk Managers in Industry and Commerce (Airmic) has produced a briefing paper and sample endorsement, which is a valuable resource for those looking to upgrade existing insurance policies to bring them in line with the provisions of the 2015 Act ahead of their next renewal. The sample Airmic endorsement is a useful starting point for discussions with insurers and brokers.

Retaining advantageous terms

In some cases, the default regime under the 2015 Act might be less favourable than existing policy arrangements.

One of the clauses from existing insurance policies that insureds may wish to retain are innocent non-disclosure clauses. These clauses tend to limit the ability of the insurer to avoid liability or refuse a claim where a non-disclosure or misrepresentation is innocent or free from fraudulent intent, or both. These clauses may exist in current policies in a variety of guises. The policyholder protections created by these clauses may, depending on the wording, be more favourable than the new position under the 2015 Act.

There are therefore two key steps to make sure that the advantages of a current policy are not lost under any renewal:

- Do not assume that the clauses are no longer needed because of the change in law; review them carefully to see if they are still more beneficial than the 2015 Act.
- Review the policy for any changes needed to make the clauses sit properly with the 2015 Act.

For example, given that insurers may now have a suite of remedies available to them in the event of a failure to make a fair presentation, clauses which limit only the rights of “avoidance” may not suffice. Organisations should consider including wording such as “[the insurer] will not avoid the policy or refuse, reduce or qualify any claim”.

More generally, insureds may want to disapply some of the proportionate remedies, given that they may be thought to have a disproportionately disadvantageous effect. In June 2016, Airmic published a helpful sample clause and explanatory note, which provides some clear wording to remove the insurer’s right to reduce the amount payable under a claim where an insurer would have charged a higher premium.

Contracting out

The 2015 Act was intended to be a default regime for non-consumer insurance contracts. However, it was recognised that some provisions may not be suitable for all markets and commercial parties. The 2015 Act therefore allows parties to non-consumer insurance contracts to contract out of the default regime, with the exception of the prohibition on basis clauses, as long as any disadvantageous term (that is, one that puts an insured in a worse position than under the default regime) meets the following transparency requirements:

- The insurer must take sufficient steps to draw the disadvantageous term to the insured’s attention before the contract is entered into or the variation agreed.
- The disadvantageous term must be clear and unambiguous as to its effect.

An insured cannot rely on any failure by the insurer to take sufficient steps to draw the disadvantageous term to its attention if it or its broker was aware of the term.

While not strictly contracting out, policyholders should also be alert to any attempt by insurers to exclude the effect of certain parts of the 2015 Act in other ways; for example, by converting basis clauses into conditions precedent to liability (see “Basis clauses” above).

Late payment of claims

A clause providing policyholders with a remedy for late payments of claims was previously dropped from the draft Insurance Bill (now the 2015 Act) because of a lack of market consensus but has found its way into law in the Enterprise Act 2016 (“2016 Act”). The 2016 Act comes into force on 4 May 2017.

Under the 2016 Act, it will be an implied term of every insurance contract that the insurer must pay any sums due in respect of the claim within a reasonable time. A reasonable time includes time needed to investigate and assess that particular claim.

Breach of this term will give rise to a claim for damages for consequential losses. This remedy is in addition to, and distinct from, the right to interest on payment of the sums due in legal proceedings.
Proof of loss is likely to be the contentious issue under the 2016 Act. There are several other restrictions on claims against insurers:

- The 2016 Act provides a defence where the insurer can show that there were reasonable grounds for disputing the claim.
- A policyholder must bring its claim for damages within one year of the insurer paying all sums due in respect of the claim.

Given the various elements that a policyholder will need to prove in order to establish a successful claim, it seems unlikely that there will be a flood of damages claims for late payment. In particular, the meaning of what is a reasonable time for payment of a claim will depend on the particular circumstances of the claim and the impact of the provisions is likely to be limited by the reasonable grounds defence that is available to insurers.

The 2016 Act will apply only to contracts of insurance made after it comes into force on 4 May 2017, so it will be some time before any claims for damages for late payment come before the courts.
NEW RIGHT FOR POLICYHOLDERS TO CLAIM DAMAGES FOR LATE PAYMENT OF INSURANCE CLAIMS

The Enterprise Act 2016 (“the Act”) received Royal Assent on 4 May 2016. Among other reforms, the Act changes English law’s approach to remedies for late payment of insurance claims and now gives policyholders a potential right to claim damages in the event of late payment. These provisions will come into effect on 4 May 2017, and will apply to every contract of insurance made after the provisions come into force.

THE ENTERPRISE ACT 2016

Damages for late payment of claims are not currently recoverable under English law. The Act amends the Insurance Act 2015 and introduces an implied term into every insurance contract that “the insurer must pay any sums due in respect of the claim within a reasonable time”. Breach of this term can give rise to a claim for damages.

The Act does not provide prescriptive guidelines as to what constitutes a “reasonable time”. Rather, it states that a reasonable time includes time to investigate and assess the claim, and provides a non-exhaustive list of matters which may need to be taken into account, including:

- the type of insurance;
- the size and complexity of the claim;
- compliance with relevant statutory or regulatory rules or guidance; and
- factors outside the insurer’s control.

The Act further provides a defence where the insurer can show that there were “reasonable grounds for disputing the claim (whether as to the amount of any sum payable, or as to whether anything at all is payable)”.

The new legislation also allows parties to contract out of these provisions in respect of non-consumer insurance contracts, subject to the “transparency” requirements of the Insurance Act 2015. However, contracting out will not be effective where the insurer’s breach is deliberate or reckless.

Claims for breach of the implied term must be brought no later than one year from the date on which the insurer has paid all the sums due in respect of the claim.

COMMENT

It will be some time before we see any claims for damages for late payment as a result of the provisions. The relevant provisions come into effect on 4 May 2017, and will then only apply to contracts of insurance made after the provisions come into force.

In order to claim such damages, an insured must show that:

1. the insured has a valid claim under the policy;
2. the insurer has failed to pay within a reasonable time (including a reasonable time to investigate and assess the claim);
3. the insured suffered loss, which was caused by the insurer’s breach of the implied term; and
4. the loss was foreseeable (i.e., the loss was in the reasonable contemplation of the parties at the date the contract was entered into).

Further, the insured will not be able to recover any loss which could have been avoided by taking reasonable steps.

There are conflicting views on what the impact of these new provisions will be. However, given the various elements a policyholder will need to prove in order to establish a successful claim for damages, it seems unlikely that the Act will lead to a flood of damages claims for late payment. What a court will consider a “reasonable time” within which to pay a claim will be highly dependent on the particular circumstances of the claim. Further, the impact of the provisions is likely to be limited by the “reasonable grounds” defence and the ordinary hurdles of establishing a claim for damages for breach of contract.

What seems more likely is that the provisions in the Act will affect the dynamics of negotiations between insurers and insureds in relation to claims.
NEW RIGHT FOR POLICYHOLDERS TO CLAIM DAMAGES FOR LATE PAYMENT OF INSURANCE CLAIMS

PRACTICAL IMPLICATIONS

Both policyholders and insurers should be aware that the following points may be relevant in any potential consideration of a claim for damages for late payment:

- Claims co-operation - insureds’ responses to requests for information by the insurer (as the insurer must have the opportunity to investigate and assess the claim);
- Contracting out – whether insurers have successfully contracted out of the late payment provisions;
- Mitigation – whether insureds have taken steps to mitigate any losses suffered as a result of the insurer’s delay (as damages for late payment are subject to the usual limitations of contractual damages); and
- Foreseeability - if there are particular circumstances which might cause the insured to suffer exceptional losses as a result of delayed payment whether these had been communicated to the insurer prior to the policy being placed.

We would also observe that damages for late payment are plainly not a substitute for business interruption cover and should not be seen as such. Insureds should obtain appropriate business interruption cover if there is a risk that their business will be disrupted by an insured loss.

Finally, there are a number of steps which insurers and reinsurers can take to minimise the risk of facing unnecessary claims for damages for delay. Most of these are simply good claims handling practices, which insurers should already be familiar with:

- Keep clear records of claims handling procedures – Insurers should maintain clear records of the handling of each claim, including when information was received, steps taken to investigate the claim, and information requests submitted to the insured.
- Merits advice – In appropriate cases, insurers may wish to obtain written legal opinions on the merits of a claim prior to denying cover, in order to demonstrate that they had “reasonable grounds for disputing the claim”. Insurers will need to monitor carefully any issues arising from potential waiver of legal privilege.
- Interim/part payments – Where appropriate, insurers should consider making interim or part payments to insureds.
- Reserves/premiums – Insurers should be aware of the prospect of damages for late payment when setting reserves and premiums.
- Reinsurance arrangements – Insurers should also be aware of the possibility of such damages when negotiating their reinsurance arrangements. As damages for late payment are not payable under the insuring clause of the contract, it seems unlikely that they would be recoverable under most current reinsurance agreements. Insurers may wish to consider revising their reinsurance arrangements to provide for the recovery of such damages.
- Settlement Agreements – Settlement Agreements for claims should contain a release of liability which is broad enough to encompass any claim for late payment.
BETTER RIGHTS AGAINST INSURERS OF ‘INSOLVENT’ ENTITIES – FINALLY HERE

A key question in any litigation is whether the defendant can satisfy a judgment. Where the defendant is both insolvent and insured a further issue is whether the claimant can ultimately recover payment from the insurer. This may be possible under the Third Parties (Rights against Insurers) Act 1930 (“1930 Act”) but there are a number of significant hurdles for a third party to overcome before it can benefit from the application of the 1930 Act.

On 1 August 2016, the Third Parties (Rights against Insurers) Act 2010 (“2010 Act”) finally came into force and replaced the original 1930 Act (although the 1930 Act will still apply in cases where the insured both incurs liability to a third party and enters insolvency proceedings before 1 August 2016).

The 2010 Act was long-awaited, having received Royal Assent on 25 March 2010. The 2010 Act provides for a less complex procedure for a third party claimant to claim directly against the insurer of an insolvent individual or corporate defendant. The new law will improve the position of third parties with claims against insolvent assureds.

BACKGROUND

In the ordinary course where a party that carries liability insurance incurs a liability to a third party, the insured party will make a claim on its insurance policy in respect of the liability and use the insurance proceeds to satisfy the third party claim. In circumstances where the insured becomes insolvent before the third party is paid any insurance proceeds, those proceeds would simply become part of the insured’s general assets for distribution to creditors. As a result the third party claimant for whom the money had in reality been earmarked would be confined to proving as an unsecured creditor in the bankruptcy or liquidation for his loss. The 1930 Act sought to deal with this problem by effecting a statutory transfer of the insured’s rights against its insurer to the third party. However, the 1930 Act has been criticised as it can be an expensive and time consuming process for third parties to pursue claims under it. The 2010 Act seeks to address these criticisms.

KEY CHANGES UNDER THE ACT

The key changes made by the 2010 Act are set out below.

New One-Stage Process

Under the 1930 Act, it was necessary for a third party claimant to have established a liability against the insured defendant before it could proceed against the insurer. Therefore, two sets of proceedings were usually required – one against the insured to establish liability and the other against the insurer to establish insurance coverage. This usually resulted in significant expenditure of time and costs for the claimant.

The 2010 Act removes the need for two sets of proceedings by allowing a third party to proceed directly against the insurer as soon as the insured is the subject of an insolvency event and resolve issues relating to both the insured’s liability and policy coverage in the same proceedings. The insured is not required to be a party to the proceedings. However, the insured can apply to
BE better rights against insurers of ‘insolvent’ entities – finally here

be joined as a claimant (if the insured has a claim under the policy over and above the liability in question, for example in respect of costs) or as a defendant (if, for example, the claim is one of professional misconduct and the insured has a reputation to defend). In addition, the third party claimant can join the insured as a defendant if there is an element of uninsured loss that the third party wishes to pursue. In practical terms, however, given that the insured will be insolvent, it will be unlikely that any significant additional recovery could be achieved in this way.

In order to access the information, the third party must reasonably believe that:
- the (potential) defendant has incurred liability to the third party;
- the (potential) defendant is insured against that liability;
- rights have been transferred to the third party under the 2010 Act; and
- the broker (or other third party) is able to provide the relevant insurance information.

In addition, a third party’s rights are much greater in terms of what information can be obtained. A third party can find out whether there is a policy that covers the supposed liability and, if so, important information including the terms of the policy, how much of the limit of indemnity has already been paid out in respect of other liabilities, whether the insurer has informed the insured that it is not liable in respect of the supposed liability and whether there are or have been any proceedings between the insurer and the insured in respect of the supposed liability and, if so, relevant details of those proceedings.

On balance, it is hoped that the improved rights to information will be beneficial to insurers, insureds and third parties alike as they should reduce the number of speculative claims brought against insureds while providing third parties with better grounds on which to decide whether or not to bring a claim.

It is worth noting, however, that in reality the improved rights to information will have their limitations. In circumstances where an insured is not insolvent but is on the verge of insolvency or where a judgment against the insured will certainly put the defendant insured into insolvency, the third party claimant has no more right to information regarding the insured’s insurance position than any other litigant.

Defences available to insurers
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, the 2010 Act removes some of the more technical defences on which insurers have previously been entitled to rely under the 1930 Act regime. In particular:
- Insurers can no longer rely on breach of a condition of the policy by the insured where the third party has fulfilled that condition.
- Insurers cannot rely on a breach of a duty to provide information or assistance where the reason that the condition has not been complied with is that the insured company has been dissolved.

Improved information
The 2010 Act provides that a third party can have access to information in relation to the insured’s insurance position as soon as the insured becomes insolvent. The third party’s rights to information are more extensive than under the 1930 Act and the procedure for accessing that information more structured.

In particular, a third party can request certain information relating to an insured’s policy position directly from any person that the third party believes will be able to provide such information which, most significantly, will cover brokers. The third party can obtain access to this information before commencing proceedings against the insurer in order to make an informed decision as to whether or not to proceed with the claim.

This change in approach will have a number of clear benefits to a third party claimant:
- In the event that the insurer is unsuccessful in defending the proceedings, the third party will be entitled to claim its costs against the insurer. Under the 1930 Act insurers have very rarely been party to the proceedings between the third party and the defendant insured in relation to liability (even though insurers generally control those proceedings and the proceedings are being run largely for the insurer’s benefit). In the event of the third party succeeding in its claim against the insured it has had to rely on the operation of section 51 Senior Courts Act 1981 (which has been interpreted to allow a successful litigant to claim costs from a non-party in exceptional circumstances) in order to claim costs from the insurer.
- There will be no need to take the costly step of restoring a defunct company to the register before proceedings can be commenced. Under the 1930 Act, where a company has been struck off before a liability has been established against it, the third party had to apply to court to restore the company to the register before it could proceed against it to establish the necessary liability, resulting in wasted time and cost.

In order to access the information, the third party must reasonably believe that:
- the (potential) defendant has incurred liability to the third party;
- the (potential) defendant is insured against that liability;
- rights have been transferred to the third party under the 2010 Act; and
- the broker (or other third party) is able to provide the relevant insurance information.
There is an express provision in the 2010 Act that insurers cannot rely on clauses which require the insured to have paid out in respect of a liability before the insurer has a liability. These “pay first” clauses effectively exclude the operation of the 1930 Act. There remains an exception as regards “pay first” clauses in respect of marine insurance.

**Insolvency Events**

The 2010 Act updates the lengthy list of qualifying “insolvency events” in order to bring it up to date with developments in company and insolvency law. 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 arrangements between the insured and its creditors.

**Clarification**

The 2010 Act also clarifies a number of uncertainties that existed in relation to the scope of the 1930 Act. In particular:

- The uncertain extra territorial effect of the 1930 Act is resolved. The 2010 Act provides broadly that it will apply in circumstances where the “insolvency event” occurs in England irrespective of the (i) governing law of the contract; (ii) the domicile of the parties; or (iii) the governing law of the dispute between the insured and the third party.

- The 2010 Act applies to voluntarily incurred liabilities such as legal expenses in the context of legal expenses insurance.

- The insurer’s right to set off money owed by the insured under the policy (for example by way of premium) from any proceeds due under the policy is affirmed. The law as it currently stands on this issue is unclear as there are conflicting decisions interpreting the 1930 Act.

**COMMENT**

Overall the Act represents a considerable advance on the previous legislation for third party claimants. However, the impact on brokers and insurers may be onerous.

For brokers, the 2010 Act’s impact may be significant as they will have to deal with requests for information from potential claimants for the first time under the legislation. Previously those requests would have come via the insolvent insured/insolvency practitioner. The information which a potential claimant is now able to seek is relatively detailed and must be provided within 28 days, failing which the third party has a right to apply to court.

Insurers may face a greater number of claims brought by third parties against insolvent insureds given that the 2010 Act makes it easier and cheaper for third parties to bring claims. In particular, aspects of the 1930 Act that may have dissuaded claims (such as the need to restore the dissolved company to the register) have been changed by the 2010 Act and the list of qualifying insolvency events is also more extensive under the 2010 Act. Insurers’ liability may also be increased as certain defences are unavailable under the 2010 Act and there is a potential for increased costs’ liability. However, it is important to remember that the third party cannot be in a better position vis-a-vis the insurer than the insured was itself. The insurer will not, therefore, be facing greater liability as a result of the insolvency of its insured than it would have faced through the ordinary operation of the policy. Insurers may also be assisted by the increased information requirements, as claimants will have access to insurance information and may therefore be dissuaded from making claims in borderline cases where the information reveals that there is a real question over coverage.
GETTING INSURED VALUES WRONG UNDER THE INSURANCE ACT 2015: DISENTANGLING AVOIDANCE, AVERAGE AND PROPORTIONATE REMEDIES

This article considers the impact of underinsurance by the insured under property and business interruption insurance policies. Such policies will commonly include an average clause permitting the insurer proportionately to reduce the value of the claim for underinsurance. The Insurance Act 2015 provides the insurer with proportionate remedies for breach of the duty of fair presentation, including a right to reduce claims proportionately if it would have charged more premium.

So what remedies would an insurer have under the Act in the event of underinsurance: could it avoid the policy, apply average or even ‘double dip’ by applying average and then proportionately reducing the claim again under the Act?

THE CURRENT LAW

Avoidance for material non-disclosure or misrepresentation

Under the Marine Insurance Act 1906, an insurance policy is a contract of the utmost good faith. The insurer may avoid a non-consumer insurance policy if the insured fails to disclose all material circumstances or makes material misrepresentations before the policy is concluded. A circumstance or representation is material if it would influence the judgement of a prudent insurer in fixing the premium, or determining whether to take the risk. If the insurer avoids the policy, it is treated as if the policy had never existed and all previous successful claims under that policy must be repaid by the insured.

Under the current law, avoidance is the sole remedy for breach of the duty of disclosure in respect of non-consumer insurance policies. This is often perceived as unbalanced given the draconian nature of the remedy and the lack of any alternative remedy that may reflect a fair outcome in the circumstances. The potentially unjust nature of the remedy of avoidance was recently described by the High Court as “a blot on English insurance law”.

Application of average

Average is a mechanism which reduces policy claims proportionately in the case of underinsurance or undervaluation. It applies automatically in marine insurance (but not in non-marine insurance). Section 81 of the Marine Insurance Act 1906 provides that: "Where the assured is insured for an amount less than the insurable value or, in the case of a valued policy, for an amount less than the policy valuation, he is deemed to be his own insurer in respect of the uninsured balance".

Average clauses are now common in non-marine insurance, particularly commercial property and business interruption insurance (unless the policy is on a declaration linked basis). They apply to reduce the policy claim in the ratio that the insured value, based on the declared values for property and/or gross profit, bears to the actual value at the time of loss. Thus, if the insured value is only 50% of the actual value, the insurer will only be able to claim 50% of any loss under the policy. This mechanism encourages the insured to make correct and accurate statements of value before concluding the policy.

The challenge of accurately declaring insured values is one of the major issues faced by insurance and risk managers. Under-declarations can leave insureds seriously underinsured in the event of a major loss and, on top of that, result in a proportionate reduction of the claim through the application of average. The insurer loses out too: if values are being under-declared, then it is not receiving full premium income for the risk.

In contrast, some business interruption policies are written on a declaration linked basis with no proportionate reduction (average clause) in the case of underinsurance. Under a declaration linked policy, the insured declares at the outset of the policy its estimated gross profit for the policy period. The premium is calculated based on this initial estimate but is subject to adjustment (upwards or downwards) at the end of the policy based on a second declaration by the insured of its actual gross profit for the policy period. The insurer’s liability will usually be limited to 133.3% of the estimated gross profit figure. Thus, if, for example, an insured estimates its gross profit at £1 million whereas its actual gross profit transpires to be £2 million, the insurer will be due an additional amount of premium and, in the event of a claim, its liability will be capped at £1.33 million but it will not be entitled to apply average for underinsurance. In practice, however, declarations of actual gross profit are very often not made and no premium adjustment is made.
Remedy for underinsurance

Where the policy contains no average clause and is not on a declaration-linked basis, the insurer is protected against underinsurance by having the right to avoid the policy for material non-disclosure or misrepresentation. On the face of it, any under-declaration that impacts the premium charged may in principle be material.

There is some uncertainty as to whether, and if so in what circumstances, the insurer may avoid a policy containing an average clause for material non-disclosure or misrepresentation in relation to underinsurance. There is a vacuum of authority on this point.

In Economides v Commercial Assurance, the insured’s flat was burgled and property worth around £31,000 was stolen, whereas under the insured’s household policy the sum insured for contents was only £16,000. The insurer sought to avoid the policy. The insured disputed the insurer’s right to avoid the policy but conceded that these facts were material. The Court of Appeal found, however, that the insurer could not avoid the policy because the insured’s relevant representation, namely that he believed the particulars given were true, had been made honestly, which was all that was required. Simon Brown LJ commented obiter that certain aspects of the insured’s concession as to materiality made him uneasy:

“Ordinarily, therefore, it appears, under-insurance, so far from being regarded as material non-disclosure justifying the avoidance of the policy, results instead in averaging, or indeed in full recovery without penalty. Why then should the position be so very different in the present case, not least given that the policy itself expressly envisages at least some degree of under-insurance… And that leads me to the second point. Just how substantial must be the extent of under-insurance… before it is said that, assuming always that the insured had knowledge of these facts, that the policy can be avoided on the grounds of non-disclosure?”

MacGillivray on Insurance Law (13th edition) submits that the contrary argument to the above is that “the value of the property is important in calculating the applicable premium, and the presence of a number of articles of disproportionately high value might have a bearing on the risk of theft” (paragraph 17-072).

The generally perceived wisdom in the industry likewise appears to be that a serious under-declaration may entitle insurers to avoid the policy. For example, the Chartered Institute of Loss Adjusters has commented in relation to business interruption insurance that in its view:

“A very significant under-declaration may constitute a failure to adequately disclose the nature of the risk presented, which might support avoidance of the policy. Notwithstanding this view … such an approach may be seen as a heavy-handed response, particularly where the BI element of a claim in a specific instance may not be large.”

In short, it is unclear in what circumstances (if at all) an insurer may avoid a non-consumer insurance policy containing an average clause for material non-disclosure or misrepresentation of insured values. The answer to this question is unlikely to be black-and-white but rather to turn on the facts in each case. In our view, in serious cases of underinsurance, the insurer would likely to be entitled to avoid the policy. An example of this may be a deliberately false declaration of insured values.

Similarly, there is a dearth of authority on underinsurance in declaration linked policies. A declaration of estimated gross profit is likely to be construed as a representation of expectation or belief rather than a statement of fact. It would therefore be treated as true if it were made in good faith such that the insurer would only have a right to avoid the policy for underinsurance if the under-declaration of estimated gross profit were made dishonestly. That may be the case where the insured has deliberately under-declared, knowing that there is a 133.33% uplift applying to the estimated gross profit figure. In these circumstances, where the insurer does not benefit from an average clause, it may well have grounds to avoid the policy for material misrepresentation.

Overall, however, the lack of case law and commentary on these issues is an indicator of the practical reality that, broadly speaking, insurers prefer to eschew the ‘nuclear’ option of ultimately seeking to avoid the policy – whether on a sum insured or declaration linked basis – and instead to adjust claims by applying average (and relying upon the liability cap in declaration linked policies) in cases of under-insurance.

THE INSURANCE ACT 2015

Duty of fair presentation and new regime of proportionate remedies

The Insurance Act 2015 (the Act) applies to all insurance (and reinsurance/retrocession) policies and variations to existing policies made on or after 12 August 2016.

Under the Act, the insured under a non-consumer insurance contract must make a “fair presentation of the risk” to the insurer. This duty replaces the existing duty relating to disclosure and representations although it retains many key aspects of the existing duty.

Unlike the current law, where the insurer’s only remedy for breach of the duty of disclosure is avoidance of the policy, the Act provides for a range of proportionate remedies if the insured breaches the duty of fair presentation. If the breach is deliberate or reckless, the remedy of avoidance will still be available and the insurer may keep the premium. For all other breaches, the onus is
GETTING INSURED VALUES WRONG UNDER THE INSURANCE ACT 2015: DISENTANGLING AVOIDANCE, AVERAGE AND PROPORTIONATE REMEDIES

on the insurer to show what it would have done had it received a fair presentation of the risk:

- The insurer will still be entitled to avoid the policy (but must return the premium) if it can show that it would not have entered into the contract;
- If the insurer shows that it would have entered into the contract but on different terms, then it may treat the policy as having included those terms from the outset; and
- If the insurer would have entered into the contract but only at a higher premium, the insurer may reduce the amount to be paid on the claim proportionately. Thus, if it would have charged double the premium, it is only liable to pay 50% of the amount of the claim.

It is open to the parties to contract out of these provisions of the Act subject to the ‘transparency’ requirements, meaning essentially that the ‘disadvantageous term’ must be brought to the insured’s attention and be clear and unambiguous as to its effect.

What remedies may the insurer have for underinsurance?

If the insured makes an under-declaration that amounts to a material non-disclosure or misrepresentation, the insurer’s remedy depends upon what it would have done had it received a fair presentation of the risk.

That raises the interesting issue of whether, if the policy contains an average clause and the insurer can also show that it would have charged more premium had it received a fair presentation, the insurer has two potential remedies, namely to apply the average clause and/or to reduce the amount to be paid on the claim proportionately. Thus, if it would have charged double the premium, it is only liable to pay 50% of the amount of the claim.

The answer as to what remedies the insurer may have available in these circumstances is probably far more straightforward. The better view is probably that the remedies operate in different circumstances. Ordinarily an under-declaration of insured values (whether under the current law or the Act) is unlikely to give rise to a breach of the duty of fair presentation and the insurer’s remedy will be in application of the average clause. Only in circumstances where the under-declaration is made deliberately or recklessly, or is otherwise extreme, is it likely to be considered material such as to constitute a breach of the duty of fair representation. In this case the insurer is more likely, in fact, to be able to show that it would not have entered into the contract had it known the actual value at risk entitling it to avoid the policy rather than have to rely upon the new regime of proportionate remedies under the Act.

Similarly in the case of declaration linked policies, if the declaration of estimated gross profit is properly construed as a representation as to a matter of expectation or belief, and that representation were not made in good faith, then the insurer’s remedy would be avoidance for a deliberate (or reckless) breach of the duty of fair presentation. If, on the other hand, the declaration were properly construed as a representation as to a matter of fact, and was made otherwise than deliberately or recklessly, the position may be more complicated. It may well be that a significant under-declaration would be considered material absent the insurer being protected by an average clause. If the insurer would have written the risk but charged a higher premium, then at first blush it would be entitled to reduce the claim proportionately – thus effectively introducing a remedy akin to average into declaration linked policies. However, there is fertile scope for debate in these circumstances about whether the regime for proportionate remedies under the Act has been varied as regards terms relating to premium given that declaration linked policies already contain a premium-adjustment mechanism.

In summary, the Act presents tricky questions to which there may be simple answers. But these are untested waters and the approach the courts may take remains to be seen.

ADDITIONAL REFERENCES

Marine Insurance Act 1906
Insurance Act 2015
Economides v Commercial Assurance Co Plc [1997] 3 WLR 1066
The High Court has held that the words "in any way involving any act, error or omission" before a certain date in an exclusion clause in a professional indemnity policy meant "indirectly caused by". The act, error or omission must be part of the chain of causation leading to the insured’s liability for the underlying claim, not merely part of the historical context or background, for the exclusion to bite. The policy in question also included (a) a notification clause providing that notification as soon as practicable was a condition precedent to recovery; and (b) a continuity of cover clause. On the facts the insured had given notice under the 2013/2014 policy in accordance with the notification clause. The Court stated, obiter dicta, that even if the insured should have notified the claim under the 2012/2013 policy, it would have been entitled to cover under the 2013/2014 policy by virtue of the continuity of cover clause.

BACKGROUND

This case concerned a claim by ARC Capital Partners Limited (the "Manager"), a fund manager, under its professional indemnity insurance policy.

The Manager managed investments for ARC Capital Holdings Limited (the "Fund"). In December 2010, the Manager invested approximately RMB 480 million (about US$75 million) in a property business on behalf of the Fund. The shares in the property business were never transferred to the Fund.

The Fund’s solicitors stated in a letter to the Manager dated 2 April 2013 (the "April Letter") that the Fund had a "strong claim against the Manager for recovery of the Payment and all related losses, costs and interest". The stated purpose of the letter, however, was to agree a process to seek recovery of the payment. The Fund reserved its rights against the Manager and stated the agreed process for seeking return of payment was not a waiver of any claim against the Manager. The Manager did not inform its professional indemnity insurers on the October 2012 to October 2013 insurance programme (the "2012/2013 Policy") of the April Letter.

In January 2014, the Fund’s solicitors sent a letter to the Manager’s solicitors enclosing draft particulars of claim for negligence and breach of contract and expressing the Fund’s intention of bringing proceedings against the Manager. The Fund informed its professional indemnity insurers on the October 2013 to October 2014 insurance programme (the "2013/2014 Policy") of the claim shortly thereafter.

The Fund and Manager reached a settlement agreement in principle, subject to the consent of the second excess layer insurers on the Manager’s professional indemnity policy (the "Insurers") (who had subscribed to both the 2012/2013 Policy and 2013/2014 Policy, which were on the same terms).

Insurers raised questions regarding cover. The Court was asked to determine whether:

1. The Fund’s claim against the manager was a claim "arising out of or in any way involving any act, error or omission committed or alleged to have been committed prior to 5th June 2009", cover for which was excluded under the second excess layer of the Manager’s professional indemnity policy programme.
2. The April Letter contained or constituted a "Claim" within the meaning of the policies. If it did constitute a Claim, it was common ground that it had not been notified in accordance with the relevant notification provisions.
3. If the April Letter did contain or constitute a "Claim" which should have been notified under the 2012/2013 Policy, cover was nonetheless available under the 2013/2014 policy pursuant to a continuity of cover extension.
HIGH COURT CONSTRUES "IN ANY WAY INVOLVING" IN LIABILITY POLICY

DECISION

Did the claim "in any way involve" acts, errors or omissions occurring before 5 June 2009?

The second excess layer policy wording excluded cover for claims “arising from or in any way involving any act, error or omission committed or alleged to have been committed prior to 5th June 2009” (the “Retroactive Date Clause”) (when the second excess layer incepted).

The Fund advanced two cases against the Manager in its particulars of claim.

- The Manager’s negligence and breach of contract in 2010 caused the Fund to suffer losses.
- In the alternative, the Fund’s loss arose from negligent acts or omissions in 2008.

The Retroactive Date Clause therefore excluded cover for the Manager’s liability under the alternative claim, but not for its liability under the primary claim.

The judge rejected Insurers’ argument that acts, errors or omissions “in any way involving” meant acts, errors or omissions which had “any connection of any kind with the past history”. The result of this argument would be the exclusion of a claim on the basis that its historical context included transactions pre-dating 5 June 2009, irrespective of (i) whether those transactions contributed to the insured’s liability; (ii) whether the acts or omissions were wrongful; and (iii) whether the acts or omissions could give rise to liability. Mr Justice Cooke held that excluding cover simply because part of the historical context of a claim against the insured pre-dated the inception date of the policy would require “clear wording”. He held that there must be a direct or indirect causal connection between the acts, errors or omissions and the claim or liability alleged for the exclusion to apply.

The judge then referred to Coxe v Employers’ Liability Assurance Corporation Limited (“Coxe”), in which Scrutton J (as he then was) found that “arising from” in an exclusion clause meant “proximate cause”. Coxe further held that a clause excluding loss caused “directly or indirectly” by an excluded peril, excluded losses with a more remote degree of causal connection to the excluded peril than a clause referring to direct losses only. The judge interpreted “arising from” as “proximately caused by” and “in any way involving” as “indirectly caused by”. This construction, he said, gave the phrases recognisably distinct meanings.

The phrase "act, error or omission" in the Retroactive Date Clause had to be read in the context of the insuring clause, which insured against loss from claims for “Wrongful Acts”, defined as “acts or omissions”. The only acts, errors or omissions occurring before 5 June 2009 which could have a causative effect were wrongful acts which could in principle give rise to liability. Thus the Retroactive Date Clause excluded cover for acts, errors or omissions which could give rise to liability, occurred prior to the Retroactive Date, and were “genuinely part of a chain of causation which leads to liability for the claim in question.”

On the facts, the events which gave rise to the Manager’s liability on the Fund’s primary case had no causal connection with events before 2009, and accordingly this claim was not excluded under the Retroactive Date Clause. The judge found that the alternative case was “not the case being actively pursued”, nor “the case that the Manager wished to settle. It is not in truth a liability which is maintained either by the Fund or the Manager”. The true nature of the claim was therefore that stated in the primary case and the claim was not excluded.

Was the April letter a “Claim”? The judge found that the April Letter was not a “Claim” as defined in the policy wording (a demand for monetary damages or non-pecuniary relief). The letter’s expressed purpose was to agree arrangements for pursuing a claim against the property business and seeking recovery of the payment, not to assert or expand on the Fund’s claims against the Manager. The Fund’s suggestion that the Manager should meet the costs of seeking to recover the payment was not a claim for money, either. The Fund reserved its rights to claim against the Manager and stated that cooperation in seeking re-payment was not a waiver of rights. It was not a written demand for monetary damages or non-pecuniary relief. The Manager had therefore not breached the notification condition in failing to notify insurers of the April Letter.

If the April Letter was a Claim, was cover extended under the Continuity of Cover clause? The judge went on to consider whether, if the April Letter were a Claim, the continuity of cover extension meant the Manager could bring its claim under a subsequent policy.

An extension to the policies described as the “Continuity of Cover” clause provided:

“[C]overage is provided for Claims or circumstances which could or should have been notified under any policy or coverage section of which this Coverage Section is a renewal or replacement or which it may succeed in time”, subject to certain conditions which were met in this case. Cover provided by the extension was on “the terms and conditions of the policy or coverage section under which the Claim or circumstance could and should have been notified”.

Another clause provided that it was a condition precedent to the Manager’s right to recover under the policy that Insurers be given written notice of any Claim as soon as practicable, and in any event within 60 days of the expiration or termination of the policy (or such longer period as Insurers agreed) (the “Notification
In the same vein, parties should when agreeing extensions to insurance policies consider the interaction between the proposed extension and the original policy wording. If they wish for specific provisions of the original policy wording (for example in relation to notification) to apply to extensions as well, it may be worthwhile for them to include specific wording to that effect.

Condition”). The parties agreed that written notice had not been given in accordance with the Notification Condition. The Manager nonetheless argued that the Continuity of Cover clause meant it was entitled to cover in a subsequent policy year. The policy was subject to a term which provided that Insurers could not avoid the policy for non-disclosure, so there was no scope for Insurers to avoid the 2013/2014 Policy for the Manager’s failure to disclose the April Letter.

Insurers argued that claims made under the Continuity of Cover extension nonetheless had to be notified to them as soon as practicable, in accordance with the Notification Condition. The Continuity of Cover clause could not “permit the Manager to notify a claim to a later policy period without any restriction of time”.

The judge rejected this argument. The purpose of the extension was to cover late-notified claims. This purpose would be defeated if the Notification Condition applied to late notified claims. Moreover, the reference to “Claim” in the Notification Condition was a reference to claims made against the insured under that policy year. The Continuity of Cover clause, however, applied to claims made against the insured under the previous policy year. As a matter of construction, the Notification Condition did not apply to claims which fell within the Continuity of Cover extension. Renewal of the policy on terms including the Continuity of Cover extension meant that the policy covered claims which should have been notified under an earlier year policy, irrespective of when the insured notifies insurers of the claim in a subsequent year. The Continuity of Cover extension was intended to provide cover for claims notified late, and on the judge’s construction this is what the extension did.

**COMMENT**

It is helpful that the Court has clarified that an exclusion of liability for claims “in any way involving” an act, omission or error does not simply mean facts which are part of the historical background to an insurance claim, but requires an element of causation (albeit indirect). Moreover, it must be right that it would take clear words to exclude cover for an event which merely formed part of the historical context of a claim.

The case provides a timely reminder of the potential consequences for insureds of claims-made policies which are subject to a retroactive date.

Provisions of policies must be interpreted in the light of the context of the policy as a whole, as the judge’s approach to the construction of the Retroactive Date Clause and Continuity of Cover clause demonstrates.

**ADDITIONAL REFERENCES**

Coxe v Employers’ Liability Assurance Corporation Limited [1916] 2 KB 629
INSURERS’ SUBROGATION RIGHTS IN RELATION TO LEASEHOLD PREMISES REVISITED

The High Court has held, applying Mark Rowlands v Berni Inns Limited, that where a landlord insured property for the benefit of herself and her tenant, the insurer could not bring a subrogated claim against the tenant for damage caused by breach of contract and/or negligence.

BACKGROUND

Mrs Frasca-Judd, the Claimant landlord (the “Landlord”), let a cottage in Wiltshire to Ms Golovina, the Defendant tenant (the “Tenant”), under a short-term tenancy agreement (the “Agreement”). The Agreement required the Tenant “to take all appropriate precautions [...] to prevent damage [...] which may be caused by frost including leaving background heat at all times during the winter months especially when Premises are vacant”. The Tenant left the property unoccupied over the New Year for a period of about eighteen days. While the cottage was vacant, the pipes froze and burst causing damage to the property and contents. The cottage was also uninhabitable for a period of seven months and two weeks. The Landlord asserted that the Tenant had left the property vacant with the heating off and this caused the pipes to freeze and burst. The Landlord’s insurer (the “Insurer”) indemnified her for damage to the property and contents and for loss of rental income during the period when the cottage was uninhabitable. The Insurer then sought to bring a subrogated claim against the Tenant for negligence and/or breach of the terms of the Agreement.

DECISION

The Court considered one legal question and one factual question:

1. The Tenant argued that as a matter of law the parties’ intention was that the property would be insured for the benefit of both parties, and accordingly the Insurer could not bring a subrogated claim against her.

2. There was a factual question as to whether the heating in fact been turned off. The parties agreed that if the Tenant had left the heating on but the heating subsequently failed, the Tenant would not be liable. Likewise the Tenant agreed that if, contrary to her evidence, the heating had not been left on, the Landlord had established causation and the Tenant would be liable unless the Insurer was precluded from bringing a subrogated claim.

The Rowlands principle

Mr Justice Holgate referred to the decision of the Court of Appeal in Mark Rowlands v Berni Inns Limited. An entire building was destroyed as a result of the negligence of a tenant of part of the building. The tenancy agreement obliged the landlord to insure the property against loss or damage caused by “insured risks” and to apply the proceeds of insurance claims in rebuilding and reinstating the property. The tenant covenanted to pay insurance rent, being the amount spent by the landlord “in effecting or maintaining the insurance of the demised premises”, as well as to pay a fair proportion of the cost of insuring the whole building.

The Court of Appeal, following a review of a range of decisions of the North American Courts, held that the crucial question was whether the terms of the lease precluded the landlord from recovering damages in negligence from the tenant. If so, the insurer could not bring a subrogated claim against the tenant. The Court of Appeal noted that the landlord covenanted to insure and apply the insurance monies to reinstate the property. The Court of Appeal then stated in a passage quoted by Holgate J and defined as the “Rowlands principle”:

“The intention of the parties, sensibly construed, must therefore have been that in the event of damage by fire, whether due to accident or negligence, the landlord’s loss was to be recouped from the insurance monies and in that event they were to have no further claim against the tenant for damages in negligence”.

Principles to be derived from subsequent authorities

Holgate J then considered a Canadian case cited in Rowlands as well as subsequent English and Scottish cases. The judge summarised the principles to be derived from these cases:

1. The Court should interpret the tenancy agreement to determine how the parties allocated risk.

2. If a landlord agrees to insure demised premises in return for mutual obligations owed by the tenant (including the payment of rent), this is an important indicator that the tenant need not insure the same risk and will not be liable to the landlord for loss or damage caused by risks which the landlord agreed to insure.

3. The strength of the landlord’s agreement to insure as an indication that the parties intend the landlord to insure the property on behalf of both parties depends on the other terms of the tenancy agreement.

4. The strength of this indicator is greater if the tenant is contractually obliged to pay, or contribute to, the landlord’s costs of insuring the premises. The Rowlands principle may apply even if the tenant is not obliged to pay or contribute to

CASE REFERENCE AND JUDGMENT DATE

Elizabeth Frasca-Judd v Galina Golovina
(2016) EWHC 497 (QB)
5 February 2016
the landlord’s costs of insuring the premises. The judge commented that a tenant paying a full open market rent will often be paying for or contributing towards the cost of the landlord’s covenant to insure.

5. Other relevant indicators include terms which:
   a. relieve the tenant from obligations to repair damage caused by an insured risk;
   b. require the landlord to use insurance proceeds to reinstate the property or repair damage; and
   c. suspend the tenant’s obligation to pay rent while damage caused by an insured risk prevents use of the property.

These are relevant factors, not prerequisites; the Rowlands principle may apply if some or all of these terms are not included in the tenancy agreement.

4. The Rowlands principle may apply to preclude a claim against a tenant for negligence notwithstanding that the tenancy agreement does not expressly exclude the tenant’s liability for negligence.

The legal issue: Application of the principles to the agreement

The judge considered the following provisions of the Agreement relevant to his analysis:

- The Agreement required the Landlord to insure the property for, amongst other things, property damage, damage to contents and loss of rent.
- Although the Tenant was not required to pay a separate insurance rent, the Tenant covenanted not to vitiate the insurance and to repay any increased premiums and reasonable expenses which the Landlord incurred if the Tenant did vitiate the insurance.
- Although there was no obligation to apply insurance proceeds in remedial work, this was not an essential requirement for the Rowlands principle to apply.
- The judge then considered the allocation of risk between the parties under the Agreement. The Tenant’s obligation to pay rent was suspended if the property was rendered uninhabitable by an insured risk, even if the Tenant had been at fault (unless the Tenant vitiated the Landlord’s insurance). The Tenant was also permitted to terminate the tenancy in these circumstances, even if she had been at fault (again, unless she had vitiated the Landlord’s insurance). This transferred the risk of loss of rent to the Landlord. The sole remedy for the Landlord’s claim for lost rent would be under the insurance policy. Holgate J stated that references to vitiation of the Landlord’s insurance in this clause implied that if the insurance were not vitiated, the Landlord’s “remedy is to recover his loss from the insurer and not from the tenant”. The allocation of risk did not distinguish losses caused by the tenant’s negligence or breach of contract.

The judge concluded that these clauses clearly showed the parties’ intention was that:

“the landlord’s insurance would be for the benefit of both parties and that risk in relation to the landlord’s loss or damage caused by insured risks (even where the tenant is responsible) be dealt with by recourse to the insurance policy which the landlord was obliged to take out, and not as a claim for damages against the tenant”.

The judge derived support for this conclusion from a special condition in the Agreement which expressly provided that the Tenant would be liable to compensate the Landlord for fire damage arising from the use of open fires within the premises. The judge considered the inclusion of this specific obligation to be consistent with his conclusion that damage from insured risks caused by the Tenant would otherwise be covered under the Rowlands principle. The Agreement did not provide that the Tenant would pay compensation or damages if she breached the heating covenant.

The factual issue: Alleged breach of the heating covenant

The Defendant gave live evidence stating that she had left the heating on. The judge considered her to be a reliable witness and stated that cross-examination did not undermine her evidence. In contrast, the insurer simply adduced an attendance note produced by an employee of the property manager. The insurer did not adduce witness evidence from that employee or from the caretaker of the property, who had found the damage. The judge considered this “surprising”, particularly given the absence of an explanation from the Insurer and the substantial legal expenses involved. He concluded that the Insurer had not established on the balance of probabilities that the Tenant had breached the heating covenant. The Insurer would accordingly have lost its claim irrespective of the judge’s conclusion on the legal issue.
COMMENT

Although it does not break new legal ground, this judgment is a helpful distillation of the principles which apply when a landlord’s insurer seeks to bring a subrogated claim against a tenant who caused property damage and loss of rent through negligence or breach of contract. Each case will turn on a construction of the tenancy agreement and parties’ contractual allocation of risks. In particular where a landlord has agreed with his tenant to insure the premises in return for mutual obligations by the tenant, this is an important indicator that the parties intended that the tenant would not be liable for loss or damage suffered by the landlord which he has agreed to cover. The Court will also consider whether the tenant is obliged to pay for, or contribute towards, the cost of insurance incurred by the landlord and whether the landlord is obliged to apply insurance payments to reinstate or repair damaged property, although none of these indicators is definitive. If parties decide that the tenant is liable for loss arising from certain risks, this is likely to imply that losses arising from other risks are insured for the benefit of landlord and tenant.
The Court of Appeal has recently decided that the *Fairchild* causation exception applies in a lung cancer case. The case is significant in that to date the *Fairchild* exception has only been applied to mesothelioma claims, and this is the first time the Court of Appeal has been asked to consider its application to a lung cancer case.

It remains to be seen how the courts now interpret this decision and whether the *Fairchild* enclave is now set to experience a period of rapid expansion but it does appear that, where medical science cannot prove that a defendant has materially contributed to a disease, but can prove that a defendant has materially increased the risk of contracting the disease, the *Fairchild* exception may be applied to establish the necessary causation, and liability will be proportionate to the increase in risk for which the defendant was responsible.

**BACKGROUND**

The Claimant was the son and executor of the deceased, Mr Heneghan, and his widow. Mr Heneghan had died of lung cancer. It was common ground that his lung cancer was caused by exposure to asbestos fibres. He had been exposed to asbestos in the course of his employment with each of the six Defendants. Other employers who had exposed Mr Heneghan to asbestos were not sued in these proceedings. It was also accepted that biological evidence could not establish which of the exposures, if any, triggered the cell changes in his body which led to the cancer. However, evidence could establish by how much the exposure by each Defendant had increased the risk that he would contract the disease.

The question for the Court was how it should deal with causation (and therefore apportionment of damages) in these circumstances.

**FIRST INSTANCE DECISION**

Mr Justice Jay concluded that the causation test established in *Fairchild v Glenhaven Funeral Services* was applicable, qualified by *Barker v Corus*.

*Fairchild* concerned mesothelioma, and the Court had found that causation could be established for the purposes of liability for mesothelioma if a defendant employer had materially increased the risk that a victim would contract the disease. *Barker* established that, where a person was so responsible, it was not liable for all the damage attributable to the mesothelioma, but only in proportion to its contribution to the risk. Applying these principles, Jay J awarded damages against each Defendant that were proportional to the increase in risk for which it was responsible. This meant they were only responsible for 35.2% of the total damages claimed. The Compensation Act 2006 was not applicable in this case because the relevant part of the Act applies only to mesothelioma claims and hence the pro-rata allocation of damages in this case. The Claimant appealed against the decision at first instance.

**COURT OF APPEAL DECISION**

The Appellant contended that there was evidence to show that each of the Defendants had materially contributed to Mr Heneghan’s lung cancer, rather than just the risk of its contraction. Therefore the position was distinguishable from the multi-employer mesothelioma case where the claimant cannot prove that each defendant materially contributed to the disease itself because of the indivisible nature of mesothelioma, including that its severity does not increase with exposure.

Lord Dyson, giving the leading judgment in the Court of Appeal, accepted the following:

1. the lung cancer had been caused by Mr Heneghan’s exposure to asbestos;
2. the causal connection between the lung cancer and asbestos was established by reason of the cumulative dose; and
3. the asbestos acted in multiple ways to promote carcinogenesis at cellular level.

He did not, however, accept the following arguments made by the Appellant:
1. the asbestos from each Defendant was likely to have been inhaled and distributed in the lungs in a similar way;
2. the fibres from each source were likely to have played a part in the carcinogenic process; and
3. each Defendant therefore materially contributed to the contraction of the disease.

The Appellant’s arguments would have allowed a recovery in full from six Defendant employers even though they were only responsible for 35.2% of the total exposure to which Mr Heneghan was subjected. Thus on the facts of this case it was the Defendant employers who were arguing for the Fairchild exception on causation to be applied to the claim.

Lord Dyson introduced his analysis with a helpful recap of the three ways in which causation could be established in disease cases:
1. Causation will be established if, but for the defendant’s negligence, the claimant would not have suffered the disease.
2. Where the disease is caused by the cumulative effect of an agency (eg. asbestos fibres) part of which is attributable to the breach of duty on the part of the defendant and part of which involves no breach of duty, the defendant is liable on the basis of the exposure has in fact contributed to the injury, the law has applied where the court is satisfied on scientific evidence that the exposure for which the Defendant is responsible has in fact caused the damage. The Fairchild solution were satisfied, namely that:
3. If causation cannot be proved in these ways (for example if a disease is indivisible) causation may be proved if the defendant materially increased the risk of the victim contracting the disease (the Fairchild exception).

It was accepted by the Appellant that the “but for” test was not satisfied. He contended, however, that this was a Bonnington scenario because the exposure attributable to each Defendant contributed to the disease itself (rather than the risk of contraction).

The judge at first instance had accepted that lung cancer was dose related. However, unlike pneumoconiosis where the greater the accumulation of dust in the lungs, the greater the damage being caused to the lung tissue, in the case of lung cancer and asbestos the greater the exposure to asbestos fibres, the greater the risk that lung cancer may result. Epidemiology could not, however, establish whether the fibres to which Mr Heneghan was exposed by each Defendant actually caused the fatal disease. Jay J concluded: “In lung cancer cases, there is no analogue to the gradual accumulation in the lungs of asbestos or cigarette smoke. The risk of the disease eventuating is proportionate to the quantum of exposure, but that is a statistical judgment, not an assessment which may be linked to the physical presence of deposits of dust in the lung.”

Lord Dyson agreed with Jay J’s decision to reject the opinion of the Appellant’s medical expert that every period of exposure contributed to the development of Mr Heneghan’s cancer. This was not a medical opinion. Rather it was an opinion that an inference of causation could be drawn from the epidemiological evidence. The epidemiological evidence enabled the quantification of the contribution to the risk of cancer attributable to an individual Defendant. It went no further than that. It was not possible to say which factor actually caused the cancer. As to this, the Appellant’s expert accepted that the current understanding of biological mechanisms does not form a basis for the practical attribution and apportionment of particular cancers.

Lord Dyson held that the Appellant’s contention that Bonnington should apply “ignores the fact that there is a fundamental difference between making a material contribution to an injury and materially increasing the risk of an injury” (emphasis added). He remarked that, if the two were the same thing Fairchild would not have been the ground-breaking decision that it was when it introduced, in the words of Lord Hoffman in Barker, “an exceptional and less demanding test for the necessary causal link between the Defendant’s conduct and the damage” than the Claimant having to prove that the Defendant did in fact cause the damage. The Bonnington test was to be applied where the court is satisfied on scientific evidence that the exposure for which the Defendant is responsible has in fact contributed to the injury. It would therefore typically be applicable to divisible injuries such as silicosis, where the severity of the disease was proportionate to the amount of exposure. Where scientific evidence does not enable the court to determine whether the exposure has in fact contributed to the injury, the law has responded by applying the Fairchild test so as to avoid an unfair result. Lord Dyson was satisfied that all the factors required for the application of the Fairchild solution were satisfied, namely that:
1. all the Defendants admitted breach of duty;
2. all the Defendants increased the risk that Mr Heneghan would contract lung cancer;
3. all exposed Mr Heneghan to the same agency (asbestos fibres) that was implicated in the causation; but
4. medical science was not able to determine which (if any) of the Defendants was responsible for the exposure which actually caused the cell changes which caused the cancer.
He therefore saw no reason not to apply the Fairchild exception to this lung cancer case and, indeed, commented that to not apply the case would make the law in this area “inconsistent and incoherent”. He referred to the recent decision of the Supreme Court in International Energy Group v Zurich Insurance Plc UK in which Lords Neuberger and Reed said that the Fairchild exception is “applicable to any disease which has the unusual features of mesothelioma”. Accordingly he dismissed the appeal. The effect of applying the Fairchild exception was that the Claimant was unable to recover from the six Defendant employers any more than their pro-rata proportion (totalling 35.2%) of the damages claimed.

**COMMENT**

The decision confirms that the courts are willing to apply the exceptional principle established in Fairchild to diseases other than mesothelioma provided that the facts of a case are truly analogous to those in Fairchild. It appears that, where medical science cannot prove that a defendant has materially contributed to a disease, but can prove that a defendant has materially increased the risk of contracting the disease, Fairchild may be applied to establish the necessary causation. The courts will not, however, apply Bonnington unless there is medical evidence to prove that a defendant has materially contributed to the disease itself. It remains to be seen how the courts now interpret the decision and whether the Fairchild enclave is now set to experience a period of rapid expansion.

**ADDITIONAL REFERENCES**

Bonnington Castings Ltd v Wardlaw [1956] AC 613
Fairchild v Glenhaven Funeral Services Ltd [2003] 1 AC 32
Barker v Corus UK Ltd [2006] 2 AC 572
Carl Heneghan (Son & Executor of James Leo Heneghan, Deceased) v Manchester Dry Docks Ltd & Ors [2014] EWHC 4190 (QB)
International Energy Group Ltd v Zurich Insurance plc (Association of British Insurers intervening) [2016] AC 509
Compensation Act 2006
The Court of Appeal has upheld a decision to make a non-party costs order against an insurer who defended its insured in proceedings. The case provides a reminder of the risk insurers face when defending proceedings on behalf of an insured. It also summarises the key factors the court will consider when deciding whether or not to make such an order against an insurer. In this case, the decisive factor was whether or not the insurer was acting exclusively or predominantly in its own interests.

**BACKGROUND**

The Claimants owned properties on the same road as a garage company, Sterte. In 2003, the Claimants started to notice an unpleasant diesel smell. It transpired that there had been a spillage of around 300 litres of diesel in August 1997 from the above ground tank at the garage. Several reports were undertaken by the local authority to ascertain the origin and timing of the contamination. All concluded that the most likely origin was the above ground tank.

Sterte was insured by Aviva under a public liability policy which excluded cover for pollution save to the extent that it was “caused by a sudden identifiable unintended and unexpected incident which occurs in its entirety at a specific time and place during the period of insurance”.

In pre-action correspondence the insurer argued that the spill in August 1997 was not the cause of the contamination, and therefore the claim was not within the scope of the policy.

The Claimants’ case, as set out in the Particulars of Claim, was that the spill of oil from the tank in August 1997 was the sole cause of their loss. The insured passed the claim on to its insurer on the basis that, as pleaded, it would be covered by the policy (even though the loss adjustor did not agree with the basis on which the claim had been formulated). The insurer instructed solicitors to defend the claim.

The insurer applied to strike out the claim on the basis that it was time-barred. As part of the application, the Claimants relied on expert evidence which introduced for the first time an alternative possible cause of the damage to the Claimants’ land – long term leaks from the insured’s underground storage tanks or pipe-work. The original claim that the damage was caused by the spill in August 1997 remained in the pleading.

Following this, the insurer withdrew representation for the insured. Judgment in default was entered and the insured went into creditors’ voluntary winding up. An order was made that the insurer pay the Claimants’ costs on two separate grounds:

i. First, in the exercise of the Court’s discretion to order costs to be paid by a non-party pursuant to section 51(3) of the Senior Courts Act 1981. The Court found that the insurer had taken over defence of the action, determined that the claim would be contested, funded the defence of the claim up to the point when it withdrew representation, had effective conduct of it and conducted the claim for its own benefit.

ii. Secondly, on the basis that the insurer was liable under the policy to indemnify the insured against its liability for costs to the Claimants and, as a result of the insured’s liquidation, the Claimant succeeded to the insured’s rights under the Third Party (Rights Against Insurers) Act 1930.

The insurer appealed against the decision on both grounds. In respect of the non-party costs order it raised a number of arguments:

i. the insurer argued that it had repeatedly made clear that the policy did not provide cover for gradual pollution damage and in its view the claims being made would not be covered by the policy;

ii. the insurer only participated in the defence because it was pleaded solely on the basis of the spill in August 1997 which, if successful, would fall within the cover provided by the policy;

iii. the insurer’s defence of that claim was substantially successful in that the Claimants effectively abandoned that claim in favour of their alternative case;

iv. insofar as there remained a claim based on the spill in August 1997, the judge should have decided the issue of fact that the damage to the Claimants’ property was not caused by that incident;
v. the insurer acted in the interests of the insured as well as its own in defending the claim and if it had not funded the defence, the insured itself would have done so; and
vi. the insurer had no choice but to defend a claim which, on its face, fell within the policy cover and the insured would have had legitimate grounds for complaint if it had not taken steps to defend the claim.

DECISION
Non-party costs order
The Court considered TGA Chapman Ltd v Christopher in which the features necessary to justify making a costs order against an insurer were set out:
- the insurer determined that the claim would be fought;
- the insurer funded the defence of the claim;
- the insurer had conduct of the litigation;
- the insurer fought the claim exclusively to defend its own interests; and
- the defence failed in its entirety.

Palmer v Palmer refined this test so that the critical issue became whether or not the insurer was motivated either exclusively or at least predominantly by its own interest in the manner in which it conducted the defence.

The Court of Appeal decided that there was “ample material” which supported the contention that the insurer in this case was acting predominantly or exclusively in its own interest. The insured was unable to meet any judgment if it was not covered by the policy. The Court found that there was no doubt that the Claimants’ property had been damaged by the presence of diesel oil and no real grounds for doubting that it was caused by leaks from the insured’s property. The insured asserted no grounds for defending the claims against it. The insurer was not defending the claim to protect the insured against an award of damages which it was unable to meet, but to defeat a claim which, as pleaded, fell within the narrow class of pollution incidents covered by the policy. To the extent that the claim was outside the cover of the policy, the insurer had no interest in defending it, as evidenced by its withdrawal of support for the defence once the Particulars of Claim were amended.

The Court noted that the insurer would have had a good answer to the claim for a non-party costs order against them if, following the new expert evidence, the Claimants had abandoned their original claim based on the 1997 spill. In substance then the insurer would have funded the successful defence of such a claim. However, the Claimants did not abandon that claim.

There was no foundation for the contention by the insurer that had it not funded the defence, the insured would have done so. The insurer failed to defend the claims once the insurer withdrew its support. It therefore appeared that, had the insurer not defended the claim, the Claimants would not have had to incur the bulk of their costs.

In order to challenge successfully the judge’s exercise of his discretion to make a costs order, the insurer would have had to show that he had regard to irrelevant considerations, failed to take into account relevant considerations or made a decision which was not justified by the material before him. The Court of Appeal held that none of these were the case and the decision was justified.

Claim under the policy
In light of the decision on the non-party costs order, it was not strictly necessary for the Court of Appeal to consider this issue but did so as it had been fully argued. The question for the Court was whether the insurer was liable to indemnify the insured for costs in circumstances where the insurer denied that an insured risk had occurred.

On the policy wording in this case, the Court of Appeal found that the insured was entitled to be indemnified against the costs order in favour of the Claimants, and by reason of the 1930 Act, that right vested in the Claimants. In coming to its conclusion, the Court of Appeal noted that the alternative conclusion would mean that the insurer would not be liable to pay costs incurred with its consent if the claim against the insured failed and found that this could not have been what the parties intended.

COMMENT
The decision in Legg does not alter the position as set out in TGA Chapman Ltd v Christopher, Cormack v Excess Insurance Co Ltd and Palmer v Palmer. It is unusual for a third party costs order to be made, but the conduct of defences by insurers is one of the contexts where the courts have been willing to do so. Both Cormack v Excess Insurance and Palmer v Palmer emphasised the importance of the insurer having acted primarily or exclusively in its own interest, and this appears to have been the decisive factor in Legg as well.

The case is a reminder to insurers of the risk that an order for costs may be made against them when they are funding the defence of an insured. It may be possible to mitigate this risk by being careful to avoid acting exclusively or predominantly in the insurer’s own interests. For example, in Cormack v Excess Insurance, an order for costs was not made on the basis that the insurer had been acting in the best interests of the insured party. In particular, it did not act contrary to the instructions or wishes of the Defendant in the conduct of the litigation, and its own interest in defending the professional negligence claim coincided with the Defendant’s wish.
COURT OF APPEAL REMINDS INSURERS OF COST RISK IN DEFENDING INSUREDS

to maintain his professional reputation. The involvement of the insurer had not added to the costs of what would have been a reasonable defence. This reasoning was upheld in the Court of Appeal.

Insurers should therefore consider, at each stage of the defence, whether or not they are acting in the best interests, and in line with the instructions, of the insured party. In particular, care should be taken to avoid a situation where the claimant is incurring costs because of a defence pursued and conducted by the insurer, and which is likely to benefit solely or primarily the insurer.

All that said, there may be compelling reasons why an insurer may wish to conduct the defence of its insured, even an insolvent one. In deciding how to proceed the insurer needs to consider a number of things including any risk it runs of having a costs order made against it. The case is a timely reminder of this.

ADDITIONAL REFERENCES
TGA Chapman Ltd v Christopher [1998] 1 WLR 12
Cormack v Excess Insurance Co Ltd [2002] Lloyd’s LR 398
Palmer v Palmer [2008] EWCA Civ 46
Third Party (Rights Against Insurers) Act 1930
NON-DISCLOSURE CLAUSES: WHEN IS A NON-DISCLOSURE "DELIBERATE OR FRAUDULENT"?

In Mutual Energy v Starr Underwriting Agents, Mr Justice Coulson considered the proper construction of a clause which prevented insurers from avoiding the policy for non-disclosure unless that non-disclosure was "deliberate or fraudulent". The judge held that a non-disclosure would only be "deliberate or fraudulent" if the insured deliberately withheld information knowing that it was required to be disclosed. Insurers were not entitled to avoid the policy where the insured withheld information in the honest but mistaken belief that the information did not need to be disclosed.

BACKGROUND

Mutual Energy Limited ("MEL") owns and operates the Moyle Interconnector linking the electricity systems of Northern Ireland and Scotland. In June and August 2011 there were two failures of the Moyle Interconnector due to short-circuiting, both of which led to loss of power flow. MEL submitted insurance claims totalling £41,022,504.

Three of MEL’s five insurers agreed to compromise the claim, but the two Defendants (the "Insurers") refused to do so. MEL commenced proceedings. The Insurers defended the claim, arguing that they were entitled to avoid the contract ab initio on the grounds that MEL had deliberately failed to disclose problems with the cables during the construction and commissioning phases in 2000-2001.

Clauses 5 and 6 of the policy provided as follows:

"5. Scope of Disclosure
The Insurers acknowledge that (i) they have received adequate information in order to evaluate the risk of insuring the Company in respect of the risks hereby insured on the assumption that such information is not materially misleading...."

"6. Non-disclosure, misrepresentation and breach
Notwithstanding any other provisions of this policy:
(a) the Insurers agree not to terminate, repudiate, rescind or avoid this insurance as against any Insured, or any cover or valid claim under it, nor to claim damages or any other remedy against any Insured or any agent of any Insured, on the grounds that the risk or claim was not adequately disclosed, or that it was in any way misrepresented, or increased, or that any term, condition or warranty was breached, or on the ground of negligence, unless deliberate or fraudulent non-disclosure or misrepresentation or breach by that Insured is established in relation thereto...."

Coulson J, sitting in the Technology and Construction Court, ordered trial of a preliminary issue on the proper construction of Clause 6. Specifically, he considered whether (as Insurers contended) "deliberate... non-disclosure" included circumstances where an insured was aware of information and was aware that it was not being disclosed to insurers, but held the honest but mistaken belief that it did not need to be disclosed. MEL disputed Insurers’ construction, arguing that, in order for non-disclosure to be deliberate, there must be dishonesty on the part of the insured.

DECISION

Coulson J began his judgment by rehearsing the lucid statement of the principles of contractual construction set out by Lord Justice Clarke in Wood v Sureterm Direct Ltd & Capita Insurance Services. The judge then considered the question of construction by reference to: (1) the words used; (2) the contractual context; and (3) business common sense.

The words used

The dictionary definition of ‘deliberate’ – “carefully thought out, studied, intentional, done on purpose” – in Coulson J’s view suggested that “deliberate...non-disclosure” entailed serious misconduct or culpability. It required that MEL should not only have been aware of the circumstances of the non-disclosure but also that the information withheld was required to be disclosed under the policy. This conclusion was supported by cases considering the meaning of “deliberate default” (De Beers UK Ltd v ATOS) and “deliberate breach” (AstraZeneca UK Ltd v Altimarle International Corp and Another).

Insurers had argued that one should distinguish between, on the one hand, “deliberate breach” or “deliberate default” which they regarded as loaded terms, and on the other hand, “deliberate... non-disclosure” which they argued was neutral. Insurers suggested that only the former involved an element of dishonesty;
NON-DISCLOSURE CLAUSES: WHEN IS A NON-DISCLOSURE "DELIBERATE OR FRAUDULENT"?

the latter did not. However, Coulson J disagreed. He considered that "deliberate non-disclosure" was also a loaded term, shorthand for a breach of MEL’s common law obligation to disclose all relevant material. There was no justification for making the distinction contended for by Insurers.

Insurers had also argued that, to avoid surplusage in Clause 6(a), ‘deliberate’ and ‘fraudulent’ must have different meanings, and it therefore followed that ‘deliberate’ did not require an element of bad faith. However Coulson J held that the presumption against surplusage was not a hard-edged rule. As Lord Justice Gross observed in Ener-G Holdings Plc v Hornell, some surplus language will often be found in commercial contracts. Indeed, arguably the very inclusion of the proviso (or at least the part regarding fraudulent non-disclosure) in Clause 6(a) was surplus, since an insured cannot exclude remedies against their own fraud. However this, like the addition of ‘deliberate’, was the product of an over-zealous draftsman.

In any event, Coulson J was not persuaded that ‘deliberate’ and ‘fraudulent’ necessarily meant the same thing. An insured might deliberately withhold information knowing that it must be disclosed (for example, because the information is embarrassing), yet they would not be acting fraudulently if there was no deceitful intention to obtain an advantage.

The contractual context

Coulson J found that his analysis of the ordinary meaning of the words “deliberate…non-disclosure” was consistent with the contract when read as a whole.

First, in Clause 5 Insurers expressly acknowledged that they had received adequate information, provided that the information given was not materially misleading. In effect therefore Insurers agreed that they had received sufficient information and no further information was required.

Secondly, the general purpose of Clause 6(a) was to exclude a wide range of remedies for numerous causes of action. A proviso which reinstated these remedies for non-disclosure which was the result of an honest but mistaken belief held by the insured would “cut across and render nugatory the wide words of the exclusion in Cause 6”.

Thirdly, had the parties intended a wider proviso to Clause 6(a), they would presumably have reintroduced the possibility of a claim by Insurers for negligent mis-statement. However this was not the case.

Business common sense

Coulson J also held that the interpretation advocated by MEL was consistent with business common sense. The judge observed that the insurance industry had been “bedevilled” by the ability of insurers to avoid a policy altogether due to non-disclosure by insureds, even where that non-disclosure was due to an honest mistake. There were circumstances in which it would be appropriate to include clauses which protect the insured from such draconian remedies. This was just such a clause.

The judge also found that Insurers’ reading of Clause 6(a) would, if correct, lead to commercially illogical results. On Insurers’ analysis: “…MEL would be punished for undertaking a rigorous disclosure exercise because they had made an honest mistake in the disclosure of one material document; but they would not be penalised if they failed to go about the disclosure exercise properly, failed to consider the document in question (or indeed any documents), and simply failed to disclose the file. It cannot be right that MEL should be in a worse position because they made an honest mistake, as opposed to an inadvertent error.”

COMMENT

Under the Marine Insurance Act 1906, insurers’ only remedy for material non-disclosure by the insured is to avoid the policy ab initio. Given the draconian nature of this remedy, insureds would commonly seek to include in their policies clauses which restrict the scope of the duty of disclosure and the remedies available to insurers for breach of that duty. The decision in Mutual Energy demonstrates the courts’ willingness to construe such clauses purposively and, where the wording allows, to ensure that insureds are afforded broad protection. The Insurance Act 2015 introduces a range of proportionate remedies for material non-disclosure and misrepresentation. However the duty of disclosure remains, and doubtless insureds will continue to seek to introduce clauses such as those in the MEL policy in an attempt to limit their duty of disclosure and the remedies available to insurers for breach. It is important for insureds, brokers and insurers to ensure that pre-Insurance Act clauses of this nature are fit for purpose in light of the Insurance Act 2015.

ADDITIONAL REFERENCES

De Beers UK Ltd v ATOS [2010] EWHC 3276 (TCC)
AstraZeneca UK Ltd v Albemarle International Corp and Another [2011] EWHC 1574 (Comm)
Ener-G Holdings Plc v Hornell [2012] EWCA Civ 1059
Wood v Sureterm Direct Ltd & Capita Insurance Services [2015] EWCA Civ 893
Marine Insurance Act 1906 c.41
Insurance Act 2015 c.4
COURT OF APPEAL CONSTRUES AGGREGATION PROVISION IN MINIMUM TERMS AND CONDITIONS OF PROFESSIONAL INDEMNITY INSURANCE

The Court of Appeal has varied the decision of the High Court in AIG Europe Limited v OC320301 LLP and Others and provided further guidance on the construction of the aggregation clause contained in the Minimum Terms and Conditions of Professional Indemnity Insurance (as published by the Solicitors’ Regulation Authority) required to be incorporated into compulsory liability insurance for solicitors. At the first instance decision, Teare J held that, in order to form a "series of related matters or transactions", the relevant transactions had to be dependent on each other. The Court of Appeal held that the appropriate test was whether the transactions had an intrinsic relationship with each other, not an extrinsic relationship with a third factor. The case has been remitted to the Commercial Court to be determined on the facts in accordance with the guidance given by the Court of Appeal.

This decision has been appealed to the Supreme Court and the Supreme Court's judgment is currently awaited.

Tom Leech QC, of the Herbert Smith Freehills advocacy unit, appeared for the Trustees.

BACKGROUND

The dispute relates to underlying claims arising out of services provided by a solicitors’ firm, The International Law Partnership (“ILP”), which had insurance cover with AIG Europe Limited (“AIG”). ILP was engaged by a UK property development company, Midas International Property Development (“Midas”), in connection with two developments of holiday homes in Turkey and Morocco. ILP held funds on behalf of investors, who upon release of the funds became beneficiaries under a trust which was intended to hold security over the land to be purchased. Before the release of funds from the escrow to the local Midas developer the trustees (who were also members of the firm) had to satisfy the Cover Test. On various occasions ILP authorised the release of monies out of the escrow. However, the local Midas companies were unable to complete the contracts for the purchase of the land in Turkey or in Morocco which led to the failure of the two developments. Midas entered liquidation and it was found that all the investment monies held in escrow had been paid out.

214 investors have brought claims alleging that ILP committed breaches of the escrow agreements and failed to apply the Cover Test correctly when releasing the investment funds, with the consequence that the investors have lost over £10 million. The investors allege, inter alia, breach of contract, negligence, breach of fiduciary duty and misrepresentation against ILP.

The MTC aggregation clause

ILP’s cover with AIG has a limit of liability of £3 million per claim and incorporates the aggregation clause contained in clause 2.5 of
Given the importance to the legal profession of the construction of the aggregation clause in solicitors’ professional indemnity insurance, the Solicitors’ Regulation Authority (“SRA”) was granted permission to intervene. The SRA argued that the MTC required a relationship between the matters or transactions. Inter-dependence would satisfy that requirement but there was also room for a wider interpretation, based on at least some “intrinsic connection” between the relevant matters or transactions, not merely a connection with some external common factor.

The Court of Appeal held that the critical question was whether the negligence or breach of duty occurred “in a series of related... transactions”. Longmore LJ considered that the word “series” itself usually implies some connection between the events or concepts which constitute the series but the question then was how that connection or relationship was to be established. There must be an intrinsic rather than a remote relation i.e. a relationship of some kind between the transactions relied on rather than a relationship with some outside connecting factor, even if that extrinsic relationship was connected to the transactions. The Court of Appeal concluded, therefore, that the judge went rather too far when he said that the transactions had to be “dependent on each other” before aggregation could occur and did not think that the terms of the policy require the degree of closeness contemplated by “dependence”.

Given the critical words of the MTC aggregation clause, the Court of Appeal had regard to the background knowledge of the availability of wide aggregation clauses as well as narrow ones. The fact that the aggregation clause contained in the MTC was not formulated in the widest form of aggregation clause indicated that it cannot, therefore, have been intended to have the same width as clauses drafted in such terms. In this regard, the Court of Appeal held that as the express language of the aggregation clause (“a related... transaction”) is both imprecise and deliberately avoids the available wide formulations, it was necessary to imply the unifying factor from the general context. It was for this reason that it concluded that the relationship must be an intrinsic relationship between the relevant transactions.

The Court of Appeal also had regard to the published history of the origin of the aggregation clause which, in its judgment, gives some support to the argument that it was not intended that the phrase “a series of related transactions” be interpreted in such a manner that any relation, however loose, will suffice. It held that there must be some restriction on the concept of relatedness and the most satisfactory approach was that the relation must be an intrinsic not an extrinsic one.

The Court of Appeal was not in a position to make findings of fact for the purposes of the aggregation clause. It considered that there might be the necessary intrinsic relationship if the escrow
accounts or contracts of the investors referred to each other. On the other hand, if there was no such reference then the requisite intrinsic relationship might not arise. The case was therefore remitted to the Commercial Court to determine the facts.

COMMENT

Prior to the first instance decision in this case, there was no authority on the construction of the aggregation clause in the MTC. The test applied by the High Court in construing the phrase "a series of related matters or transactions" went too far in requiring that the matters or transactions had to be dependent on each other. In the Court of Appeal’s judgment the question is whether the matters or transactions have an intrinsic relationship with each other, not an extrinsic relationship with a third factor. This in turn will depend upon the findings of fact. The case also reinforces that, given the availability of wide aggregation clauses, where the parties have chosen a narrower aggregation clause, the court will give effect to that decision.

Professional indemnity insurers and solicitors will wish to consider the implications of the Court of Appeal’s decision in the context of aggregation of claims. Given that the decision focused heavily on the wording in the MTC aggregation clause it may be that it will have limited application outside the realm of solicitors’ professional indemnity insurance.

While the Court of Appeal’s decision provides greater scope for aggregation of claims than the first instance decision where there is an intrinsic relationship between the relevant matters or transactions, there is likely to remain room for argument on the facts on whether or not the relevant intrinsic relationships exists. What is clear, however, is that the relevant matters or transactions need not be inter-dependent, but conversely a relationship with some outside connecting factor (such as commonality of geography) will not be sufficient for them to be aggregated.

As noted above, this decision has been appealed to the Supreme Court and we await that decision with interest.

ADDITIONAL REFERENCES

AIG Europe Ltd v OC320301 LLP [2015] EWHC 2398 (Comm)
In The Mayor’s Office for Policing and Crime v Mitsui Sumitomo Insurance the Supreme Court allowed the appeal and reinstated the finding of Mr Justice Flaux at first instance that consequential losses are not recoverable under the Riot (Damages) Act 1886 (“RDA”) in relation to the looting and burning down of a warehouse during the 2011 London riots. The appeal concerned only one issue: whether as a matter of statutory construction persons who suffer loss when rioters destroy their property can in principle obtain compensation for losses, including loss of profits and loss of rent, under section 2 of the RDA, and if so on what basis. Lord Hodge (with whom Lord Neuberger, Lord Clarke, Lord Hughes and Lord Toulson agreed) gave the judgment of the Supreme Court finding that the answer to the question was not found in linguistic analysis of the RDA itself which did not provide a clear-cut answer but rather by interpreting the RDA against the backdrop of the prior legislative history which showed that the intention of Parliament had been only to cover certain categories of property damage losses.

BACKGROUND

During the London riots of August 2011, a Sony distribution warehouse in Enfield was looted and set alight by a gang of youths. The warehouse and its contents were completely destroyed by the fire. Sony occupied the warehouse and its insurers paid out for losses of £49.5 million, including £9.8 million in respect of business interruption. The insurers of the building owners also paid out. Further losses were suffered by the owners of the contents (and their insurers). The insurers, and third parties who had lost uninsured stock, claimed against the compensation authority under the RDA for their losses including both property damage and consequential losses.

The RDA provides compensation for losses caused by riot damage. Under section 2(1):

“Where a house, shop, or building in a police area has been injured or destroyed, or the property therein has been injured, stolen, or destroyed, by any persons riotously and tumultuously assembled together, such compensation as hereinafter mentioned shall be paid out of the police fund of the area to any person who has sustained loss by such injury, stealing, or destruction; but in fixing the amount of such compensation regard shall be had to the conduct of the said person, whether as respects the precautions taken by him or as respects his being a party or accessory to such riotous or tumultuous assembly, or as regards any provocation offered to the persons assembled or otherwise”.

At first instance Flaux J determined two preliminary issues, including relevantly whether the obligation to compensate under the RDA extended to consequential losses. He found that such losses were not covered by the Act, placing particular weight on the wording of the repealed preamble (which referred to compensation “for” property damage) and of section 7 of the RDA (which refers to loss “from” property damage in relation to the “building and property therein”).

The Claimants appealed against Flaux J’s finding on this issue and the Court of Appeal allowed the appeal. It applied a liberal construction and found nothing in the RDA to exclude consequential losses. Unlike Flaux J, the Court of Appeal considered it permissible to look at the legislative history behind the RDA as a guide to its construction. It considered that the RDA

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provided a right to compensation for all losses, including consequential losses, proximately caused by the physical damage to property by the rioter ‘as trespasser’ (ie. applying the rules of causation in tort), save to the extent that such compensation was excluded or varied by the RDA.

The compensation authority appealed this finding to the Supreme Court.

**DECISION**

The Supreme Court held that linguistic analysis of the RDA by itself does not provide a clear-cut answer to the question of whether the RDA covers consequential losses. The resolution was rather to be found in “history rather than legal theory” by construing the words of the RDA against the backdrop of the prior legislative history. It focused on tracing the development of the RDA from its embryonic beginnings in the Riot Act 1714 under which the ‘hundred’ or community held the place of the compensation authority under the RDA. The open-textured wording of the 1714 Act, referring to recoverable damages suffered “by such” property destruction, was extended by 18th and 19th century case law and the following Seditious Meeting Act 1817 to include the contents of a building but no further. Over time, the class of property covered was extended still further (in part to account for the impact of the industrial revolution). However, there was no historical extension of liability for consequential loss. The RDA did not alter the basis on which compensation would be paid but rather made changes to the arrangements for the compensation scheme, such as transferring the liability to pay compensation from ‘the hundred’ to the local police authority as the compensation authority.

The judgment of the Court of Appeal had highlighted the fact that the statute did not exclude the recovery of consequential loss and that under the RDA the compensation authority (and previously the hundred) stood as surety for the rioter ‘as trespasser’ such that there was no reason to think that the rioter would not have been liable in tort for consequential losses. The Supreme Court disagreed, stressing that there was no suggestion that Parliament had ever intended that the compensation scheme should mirror the offenders’ liability in tort. To the contrary, the RDA provides only partial compensation for loss (for example, there is no cover for personal injury or damage to property such as a car parked in the street). The severity of the Riot Act 1714 and following legislation (introducing the death penalty for offenders) drew a line between trespass and riot.

As a result of this historical interpretation of the statute, the Supreme Court held that the RDA represented a self-contained statutory scheme to compensate specific losses in the event of riot. The RDA was not intended to mirror the law of tort but instead to legislate to ensure that the local authority supported those who suffered loss from a rare and specific event. Consequential losses fell outside of the statutory schemes that preceded the RDA for these events and therefore should be interpreted as falling outside of the statutory scheme of the RDA.

The appeal was accordingly allowed, restoring Flaux J’s decision on this point at first instance.

**COMMENT**

The decision of the Supreme Court conclusively answers the question of whether the RDA covers consequential – or ‘business interruption’ – losses, in the face of vacuum of previous authority on the point. The outcome is bad news for insurers and uninsured property owners and occupiers pending the Riot Compensation Act 2016 (“RCA”) coming into force (see below) although it is perhaps unsurprising in view of the generally perceived wisdom that the RDA does not extend to consequential losses.

As we have commented previously, the proper construction of the RDA is far from black and white. The RDA compensates victims who have “sustained loss by” injury, destruction or theft in respect of buildings and contents. The relevant provisions of the RDA do not provide for compensation against all losses suffered by the victim (for example, personal injury and some property damage losses are not covered) but nor do they expressly exclude consequential losses. As in the Yarl’s Wood litigation (see Yarl’s Wood Immigration Ltd v Bedfordshire Police Authority), this case further illustrates the willingness of the courts to look back into history and trawl through predecessor legislation and case law – in this instance as far back as the time of King Cnut prior to the Norman conquest – to establish what Parliament intended.

Insurers may however already be steeling against the impact of this decision which brings forward their inability to recover such consequential losses under new legislation. In that regard, due to the unprecedented impact of the 2011 riots and archaic language of the RDA, the Government commissioned an independent report on the RDA published on 8 November 2013 leading to a public consultation in 2014 on the reform of the RDA. A response to the consultation was published on 12 March 2015 along with a draft Bill. The RCA received Royal Assent on 23 March 2016 and will come into force when commencement regulations are passed (as yet there is no indication as to when this will be). The RCA repeals the RDA and creates a new compensation scheme which in many aspects continues to reflect the RDA but has been substantially overhauled and updated.

Among the key reforms provided for by the RCA, compensation will be capped at £1 million per claim (although this can be changed by regulations) and consequential losses will be expressly excluded (except for the cost of alternative accommodation if the victim’s home is rendered uninhabitable).
AUGUST 2011 RIOTS: CONSEQUENTIAL LOSSES NOT RECOVERABLE UNDER THE RIOT (DAMAGES) ACT 1886

Other key reforms include as follows:

- The scope of the property covered is increased. The RDA covers only loss or damage to a house, shop or building (and loss, damage or theft of contents). The RCA encompasses a wider class of property, including for example certain motor cars, buildings being constructed and property kept on land being used for the purpose of the claimant’s business;

- Compensation will be excluded in respect of damage to prisons, immigration centres and similar locations from the scheme. This last reform was made to counter the effect of the decision of the Court of Appeal in the Yarl’s Wood litigation which determined that claims could be made by claimants even if they had custodial powers in relation to the rioters;

- Regulations may prescribe in detail the basis upon which compensation will be calculated, the aim being consistency with the insurance industry. It appears contemplated in particular that claims may be paid on a new-for-old basis rather than old-for-old under the RDA;

- Interim payments may be made in respect of a claim under the RCA;

- There will be minimum time periods for notifying a claim to the relevant authority (42 days from the date of the riot) and, thereafter, submitting evidence and details in support of a claim (90 days from the date when the claim has been notified); and

- The claims process will be streamlined and decision making authority may be delegated – for example, claims handling may be outsourced to loss adjusters.

The 2011 riots laid the public purse open to a huge volume of claims under the RDA. The underlying object of the RCA is to limit that exposure and focus compensation on the public policy aim of protecting those who most need such support. The question for insurers is whether, or at what price, they are prepared to cover riot damage losses that do not fall for compensation under the RCA. The RCA – and indeed the decision of the Supreme Court in the Mitsui case – may, therefore, impact the availability, pricing or other terms of insurance against property damage caused by riot, not least in high risk areas. In the long-run, the new legislation could have adverse implications for property owners and occupiers – particularly SMEs – who cannot obtain or afford insurance cover against riot damage losses, absorb property damage losses in excess of the £1 million compensation cap or fund business interruption losses which may well significantly exceed property damage losses.

ADDITIONAL REFERENCES

Yarl’s Wood Immigration Ltd v Bedfordshire Police Authority [2009] EWCA Civ 1110
Mitsui Sumitomo Insurance Co (Europe) Ltd v Mayor’s Office for Policing and Crime [2013] EWHC 2734 (Comm)
Mitsui Sumitomo Insurance Co (Europe) Ltd v Mayor’s Office for Policing and Crime [2014] EWCA Civ 682
Riot Act 1714
Seditious Meeting Act 1817
Riot (Damages) Act 1886
Riot Compensation Act 2016
COMMERCIAL COURT FINDS ENGLAND TO BE THE NATURAL FORUM FOR A DISPUTE INVOLVING A GLOBAL INSURANCE POLICY BUT THAT DUAL PROCEEDINGS IN AUSTRALIA NOT VEXATIOUS OR OPPRESSIVE

The Commercial Court has held that England is the appropriate forum to determine a coverage dispute under global insurance policies which were issued in England and governed by English law but which lacked a jurisdiction clause.

However, the Court declined to grant an anti-suit injunction restraining parallel proceedings in Australia. The Court found that whilst the issue of such proceedings in a foreign court might have been tactical it was a legitimate step to have taken and did not amount to unconscionable conduct. The Court also held that the proceedings in Australia, which included claims under both the insured’s local underlying Australian policy and the global policies, should proceed first on the basis that determining the parties’ positions under the local policy is a logical first step to determining their positions under the global policies.

Herbert Smith Freehills acted for the Defendant insured in this case.

BACKGROUND
The matter concerned two jurisdiction applications in the Commercial Court arising out of proceedings issued in both England and Australia concerning an insurance policy dispute between the Claimant insurer, AXA, and the insured Defendant, an Australian subsidiary of Weir Group plc (“Weir”).

The Insurance Policy Dispute
Weir was defendant to arbitration proceedings in Australia bought by a Philippines mining company. Although the tribunal ultimately found Weir not to be liable, Weir had, prior to the issue of the award, entered into a confidential agreement under which it agreed to pay the claimant mining company a minimum confidential amount (the “Collar”) and to cover its own defence costs regardless of the outcome of the arbitration proceedings. Weir sought to recover the Collar and its defence costs from Axa.

At the relevant time AXA insured Weir under two sets of policies which formed part of a worldwide, integrated liability insurance programme:

1. A local Australian Policy arranged in Australia between AXA’s Australian branch and the Australian office of Weir’s insurance broker (the “Australian Policy”).

2. Global policies written on the London market and arranged in England between AXA’s London branch and Weir’s insurance broker in London on behalf of the Weir group (the “Global Policies”).

The Global Policies made clear that they provided cover on a DIC/DIL (difference in conditions/difference in limits) basis, the effect being that the Global Policies would only respond to the extent that the limit in the local underlying policy (in this case the Australian Policy) is exceeded and/or the local underlying policy does not respond to the whole or part of the claim by reason of its
COMMERCIAL COURT FINDS ENGLAND TO BE THE NATURAL FORUM FOR A DISPUTE INVOLVING A GLOBAL INSURANCE POLICY BUT THAT DUAL PROCEEDINGS IN AUSTRALIA NOT VEXATIOUS OR OPPRESSIVE

scope. On the facts therefore Weir had to look to the Australian Policy first and then to the Global Policies. It was accepted by the parties that sums that Weir was claiming fell within the limit of indemnity of the Australian Policy.

Neither the Global nor Australian policy contained a jurisdiction clause. The Global Policies contained a clause which in effect amounted to a choice of English Law.

Following notification of the underlying dispute to the Australian and the Global Policies, AXA maintained that coverage was not available.

In August 2015, AXA issued a claim in the Commercial Court under the Global Policies for declaratory relief (the “English Proceedings”). Permission was granted to serve on Weir out of jurisdiction however the claim was not served on Weir until 10 March 2016.

In the meantime, on 8 March 2016, Weir issued and served proceedings in New South Wales on AXA seeking indemnity under the Australian Policy or alternatively the Global Policies (the “Australian Proceedings”).

The Applications

There were two applications before the Court:

1. AXA’s application for an anti-suit injunction to restrain Weir from pursuing the Australian proceedings insofar as they related to the Global Policies. AXA did not seek to restrain Weir from pursuing its claim in Australia under the Australian Policy but maintained that England was the appropriate forum for a claim in relation to the Global Policies and that the English Proceedings should go first.

2. Weir’s application seeking to set aside the Order of the Commercial Court granting AXA permission to serve the English Proceedings on Weir out of jurisdiction on the basis that AXA could not show that England was the proper place to bring the claim.

The effect of the two applications was that AXA wanted the claim under the Global Policies to be determined first in the English Court followed by a determination by the Court in New South Wales if the position under the Australian Policy became relevant. Weir, on the other hand, wanted all matters determined by the Court in New South Wales.

DECISION

Mr Justice Blair refused both applications. On the question of natural forum, he recognised that this was a balanced debate but held ultimately that England was the natural forum for the determination of the dispute in relation to the Global Policies. The decisive factor was that the Global Policies were subject to what was in effect a choice of English law clause. Where the primary

issues in a case concern the construction and application of terms in an insurance policy written in England and subject to English law, the governing law is a significant factor in favour of English jurisdiction. He also noted that in cases concerned with insurance written on the London market and governed by English law there is a strong tendency for the court to consider England as the natural forum. Blair J held that the Global Policies stood at the apex of a worldwide, integrated liability insurance programme which AXA provided for the Weir group and that since such policies are widely held by AXA and generally governed by English Law, it is desirable that key provisions are construed by the English Courts.

Turning to the question of whether Weir’s pursuit of the Australian Proceedings was vexatious and oppressive (which AXA was required to show in order to succeed in its anti-suit injunction absent a jurisdiction clause), Blair J held that it was not. Neither the fact that Weir’s claim under the Global Policies was bought in a forum other than the natural forum, nor the risk of inconsistent judgments, were in themselves grounds to grant an anti-suit injunction. The issue of the Australian Proceedings may have been a tactical move on Weir’s part in the sense that it intended to strengthen its aim of having its insurance claim tried in Australia but that was not an illegitimate aim nor does it amount to unconscionable conduct.

Blair J rejected AXA’s submission that the English Proceedings should go first. He accepted Weir’s submission that, since AXA is liable under the Global Policies only to the extent that indemnity is not available under the Australian Policy, determining the parties’ positions under the Australian Policy is a logically anterior step to determining their positions under the Global Policies. Accordingly the English Proceedings should be stayed pending resolution of the claim under the Australian Policy. Should the claim under the Global Policy remain relevant then the position could be reviewed and the English Proceedings could be determined if necessary. As to the course of action to be taken in Australia, Blair J rightly recognised that such decisions were solely for the Australian Court.

COMMENT

The judgment reiterates the challenges a party will face to show vexatious and oppressive conduct of the sort that will justify the granting of an anti-suit injunction in the absence of a contractual jurisdiction clause. In a finely balanced debate the point that was decisive was that the Global Policies were subject to what was in effect a choice of English law.

Policyholders considering similar global insurance arrangements should seek to secure policy wording that ensures that where a dispute arises which engages both a local and global policy, the dispute in relation to both policies will be determined in the same jurisdiction as part of the same proceedings. This will minimise the costs and case management impact of having to run separate proceedings under two interconnected policies.
TIMING OF NOTICES OF ABANDONMENT AND COSTS TO BE CONSIDERED FOR A CONSTRUCTIVE TOTAL LOSS

In Connect Shipping v The Swedish Club the Commercial Court considered whether a Notice of Abandonment (“NOA”) was served too late by an insured and whether recovery and repair costs incurred pre-NOA should form part of the calculation of a constructive total loss (“CTL”). In delivering its judgment, the Court departed from earlier decisions on similar questions and thus potentially widened the scope for future CTL claims, both in terms of numbers and time.

BACKGROUND

The Claimants were the owners of a vessel, the MV Renos (the “Owners”). The vessel was insured with the Defendants (the “Insurers”) under hull and machinery policies, which contained the Institute Time Clauses – Hulls (1/10/83). The vessel was also insured with the first Defendant only under an increased value policy, incorporating the Institute Time Clauses – Hulls Disbursement and Increased Value (Total Loss Only) Clauses (1/10/83).

In August 2012, the MV Renos was in the Red Sea off the Egyptian coast and laden with cargo. A fire broke out in its engine room and the vessel sustained significant damage. To recover the vessel, the Owners engaged salvage operators under a special compensation protection and indemnity clause (“SCOPIC”). The MV Renos was ultimately towed to Suez for inspection and to assess the extent of the damage.

It was common ground that the casualty was an insured peril under the policies. The dispute was over the measure of indemnity, the Owners seeking indemnity on a CTL basis and the Insurers contending that the Owners were entitled to indemnity on a partial loss basis only.

DECISION

The claim raised a number of issues considered by Mr Justice Knowles in the Commercial Court. The key ones are considered below.

Was the NOA given too late?

Under section 62(3) of the Marine Insurance Act 1906, a NOA “must be given with reasonable diligence after the receipt of reliable information of the loss, but where the information is of a doubtful character, the assured is entitled to a reasonable time to make inquiry”.

In this case, the Owners gave NOA to the Insurers on 1 February 2013, some six months after the damage was sustained. Nonetheless Knowles J did not consider that the NOA was given too late. The judge made clear that the test of whether an NOA was given within a reasonable time depended on the particular circumstances of each case. In this case, he accepted that relevant factors to be considered included the nature of the casualty, its impact on the complexity of obtaining reliable information, the existence of conflicting opinions on the amount of the repair costs, and the involvement of Insurers in providing that conflicting information.

The nature of the loss in this case was such that achieving reliable information was a complex task and took time. The Owners were in receipt of conflicting information on the estimated cost of repairs, including from the Insurers’ own appointed loss adjusters (who repeatedly suggested that the vessel was well short of a CTL). In those circumstances Knowles J confirmed that “it was not realistic to take once source in isolation; the presence of conflicting information from other sources threw the reliability of any one source into question”. He also made clear the need to distinguish between the calm of the courtroom and the moving situation at the time of the adjustment.

In light of the conflicting information contained in initial adjustment estimates, Knowles J considered that the drafting of a repair specification and the seeking of repair quotations from shipyards were appropriate steps for the Owners to have taken prior to giving the NOA. The Owners had been entitled to take their time and consider the information available before deciding whether to serve an NOA. He made clear that whilst it was important to distinguish knowledge of the facts of the loss from the proper conclusions to be drawn from them, the work in this case was to ascertain what repairs were required. The cost of those repairs was “on the ‘fact’ rather than the ‘conclusion’ side of the distinction”. He was also unimpressed by the Insurers’ approach which “included stages that seemed designed simply to press the Owners into agreeing a partial loss figure”.

The NOA given on 1 February 2013 was therefore found still to be within the reasonable timeframe envisaged by statute. Although acknowledging that an insured cannot strive for absolute certainty...
TIMING OF NOTICES OF ABANDONMENT AND COSTS TO BE CONSIDERED FOR A CONSTRUCTIVE TOTAL LOSS

when assessing costs, Knowles J accepted that a delay in service of the NOA would be justified where the complexity of a matter complicated the insured’s task of obtaining reliable information.

**Should the cost of recovery and repair incurred before the NOA be included in the total loss calculation?**

Pursuant to section 60(2) of the Marine Insurance Act 1906, there is a CTL “in the case of damage to a ship, where she is so damaged by a peril insured against that the cost of repairing the damage would exceed the value of the ship when repaired”.

Insurers argued that the cost of recovery and repair to be taken into account for these purposes ought to be limited to the cost of recovery and repair after NOA. Knowles J disagreed and held that pre-NOA recovery and repair costs should be included in the CTL calculation. There was no basis to find otherwise, either in principle or based on the policy wording in this particular instance.

First, Knowles J clarified that an NOA is not an “essential ingredient” of a CTL, but only of the right to claim for a CTL. The existence of a NOA, or the time when it was given, was therefore irrelevant when calculating the amount of the loss.

Second, Knowles J referred to clauses in both of the Institute Time incorporating into the Owners’ policies, which provided:

“No claim for constructive total loss based upon the cost of recovery and/or repair of the Vessel shall be recoverable hereunder unless such costs would exceed the insured value...”

Knowles J found that there was no indication that costs incurred before the NOA should be excluded. The clause simply contemplated that the insured had to compare the costs of recovery and repair to the insured value before being able to recover.

Third, Knowles J found that the Marine Insurance Act did not suggest a different conclusion. The wording of section 60(2)(ii) referred to the “cost of repairing the damage”, being the damage to a ship by a peril insured against and “not some part of that cost or that cost for a period commencing other than when the ship is damaged”.

The word ‘future’ in that sub-section of the Act (“account is to be taken of the expense of future salvage operations and of any future general average contributions to which the ship would be liable if repaired...”) merely intended for future costs to be considered in the CTL calculation in addition to, not at the expense of, past and present expenses. Knowles J accepted that in so finding, he was declining to follow the previous decision in The Medina Princess on the issue.

Finally, Knowles J was not persuaded by Insurers’ argument that if the Owners were correct there would be double-counting, with pre-NOA costs being taken into account both in calculating the CTL and potentially by way of recovery as a separate additional sue and labour indemnity. He made clear that the two were different in nature; the CTL calculation was undertaken to determine the cost of repair, whereas entitlement to the additional sue and labour indemnity was a matter for the policy terms.

**Should the remuneration paid to salvors under the SCOPIC be included in the total loss calculation?**

It was not disputed that salvage operations were necessary, and salvors were engaged under a Lloyd’s Open Form containing the SCOPIC. Insurers argued that certain elements of the SCOPIC remuneration paid to the salvors was not properly a ‘cost of repair’ as it was an additional payment made to encourage the salvors to minimise the environmental damage following a casualty. They also pointed to Paragraph 15 of the SCOPIC which provides:

“any liability to pay such SCOPIC remuneration shall be that of the Shipowner alone and no claim whether direct, indirect, by way of indemnity or recourse or otherwise relating to SCOPIC remuneration in excess of the Article 13 Award shall be made in General Average or under the vessel’s Hill and Machinery Policy by the owners of the vessel”.

Knowles J held that as a matter of construction the SCOPIC remuneration formed part of the cost of repair and was to be included in the calculation of a CTL.

**What level of contingency should be applied to the costs of repair?**

The Owners and the Insurers accepted the need to allow a contingency in respect of post-NOA repairs but disagreed as to the amount: the Owners argued for a contingency of 10% and the Insurers 5%.

The judge followed the decision of Mr Justice Flaux in the Brilliante Virtuoso. There the Court emphasised that in matters which cannot be determined with precision (such as damage to items that cannot be inspected) the Court should apply to any repair estimate a ‘large margin’, in that case in excess of a contingency of 10%. In that light Knowles J found that a general margin of 10% would neither be exaggerated nor overly generous, but serve as a ‘suitable allowance for uncertainty’. Whilst accepting that the exact size of the contingency was a matter of judgment in each case, he conceded that the complexity of this matter, and the resulting extent of uncertainty, swayed his decision in favour of the Owners. In particular, he identified “the nature of the casualty, the location of the vessel [and] the range of estimates and quotations” as decisive factors in his decision.
COMMENT

The decision brings welcome clarity on a number of issues, in particular the right for policyholders to include in calculating whether a loss is a CTL any recovery or repair costs incurred prior to the date of the NOA (where there had been previous decisions indicating to the contrary). It also serves to make clear that following the Brilliante Virtuoso case, the Courts are unlikely to consider a contingency of 10% unusual.

Whilst the adequacy of timing of the NOA will continue to be a question of fact in each case, the decision suggests that policyholders have greater leeway, at least where the circumstances of a matter are sufficiently complex. Insurers will need to take care that if they muddy the waters by putting forward low adjustment figures in order to encourage acceptance of a partial loss, that may of itself give the insured a longer period within which to carry out enquiries as to whether there is a CTL.

Ultimately, therefore, the MV Renos is likely to provide comfort to policyholders engaged in complex claims adjustment that reasonable steps taken to accurately ascertain the cost of repairs before giving NOA will not be held against them.

ADDITIONAL REFERENCES

Yelmville Ltd v Yorkshire Insurance Company Ltd (The "Medina Princess") [1965] 1 Lloyd’s Rep 36
Suez Fortune Investments Ltd v Taibot Underwriting Ltd & Ors (The “Brilliante Virtuoso”) [2015] 1 Lloyd’s Law Rep 651
SUPREME COURT DECLINES TO PIERCE CORPORATE VEIL FOR AN EMPLOYER’S BREACH OF ITS DUTY TO PROCURE APPROPRIATE EMPLOYERS’ LIABILITY INSURANCE

In Campbell v Gordon the Supreme Court held that a director of a company was not personally liable in damages to an employee of that company for the company’s failure to procure appropriate employers’ liability insurance. In reaching this decision, on a strict reading of the statute the majority of the Supreme Court took what the minority characterised as a “formalistic” approach to statutory interpretation.

BACKGROUND
The appellant, Mr Campbell, was employed as an apprentice joiner by a company of which the respondent, Mr Gordon, was the sole director. In June 2006 Mr Campbell suffered an injury at work.

In breach of its obligations under section 1(1) of the Employers’ Liability (Compulsory Insurance) Act 1969 (the “1969 Act”), the company did not have appropriate employers’ liability insurance in place to cover Mr Campbell’s accident. The company itself went into liquidation in 2009. Mr Campbell therefore sought to hold Mr Gordon, as the director, liable in damages for the company’s failure to provide adequate insurance cover.

The claim was upheld at first instance but dismissed on appeal. The question for the Supreme Court was whether civil liability attached to the director for the company’s failure to procure appropriate employers’ liability insurance.

Employer’s duty to insure
Section 1(1) of the 1969 Act places a duty on the employer as follows:

“Insurance against liability for employees. Except as otherwise provided by this Act, every employer carrying on any business in Great Britain shall insure, and maintain insurance, under one or more approved policies with an authorised insurer or insurers against liability for bodily injury or disease sustained by his employees, and arising out of and in the course of their employment in Great Britain in that business…” (emphasis added).

The penalty for failure to comply is set out at Section 5:

“Penalty for failure to insure. An employer who on any day is not insured in accordance with this Act when required to be so shall be guilty of an offence …; and where an offence under this section committed by a corporation has been committed with the consent or connivance of, or facilitated by any neglect on the part of, any director, manager, secretary or other officer of the corporation, he, as well as the corporation shall be deemed to be guilty of that offence and shall be liable to be proceeded against and punished accordingly.” (emphasis added)

Three points are significant:
1. The statute by its terms imposes the duty to insure on the corporate employer, not the directors or officers.
2. The consequence of failure to comply with the duty is that the employer is guilty of a criminal offence; no civil liability is imposed.
3. The veil of incorporation is pierced for a limited purpose where an offence is committed by the company, and then in defined circumstances imposes equivalent criminal liability on the director or other officer on the basis, not that he is directly responsible, but that he is “deemed to be guilty” of the offence committed by the company.

Mr Campbell’s argument
Mr Campbell’s counsel accepted that as a general rule, where a statute imposes an obligation and imposes a criminal penalty for failure to comply, there is no civil liability. However, he argued that this is subject to exceptions, including where “upon the true construction of the Act it is apparent that the obligation or prohibition was imposed for the benefit or protection of a particular class of individuals, as in the case of the Factories Acts and similar legislation” (per Lord Diplock, Lonrho v Shell Petroleum (No 2), at 185). He argued that this exception applied to Mr Campbell’s case because the duty in question was imposed for the protection of employees such as Mr Campbell.

By way of analogy, this exception was applied to a failure to insure in the context of compulsory motor insurance in the case of Monk v Warbey. In that case the Court of Appeal held that, where the owner of a car permitted its use by a person uninsured against third party risks and injury to a third party was caused by the...
negligent driving of that person, the owner was liable in damages to that third party for breach of his statutory duty to insure.

DECISION

The Supreme Court, by a majority of three to two, rejected Mr Campbell’s argument. Lord Carnwath, giving the leading judgment, held that whilst Lord Diplock’s exception may allow civil liability to attach to a person who is bound by a statutory obligation, there is no suggestion that a person can be made indirectly liable for breach of an obligation imposed by statute on someone else. In this case the obligation to insure was imposed on the company (not the director). Lord Carnwath held that there was no basis in case law for looking through the corporate veil to impose civil liability on directors or other individuals through whom the company acts. That can only be done if expressly or impliedly justified by the statute.

The case of Monk v Warbey was distinguished. The relevant legislation made it illegal to use or to cause or permit any other person to use a motor vehicle without third party motor insurance. In that case Parliament dealt specifically with both the user, and any person causing or permitting the use, and determined to impose direct responsibility on each. In contrast the 1969 Act imposes direct responsibility only on the employer. Parliament had recognised that a director or officer may bear some responsibility for the failure to insure, but dealt with it not by imposing direct responsibility equivalent to that of the company, but by a specific and closely defined criminal penalty, itself linked to the criminal liability of the company.

COMMENT

Whilst this decision will no doubt be of comfort to company directors, it should be noted that the decision was not unanimous. The Supreme Court was divided on the fundamental question of the approach to statutory interpretation. The decision of the majority relied on a strict interpretation of the language of the statute. Lord Carnwath expressly rejected the notion that the issue might depend on “general questions of fairness”. By contrast, Lord Toulson and Lady Hale, dissenting, took a more purposive approach to statutory interpretation and looked to “the function, substance and effect of the obligation to procure employers’ liability insurance in real terms”. In their view, the legislation was intended for the protection of employees and the form of the language used in the 1969 Act did not preclude a civil right of action against the directors.

ADDITIONAL REFERENCES

Employers’ Liability (Compulsory Insurance) Act 1969
Monk v Warbey [1935] 1 KB 75
Lonrho Ltd v Shell Petroleum Co Ltd (No 2) [1982] AC 173
SUPREME COURT RULES THAT A "COLLATERAL LIE" IS IMMATERIAL TO THE INSURANCE CLAIM

The Supreme Court held that policyholders who advance otherwise valid insurance claims by lies which are irrelevant to their rights to recover do not forfeit their claims under the policy: "the lie is dishonest but the claim is not". In doing so, the Supreme Court overruled the decision of the Court of Appeal, and rejected the analysis of the law by Mance LJ (as he then was) in Agapitos v Agnew (The Aegeon) (on which the Court of Appeal decision had been based) that an insured who supports a valid claim with a lie forfeits his claim.

BACKGROUND

The Appellants (the “Owners”) were owners of the DC Merwestone, a cargo ship (the “Vessel”). The main engine was damaged beyond repair by the ingress of water into the engine room. The Owners claimed for the damage under their marine insurance policy (the “Policy”) underwritten by the Respondents (the “Underwriters”).

The Underwriters denied liability on a number of grounds, including on the bases that:

- the loss was not caused by an insured peril;
- the Owners were aware that the Vessel was unseaworthy when it was sent to sea and accordingly under section 39(5) of the Marine Insurance Act 1906 the Underwriters were not liable for loss attributable to the fact that the Vessel was unseaworthy at the commencement of the voyage; and
- the Owners forfeited their claim when one of the Vessel’s managers lied about the circumstances of the water ingress.

Mr Justice Popplewell at first instance held that the loss was caused by an insured peril, namely the fortuitous entry of seawater through the sea inlet valve during the voyage, and the Owners were not aware that the Vessel was unseaworthy at the commencement of the voyage. The Policy excluded cover for losses caused by want of due diligence by the Owners but the judge held that, contrary to the Underwriters’ arguments, the loss was not caused by want of due diligence of the Owners. The loss was therefore in principle covered under the Policy.

In advancing the Owners’ claim, however, Mr Kornet, one of the managers of the Vessel, told the Underwriters that the Master and crew of the Vessel had claimed to have heard the bilge alarm begin sounding hours before water was seen under the floor plates but the crew had been unable to investigate or deal with the leak because of the rolling of the ship in heavy weather. This was a lie told to prevent it from appearing that the Owners had not exercised due diligence and to encourage Underwriters to grant an indemnity sooner.

Mr Justice Popplewell considered himself bound to hold that an insured who advances an otherwise wholly valid claim by fraudulent means or a fraudulent device forfeits the entire claim, although he considered the result disproportionate and reached this decision with some regret.

COURT OF APPEAL DECISION

The Court of Appeal held that the judge had been entitled to find that the Owners were at least reckless as to whether Mr Kornet’s explanation for the flooding was supported by the crew’s recollection. Mr Kornet’s untruth was directly related to and intended to promote the claim. The Court of Appeal applied Mance LJ’s analysis of the law in The Aegeon on the following bases:

- whilst not binding, The Aegeon is authoritative;
- a fraudulent device is a sub-species of a fraudulent claim;
- there is a public policy justification for the rule that policyholders who advance fraudulent claims, or valid claims by fraudulent devices, forfeit their claims;
- the Law Commission proceeded on the basis that fraudulent devices fall within the fraudulent claims doctrine;
- case law provided some support for the application of the fraudulent claim rule to fraudulent devices; and
- The Aegeon was cited without disapproval in a number of subsequent cases and academic authorities.

SUPREME COURT DECISION

The Supreme Court, by a majority of four to one (Lord Mance dissenting) allowed the Owners’ appeal and accordingly judgment was entered in favour of the Owners.
Lord Sumption, with whom Lord Clarke, Lord Hughes and Lord Toulson agreed, delivered the leading judgment.

**The fraudulent claims rule**

Insurers are not liable at common law to pay fraudulent claims. “Fraudulent claims” include (1) claims which are wholly fabricated; and (2) legitimate claims which have been dishonestly exaggerated. In these situations, the insurer is not liable (even, in the second instance for the legitimate portion of the claim). The question before the Supreme Court was whether a justified claim supported by “dishonestly embellished” information is also forfeited. The rationale of the fraudulent claims rule is the deterrence of fraud. By providing that insureds who make fraudulent and fraudulently exaggerated claims forfeit any claim, the law protects insurers from a “one way bet” in which if the insured is caught, he loses nothing, and if he is not caught he stands to benefit.

"Collateral lies", not “fraudulent devices”

Lord Sumption noted that such embellishments have been described as "fraudulent devices" but rejected this expression as "archaic" and failing to describe the problem. He adopted (as did Lords Clarke, Hughes, and Toulson) the expression “collateral lies”, meaning lies which, when the facts are found, are not relevant to the insured’s right to recover.

**Collateral lies distinguished from fraudulent and fraudulently exaggerated claims**

An insured’s right of indemnity arises as soon as he suffers loss. Lord Sumption distinguished between (a) fraudulently exaggerated and fraudulent claims; and (b) justified claims supported by collateral lies. In the former case, an insured seeks something to which he is not entitled. The law declines to sever the honest part of the claim from the invented part. In the case of the latter, Lord Sumption said “the lie is dishonest, but the claim is not”. The immateriality of the lie makes it “not just possible but appropriate to distinguish between them”.

If the fraudulent claims rule applied to valid claims supported by collateral lies, however, insurers would be protected from their obligation to pay an indemnity for which they have been liable in law ever since the loss was suffered”. This suggested that the fraudulent claims rule should not be applied to valid claims supported by collateral lies.

**The anomaly of no requirement of inducement**

Lord Sumption considered the fact that an insured might forfeit his claim by telling a collateral lie, irrespective of whether the insurer relied on that lie, an anomalous result in civil law. Claims in deceit, for rescission of a contract for misrepresentation, and indeed to avoid an insurance contract for material misrepresentation or non-disclosure all require that the claimant establish that the defendant’s misrepresentation or lie induced it to act upon it. If an insured forfeited an otherwise valid claim by telling a collateral lie, irrespective of whether the insurer relied upon it, this would be anomalous.

**The materiality threshold**

The Underwriters contended that the only connection between the collateral lie and the claim which was required for the fraudulent claims rule to bite was that the lie was material to the merits of the claim as they would have appeared to a hypothetical insurer at the time the lie was uttered. In The Aegeon, Mance LJ (as he then was) had tentatively suggested that a lie would be material if it led to a “not insignificant improvement” in the insured’s prospects. Christopher Clarke LJ suggested in the Court of Appeal that the materiality threshold should be whether the lie led to a “significant improvement” and Lord Mance endorsed this proposal in his dissenting judgment.

Lord Sumption rejected this argument, which he noted was similar to the test for the materiality of pre-contractual misrepresentations and non-disclosures, for two reasons. First, given that inducement was irrelevant, “it was difficult to see” why materiality should be judged on the basis of the apparent merits of the claim at a particular time rather than the actual merits of the claim. Secondly, the insurer has discretion in deciding whether to accept a risk at the pre-contractual stage. In contrast, when deciding whether to accept a claim under an existing contract, the insurer’s position is very different. The insurer has no discretion because he is already bound. The materiality of a lie must therefore be “based on its relevance to a Court which is in a position to find the relevant facts”. Thus the fraudulent claims rule applies to wholly fabricated claims and to exaggerated claims, but not to a lie which “the true facts, once admitted or ascertained, show to have been immaterial to the insured’s right to recover”.

**Telling collateral lies is not without risk**

Lord Hughes added that there are a number of potential penalties which fall short of forfeiture for an insured who told a collateral lie in support of a valid claim:

- The insured who tells a collateral lie will have committed a criminal offence (although the risk of prosecution is relatively slight).
- The insured may be held liable in damages to insurers.
- An insured who tells a collateral lie is in practice likely to lose most or all of his credibility, in Court and out, in a debate about his entitlement under the policy. Lord Toulson made the same point in his judgment, referring to the “Lucas direction” in criminal trials, which directs the jury that even if it appears a defendant has lied, he may nonetheless be innocent and seeking to bolster a just cause.
SUPREME COURT RULES THAT A “COLLATERAL LIE” IS IMMATERIAL TO THE INSURANCE CLAIM

- If there is litigation, there are likely to be “expensive inter partes costs orders as a result of [the] fraud.”
- Insurers are likely to terminate the policy, at least prospectively.
- The history will be a material fact to be disclosed in future insurance proposals and is likely to lead either to a refusal of cover or to higher premiums.

These are in addition to any express penalties in the policy.

Lord Hughes considered this result consistent with the evolution of the common law rule on fraudulent claims to exclude from its operation fraud committed after litigation begins. He also considered the result consistent with the Consumer Insurance (Disclosure and Representations) Act 2012 and the Insurance Act 2015, which leave open the definition of “fraudulent claims”.

**Lord Mance’s dissenting judgment**

Perhaps unsurprisingly, given his view in The Aegeon, Lord Mance dissented. Lord Mance argued that the assessment of risk and the settlement of claims depend on good faith and fair information, which are consensual processes. He considered that the materiality of a lie must be based on its relevance to:
- the underwriter’s assessment of how a Court would rule in a case; and
- the underwriter’s decision whether to pay.

Lord Mance said he would reach the same conclusion now as he reached in The Aegeon for the same reasons, although he would require that a fraudulent device led to “a significant improvement of the insured’s prospects” (as Christopher Clark LJ suggested in the Court of Appeal) before a claim was barred. He considered that the fraudulent devices rule serves an important role in encouraging integrity and deterring fraud in the claims process.

In particular, the rule adds an additional protection against fabricated or exaggerated claims: the discovery of a fraudulent device formerly barred any claim at all. Lord Mance suggested that fraudsters could now try their luck with other devices or lies with “virtual impunity”. This would distort the claims process. Lord Mance considered that the loss of a claim was not disproportionate, given the policy underlying the fraudulent claims rule, and in any event “a person who uses fraudulent devices in the context of an insurance relationship deserves no real sympathy”.

**The Owners’ human rights arguments**

The Owners had contended that the rule under which valid claims advanced by fraudulent devices are forfeited was a disproportionate interference with their property rights under the First Article of the First Protocol to the European Convention on Human Rights (“A1P1”).

The Court of Appeal had rejected this argument and held that the aim of deterring fraud in insurance claims was legitimate and although admittedly “very harsh” the sanction of forfeiture was not disproportionate.

Given the majority judgment on the common law position, the Owners’ arguments that the rule on forfeiture of claims advanced by collateral lie was a disproportionate interference with their property rights under A1P1 did not arise in the Supreme Court.

Lord Mance commented, obiter, that he considered the deprivation would be and was a proportionate means of pursuing the legitimate aim of deterring fraud.

**COMMENT**

The Supreme Court ruling represents a significant change in the law on “fraudulent devices” (or “collateral lies”) used to support legitimate claims. It is clearly a favourable development from the perspective of policyholders, who will not now stand to forfeit otherwise legitimate insurance claims for telling an irrelevant lie told at some point in the claims process.

The Insurance Act 2015, which came into force on 12 August 2016, does not alter the position. Although section 12 of the 2015 Act, which applies to consumers and non-consumers, sets out remedies for fraudulent claims, the 2015 Act does not define “fraud” or “fraudulent claims” which will fall to be determined in accordance with common law principles.

Lord Mance’s concerns, which have been reiterated by the Association of British Insurers which described the Supreme Court ruling as “a blow for honest customers”, are understandable. Nonetheless the significance of the ruling should not be overstated:

- Fabricated and exaggerated insurance claims will continue to be forfeited in their entirety. For example, the policyholder with a household contents policy claims for the theft of his television. If the policyholder’s television was stolen but he submitted a forged receipt for the actual value of the television, he would now be entitled to an indemnity. If, however, the forged receipt was for more than the value of the television, or his television had not been stolen, he would forfeit the entire claim.
- Insurers may wish to provide in policy wordings that policyholders forfeit claims which they seek to support with false statements irrespective of whether such statements are relevant to cover. As Lord Mance said in his dissenting judgment, “insurers will no doubt be advised about whatever may be the potential merits of making express in future whatever understanding they have, or action they may wish to take, regarding the effect of fraudulent devices”.

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The risks of supporting legitimate claims with lies, in particular the risk of being unable to procure insurance in the future, may act as a deterrent.

As Lord Toulson said, “I am sceptical about the idea that knowledge of this judgment will incentivise people with valid insurance claims to lie in support of their claims. Those who are honest will not [lie in support of their claims] because it would not be in their nature, while some who are dishonest may do so if they think that they will get away with it, despite the risk of it having a boomerang effect on whether the Court believes anything that they say.”

ADDITIONAL REFERENCES
Agapitos v Agnew (The Aegeon) [2003] QB 556
Versloot Dredging BV v HDI Gerling Industrie Versicherung AG [2013] EWHC 1667 (Comm)
Versloot Dredging BV v HDI Gerling Industrie Versicherung AG [2014] EWCA Civ 1349
Consumer Insurance (Disclosure and Representations) Act 2012
Insurance Act 2015
The Supreme Court has ruled that where a UK resident was severely injured by an uninsured driver while on holiday in Greece and made a claim against the UK Motor Insurers’ Bureau (the “MIB”), the compensation available was to be assessed in accordance with the law in the country where the accident happened, in this case Greece. The Supreme Court overruled the Court of Appeal decisions in Jacobs and Bloy on this issue.

BACKGROUND
In 2011, Ms Moreno, a UK resident on holiday in Greece, was severely injured while walking along the verge of a road when she was struck from behind by a vehicle registered in Greece and driven by an uninsured driver. It was accepted that the accident was the fault of the driver. Under various EU Directives brought into effect in England & Wales in part by The Motor Vehicles (Compulsory Insurance) (Information Centre and Compensation Body) Regulations 2003 (the “2003 Regulations”), each member state is obliged to set up a body to provide compensation to victims of motor accidents who are injured by unidentified or insufficiently insured vehicles. The intention being that such victims should be entitled to equivalent protection as that available to persons injured by identified and insured vehicles. The MIB fulfils this role in the UK. Ms Moreno was therefore entitled to bring a claim for compensation against the MIB.

Ms Moreno’s concern was that the amount of compensation recoverable under Greek law would be less than that recoverable under English law. Ms Moreno therefore relied on regulation 13(2)(b) of the 2003 Regulations, which states that where it is not possible to identify an insurer, the MIB “shall compensate the injured party [...] as if [...] the accident had occurred in Great Britain.” In Jacobs, the Court of Appeal held that this wording obliged the MIB to assess compensation based on English, Scottish or Northern Irish law as the case may be.

In following the decision in Jacobs, the judge at first instance, Mr Justice Gilbart, expressed concern that this put injured parties on a different footing depending on whether they were injured by insured or uninsured drivers. In a claim where the driver is identifiable or insured, the level of compensation would fall to be assessed under the law where the accident happened, whereas a claim against an unidentifiable or uninsured driver would be based on the law where the injured person is resident. Despite the difficulties in this approach, Mr Justice Gilbart held himself bound by the decision in Jacobs. Accordingly, he granted the MIB’s application for a “leap-frog” appeal to the Supreme Court.

DECISION
The Supreme Court held unanimously that compensation in these circumstances should be assessed under the law of the country where the accident happened. Lord Mance, who gave the leading judgment, relied on the following reasoning:

1. The 2003 Regulations must, as far as possible, be interpreted consistently with the EU Directives on which they are based. There is no suggestion in the 2003 Regulations themselves or elsewhere that the UK legislator intended to depart from the scheme envisaged by the Directives.

2. The EU scheme is intended to provide a consistent measure of compensation for victims whatever the route to recovery taken by the victim. An injured person should be entitled to the same compensation from the scheme that they would have been able to obtain from the driver responsible or their insurer.

3. The agreements between member states’ compensation bodies make specific reference to applying the law where the accident occurred. The agreements also contain mutual obligations for each member state to provide advice on the applicable local law. These agreements have been made and approved by the European Commission and are therefore indicative of how the scheme is intended to operate.

4. Compensation bodies in the country where the accident happened could ultimately be subrogated in a claim against the responsible driver or his/her local insurer. It would not be possible for the compensation body to be subrogated to an injured person’s claim unless that person could themselves pursue the claim. Therefore the scheme clearly intended that the amount of compensation payable to an injured party should correlate with the amount that the subrogated compensation body could claim from the insurer.
5. The Court of Appeal in Jacobs had erred by finding that the old common law distinction between heads of damage and assessment of damage, recognised in Harding v Wealands and now removed from English law by Rome II, was reflected in regulation 13(2)(b). Regulation 13(2)(b) has “a purely mechanical or functional operation” in imposing liability on the MIB in respect of accidents happening abroad, and does not operate to determine the applicable law.

COMMENT

The purpose of the EU Directives and 2003 Regulations is to ensure that compensation is available for victims of motor accidents occurring anywhere in the EU and to facilitate the recovery of compensation. The EU Directives proceed on the basis that a victim’s entitlement to compensation will be measured on a consistent basis, by reference to the law on the state of the accident, whichever of the recovery routes provided by the Directives he or she pursues.

In holding that Ms Moreno’s claim for compensation against the UK MIB should be assessed under the law of Greece where the accident happened, the Supreme Court construed the 2003 Regulations so as to give effect to the scheme of the EU Directives. While this may in some instances result in the recovery of lower awards of compensation by UK victims of motor accidents involving unidentified or uninsured drivers in other EU member states, the Supreme Court’s decision seeks to give effect to the scheme of the EU Directives such that the measure of liability of the body or person ultimately responsible for compensation should be the same, whichever route of recovery is pursued.

ADDITIONAL REFERENCES

Motor Vehicles (Compulsory Insurance) (Information Centre and Compensation Body) Regulations 2003
Moreno v Motor Insurers’ Bureau [2015] EWHC 1002 (QB)
Bloy v Motor Insurers’ Bureau [2013] EWCA Civ 1543
Jacobs v Motor Insurers’ Bureau [2010] EWCA Civ 1208
Harding v Wealands [2006] UKHL 32
COURT OF APPEAL CONFIRMS INSURED’S ENTITLEMENT TO A DECLARATION OF INDEMNITY FOR COST OF REINSTATEMENT OF PROPERTY DAMAGED BY FIRE

The Court of Appeal has confirmed that the Court may make a declaration that an insured under a property insurance policy is entitled to be indemnified for the cost of reinstating property damaged by an insured peril, particularly in circumstances where it is unclear whether the insured intends or is able to reinstate the property. The case also provides helpful guidance on the insured’s right to be indemnified on a reinstatement basis under a property insurance policy.

BACKGROUND

The case concerned two neighbouring buildings: (i) the principal building at 1-7 Station Street, Walsall, known as the Boak Building, a listed building and (ii) No 8 which was part of a terrace (together the “Property”). The Property was owned by Chinderpal Singh but insured by Western Trading Limited (“Western Trading”) which held and managed Mr Singh’s property portfolio. The Property was insured under a property insurance policy (the “Policy”) with Great Lakes Reinsurance (UK) SE (the “Insurer”) for £2,121,800, which was understood to be the rebuilding cost of the Property.

The Property was destroyed by fire and Western Trading sought a declaration that it was entitled to be indemnified under the terms of the Policy for the losses it had suffered up to the limits of indemnity within the Policy. The Insurer argued that (i) Western Trading did not have an insurable interest in the Policy; (ii) the Policy was avoidable for misrepresentation and non-disclosure; and (iii) Western Trading was in breach of warranty. The judge at first instance rejected these defences. He held that the Western Trading was entitled to the cost of reinstatement provided it reinstated the Property and granted a declaration that “The Claimant is entitled to be indemnified by the Defendant in respect of the losses it has suffered (and is continuing to suffer) as a result of the fire on 24th July 2012, up to the limits of indemnity within the policy”.

The Insurer appealed against the grant of the declaration.

The Insurer submitted that there should be no declaration and that the Court should determine the measure of indemnity and in particular whether Western Trading was entitled to recover the cost of reinstating the Property. The Insurer argued that the measure of indemnity was the reduction, if any, in the open market value of the Property. The Property was worth about £75,000 before the fire but after it (following delisting) it was worth about £500,000. Hence, the Insurer submitted there had been no reduction in the market value and there was no loss to be indemnified.

Terms of the policy

The Insuring Clause of the Material Damage – Section A of the Policy provided:

“Subject to the General Conditions and Exclusions of this Certificate, and the conditions and exclusions contained in this Section, we the Underwriters agree to the extent and in the manner provided herein to indemnify the Assured against loss of or damage to the property specified in the Schedule (hereinafter referred to as ‘the Property’) caused by or arising from the Perils shown as operative in the Schedule, occurring during the period of this insurance.

“Underwriters shall not be liable for more than the Sum Insured stated in the Specification or in the Certificate in respect of each loss or series of losses arising out of one event at each location as stated in the Schedule.”

A memorandum to Section A of the Policy (the “Memorandum”) provided that the amount payable for loss, destruction or damage of insured property would be the reinstatement value provided certain conditions were met. For the purpose of the Memorandum ‘reinstate’ meant:

“a) the carrying out of the following work, namely,

i) Where property is lost or destroyed, the rebuilding of the property, if a building ... in a condition equal to but not better or more extensive than its condition when new.”

The Special Provisions in the Memorandum which had to be met included in particular:

“a) The work of reinstatement (which may be carried out upon another site and in any manner suitable to the requirements of the Assured
subject to the liability of the Underwriters not being thereby increased) must be carried out with reasonable despatch otherwise no payment beyond the amount which would have been payable under the Policy if this Memorandum had not been incorporated therein shall be made;

... 

c) No payment beyond the amount which would have been payable under the Policy if this Memorandum has (sic) not been incorporated herein shall be made until the cost of reinstatement shall have been actually incurred.”

**DECISION**

**Measure of indemnity**

Following a line of authorities the Court of Appeal found that the measure of indemnity to which the insured is entitled where insured real property is destroyed depends on “(i) the terms of the policy; (ii) the interest of the insured in, or its obligations in respect of, the property insured; and (iii) the facts of the case including, in particular, the intention of the insured at the time of the loss”.

**Measure of indemnity under the Memorandum**

Christopher Clarke LJ (who gave the leading judgment of the Court of Appeal) found that the measure of Western Trading’s indemnity under the Memorandum was the cost of reinstating the Property. Western Trading was bound to insure the property and to replace it in the event of fire. Western Trading therefore had an express entitlement under the Memorandum to the reinstatement cost, provided certain conditions were met.

With regard to the conditions, he held that in many cases the insured will not have failed to act with reasonable despatch whilst insurers deny any liability or assert that the insured is not entitled to be compensated on the basis of reinstatement. He did not therefore regard Western Trading as having failed to act with reasonable despatch because it had not commenced reinstatement before the conclusion of the proceedings.

**Measure of indemnity under the Insuring Clause alone**

Since no reinstatement had actually begun and no costs had been incurred, the Court of Appeal also considered what would have been payable under the Policy if the Memorandum had not been incorporated.

It found that: “Where the insured is obliged to replace the lost property the cost of doing so is prima facie the measure of indemnity ... at any rate where there is a genuine intention to replace”. Even where the insured owns the property and is not under an obligation to reinstate or repair it, the indemnity is assessed by reference to the value of the property to the insured at the time of the peril. In most cases, this will be the reinstatement cost although that may not be the case if the insured was planning to sell the property, intending to destroy it anyway, or no one in their right mind would reinstate.

The problem in this case was that there was a real possibility that reinstatement would not take place. Christopher Clarke LJ said that it seemed to him that the insured’s intention needs to be not only genuine but also fixed and settled and what he intends must be at least something which there is a reasonable prospect of him bringing about. He inclined to the view that in such a case it was open to the Court to decline to make an immediate award of damages and either to make some form of declaratory relief, alternatively to postpone assessment of the indemnity.

**Declaration**

In light of its conclusion on the measure of indemnity under the Memorandum, the Court of Appeal was satisfied that it was open to the judge to make a declaration to the effect that, if Western Trading reinstated the Property, it would be entitled to an indemnity from the Insurer. As the judge had pointed out, a declaration gave the insurers a measure of protection which an award of damages would not. If Western Trading did not reinstate, the Insurer would be spared the consequences of the declaration.

However, something had gone awry in the link between the judgment and the declaration. The judgment provided that if reinstatement took place, the Insurer would have to pay the cost of reinstatement but the declaration provided that the insured was entitled to be indemnified “for its losses”. The declaration therefore did not make it clear that the Insurer would be required to indemnify Western Trading if it reinstated the Property. This defect was remedied by amending the declaration to provide that “if the Claimant carries out reinstatement of the property lost then it will be entitled to be indemnified by the Defendant for the cost of so doing, up to the limit of indemnity”.

The Court of Appeal also considered whether the grant of a money judgment, rather than a declaration, was the appropriate remedy. This necessarily required a determination as to whether Western Trading was entitled to recover the cost of reinstating the Property under the Insuring Clause even though it had not yet been reinstated. This in turn required a determination as to whether there was a genuine intention to reinstate.

Notwithstanding what the Court of Appeal held to be the measure of indemnity under the Insuring Clause and the judge’s finding that Mr Singh intended that Western Trading should reinstate, Christopher Clarke LJ came to the conclusion that the Court of Appeal should not order a money judgment and regarded a declaration in the amended terms as the appropriate remedy.
COMMENT

The Court of Appeal decision provides helpful guidance in light of the authorities on the measure of indemnity under a property insurance policy and in particular the circumstances in which the insured is entitled to be indemnified on a reinstatement basis.

Where the policy does not include an express reinstatement clause, prima facie the measure of indemnity is the cost of reinstatement where the insured is obliged to replace the lost property, at least where there is a genuine intention to replace. Where the insured is the owner of the property, and is not obliged to reinstate or repair, the measure of the indemnity is the value of the property to the insured at the time of the peril. In many cases the insured’s loss will be the cost of reinstatement unless the insured was trying to sell the property at the time of the loss or intending to destroy it or if no one in his right mind would reinstate it.

Where there is a real possibility that reinstatement may not take place, the Court may decide not to make an award of damages and instead make some form of declaration. This gives insurers a measure of protection which an award of damages would not. The insurers will only have to pay for the cost of reinstatement if the property is actually reinstated.

The benefits to the insured under an express reinstatement clause are usually wider than would otherwise be the case under the policy. Where an express reinstatement clause is included in the policy, this is normally subject to conditions including that the work of reinstatement is commenced and carried out with reasonable despatch and the cost of reinstatement has actually been incurred. However, the requirement on an insured to begin to reinstate cannot be regarded as arising until the insurer has confirmed that it will indemnify the insured. It is similarly open to the Court to make a declaration to the effect that if the insured reinstates the property, it will be entitled to an indemnity from insurers for the cost of reinstatement.
WTC AND AGGREGATION:
THE MEANING OF "ARISING FROM ONE EVENT"

Mr Justice Cooke considered an appeal against the decision of an arbitral panel on whether certain reinsurance claims following the World Trade Center attacks on 11 September 2001 (the "WTC attacks") could be aggregated. The arbitrators had decided by a majority that the claims could be aggregated as losses "arising from one event". The judge dismissed the appeal, concluding that there was no error of law by the arbitrators in reaching their decision, nor was the arbitrators' conclusion one which no reasonable arbitrator, properly directed, could reach.

BACKGROUND
The Port of New York ("PONY") owned the land on which the WTC stood and, following the attacks, carried out a massive clear-up operation. A large number of employees subsequently brought claims against PONY. Those claims included:
- Workers' Compensation Claims in respect of those who were struck by or trapped under the debris (the "WCA Claims"); and
- Claims for damages for negligence by thousands of firefighters, police officers, clean-up workers and others who claimed to have suffered respiratory damage due to the alleged negligence of PONY in failing to provide necessary protective equipment and/or training (the "Respiratory Claims").

PONY settled the claims and then sought to recover from its liability insurers, including Syndicate 102 (the "Reinsured"). The Reinsured in turn sought to recover from its reinsurers, including Syndicate 994 (the "Reinsurer"), under a USD1.5m excess USD1m excess of loss reinsurance contract (the "Reinsurance Contract"). The Reinsurance Contract, which incorporated the Joint Excess Loss Committee (JELC) wording, provided that the limits applied "each and every loss", with "Loss" defined as "loss, damage, liability or expense or a series thereof arising from one event".

A dispute arose as to whether the WCA Claims and Respiratory Claims could be aggregated. The Reinsured argued that they could, as they were losses arising from one event, namely the WTC attacks. The Reinsurer argued that the aggregation wording did not permit such a broad reading: failure to provide adequate equipment and training was not an "event" but a continuing state of affairs and the WTC attacks were too remote to constitute an "event". The Reinsurer also queried whether the Reinsured was in fact liable under the underlying policies, since there were "strong defences available" to the Respiratory Claims.

The dispute was referred to arbitration. On 21 December 2015, the arbitrators found in favour of the Reinsured, by a majority of two to one. The Reinsurer was granted permission to appeal on the aggregation point. The appeal was heard on 10 October 2016.

DECISION
Cooke J summarised the relevant legal principles as follows:
1. An 'event' is something which happens at a particular time, at a particular place, in a particular way (AXA v Field).
2. An event cannot be a state of affairs or series of different negligent acts.
3. Where a policy aggregates "a series of losses and/or occurrences arising out of one event", there should be: (a) a common factor properly described as an event; (b) that event must satisfy the test of causation; and (c) the event must not be too remote for the purpose of the insurance (Caudle v Sharp).
4. An event must be something out of which a loss arises or series of losses arises, not a state of mind.
5. An 'occurrence' (or 'event') could include a number of losses if there is the necessary degree of unity, as viewed from the point of view of an informed observer in the position of the insured, taking into account the four unities i.e. cause, locality, time and intentions of the human agents (KAC v KIC).
6. Losses "arising out of one event" require: (a) something that can be called an event; (b) an event prior to the aggregated losses; (c) a causative link between the losses and event, which is looser than a proximate cause; and (d) that the event and losses are not remote (Scott v Copenhagen Re).
7. Although the link is looser than that of proximate cause, the Courts will look for a significant rather than weak causative link (Scott).
In this case, Cooke J was satisfied that the arbitrators cited the relevant authorities and fully understood the test they had to apply. In doing so, they were influenced by commercial experience and common sense. There was no error of law: the arbitrators exercised their judgement, applying the correct test.

The ‘four unities’ were merely an aid to determine whether there was the necessary degree of unity. It did not therefore assist the Reinsurer to point to the fact that, in their Award, the arbitrators referred only to the unities of time and place.

When considering whether there was sufficient causal connection between the event and loss, the arbitrators are not required to look for a proximate cause. It was appropriate for the arbitrators to apply the ‘but for’ test (i.e. to ask whether there would have been any claims but for the WTC attacks).

It was also within the province of the arbitrators to find, as they did, that there was no new phase in the rescue and clean-up operations which would permit the Reinsurer to distinguish between Respiratory Claims arising from operations on 9/11 itself and Respiratory Claims arising from a later period.

In short, in reaching their decision on aggregation, the Arbitrators were involved in an exercise of finding fact or reaching mixed conclusions of law and fact. These were matters with which the Court would not interfere. The conclusion reached by the Tribunal was not perverse, nor was it a conclusion which no reasonable arbitrator, properly directing himself, could reach. The fact that there was a dissenting opinion merely illustrated that judgement is often involved in applying the relevant legal test to the facts.

**COMMENT**

The 9/11 terrorist attacks have given rise to a number of reinsurance disputes, including on aggregation. In the case of, Aioi v Heraldglen, the Commercial Court considered an appeal from an arbitral award on whether the attacks on the twin towers should be aggregated as one event or two under excess of loss reinsurances. In both cases, the starting point was to consider the aggregation wording in the reinsurance contracts and the well-known legal authorities on aggregation. However, the outcome may ultimately turn on the tribunal’s application of the relevant legal principles to the facts. Simmonds demonstrates that it is perfectly possible and reasonable for two arbitrators to reach different conclusions on the same facts and the English Court will be slow to interfere with a tribunal’s findings of fact or mixed fact and law.

**ADDITIONAL REFERENCES**

- AXA Reinsurance (UK) Ltd v Field [1996] 1 W.L.R. 1026
- *Scott v Copenhagen Reinsurance Co (UK) Ltd* [2003] EWCA Civ 688
- *Aioi Nissay Dowa Insurance Co Ltd v Heraldglen Ltd* [2013] EWHC 154 (Comm)
SUPREME COURT FINDS SOLICITOR’S LIABILITY TO LITIGATION FUNDER EXCLUDED UNDER PROFESSIONAL INDEMNITY POLICY

The Supreme Court has held that an insurer, AIG, was not liable in its capacity as a professional indemnity (“PI”) insurer of the law firm, Barrington, for its contractual liability to a litigation funder, Impact Funding Solutions (“Impact”). This reversed the earlier Court of Appeal judgment which had allowed Impact’s appeal against the judgment of the High Court.

This article was first published on the Practical Law Dispute Resolution Blog.

BACKGROUND

Barrington acted on numerous claims for claimants pursuing damages for industrial deafness. Impact entered into a funding agreement with Barrington. The purpose was to provide loans to Barrington’s clients so as to meet disbursements in litigation to be funded through conditional fee agreements (“CFAs”). In breach of its duties to its clients, and in breach of the funding agreement with Impact, Barrington failed to exercise proper care:

- in investigating the merits of the claims; and
- through the misapplication of funds provided by Impact.

Barrington’s clients were not able to repay their loans and Impact sought recovery from Barrington under the funding agreement. Impact was successful in a separate action against Barrington and, on Barrington’s insolvency, sought to recover the sum it had been awarded from AIG, under the Third Parties (Rights against Insurers) Act 1930.

The issue in the appeal was whether an exclusion in Barrington’s PI policy for “loss arising out of, based upon, or attributable to any… breach by any Insured of terms of any contract or arrangement for the supply to, or use by, any Insured of goods or services in the course of providing Legal Services” applied to the losses claimed by Impact.

The Supreme Court found that the funding agreement and resulting loans to Barrington’s clients were a service which Impact provided to Barrington; therefore the funding agreement was a contract for the supply of services to Barrington. The Supreme Court also saw no basis for implying additional words into the exclusion to limit its scope.

The Supreme Court held that the boundaries of AIG’s liability fell to be ascertained by construing the broad statement of cover and the broad exclusions in the context of the regulatory background. The general doctrine, that exclusion clauses should be construed narrowly, had no application to the exclusion in Barrington’s PI policy.

The Supreme Court found that the boundaries of AIG’s liability fell to be ascertained by construing the broad statement of cover and the broad exclusions in the context of the regulatory background. The general doctrine, that exclusion clauses should be construed narrowly, had no application to the exclusion in Barrington’s PI policy.

DECISION

Impact argued successfully before the Court of Appeal that the funding agreement with Barrington was for the purpose of providing loans to Barrington’s clients and that Barrington’s duties under the agreement were part and parcel of a solicitor’s professional duties to the client. The Supreme Court came to a different conclusion (by a majority of four to one).

The Supreme Court found that the funding agreement and resulting loans to Barrington’s clients were a service which Impact provided to Barrington; therefore the funding agreement was a contract for the supply of services to Barrington. The Supreme Court also saw no basis for implying additional words into the exclusion to limit its scope.

The exclusion therefore applied to defeat Impact’s claim against AIG. That conclusion accorded with the essential purpose of the Solicitors’ Indemnity Insurance Rules 2009 to safeguard the public that makes use of solicitors’ services; they are not intended to cover trading liabilities that solicitors may incur as a result of a breach of a commercial agreement.

COMMENT

The judgment is of general importance to the proper approach to the interpretation of PI insurance, and in particular the exclusion of trading liabilities, which is a standard form of wording in solicitors’ PI policies.

While the judgment is likely to be welcomed by PI insurers, litigation funders and others providing services to law firms in the conduct of litigation should take note. The minimum terms of cover, which law firms are required to maintain, are intended to safeguard the lay public that makes use of solicitors’ services; they are not intended to cover trading liabilities that solicitors may incur as a result of a breach of a commercial agreement.

ADDITIONAL REFERENCES

Third Parties (Rights against Insurers) Act 1930
HIGH COURT CONSTRUES WORDING AS AGGREGATING LANGUAGE TO GIVE EFFECT TO LIMIT OF LIABILITY

The High Court considered the wording of a clause in an insurance policy and was prepared to interpret the clause as an aggregating clause. Although aggregating provisions are normally worded so as to aggregate claims both for the purposes of the insured’s excess and the insurer’s limit of indemnity, the Court was not prepared to “rewrite” the policy to achieve this effect here. The aggregating provision applied only to the limit of indemnity.

BACKGROUND

Spire Healthcare Limited (“Spire”) held a combined liability insurance policy (“the Policy”) with Royal & Sun Alliance Insurance Plc (“RSA”), providing, inter alia, cover for medical negligence. A large number of clinical negligence and related claims were brought against a number of Spire hospitals (insured under the Policy) relating to allegedly unnecessary and/or inappropriate and/or negligent procedures carried out by Mr Ian Paterson, a Consultant Breast Surgeon who carried on his private practice at these hospitals between 2004 and August 2011.

Spire applied for declaratory relief as to the effect of certain provisions in the Policy, arguing that there was no operative aggregation clause so far as any limits on cover were concerned and that the maximum cover was £20 million. In the alternative, Spire contended that if there was aggregation, then there was also aggregation in respect of the excess payable by the insured.

RSA argued that there was aggregation in respect of limits of cover which limited cover to £10 million, but none in respect of the excess.

DECISION

Judge Waksman QC considered that the relevant part of the Policy plainly contained aggregating language, aggregating linked claims to a limit of indemnity of £10 million, treating them as if they were a single claim. As to the question of the excess, the judge declined to rewrite the Policy, and no aggregation was to apply.

Aggregation for Cover

Section 4 of the Policy provided cover for medical negligence claims brought on a “claims made” basis. The Schedule “Limits of Liability” (the “Schedule”) set out limits to cover, and a further schedule set out the excess. The relevant part of proviso 5 of Section 4 (which Judge Waksman QC referred to as 5(a) for clarity) provided as follows:

“(a) The total amount payable by the Company in respect of all damages costs and expenses arising out of all claims during any Period of Insurance consequent on or attributable to one source or original cause irrespective of the number of Persons Entitled to Indemnity having a claim under this Policy consequent on or attributable to that one source or original cause shall not exceed the Limit of Indemnity stated in the Schedule.”

The judge referred to the judgment of Longmore LJ in AIG v The Law Society which set out examples of the traditional wording for a wide aggregation clause, such as “any claim or claims arising out of all occurrences...Consequent on or attributable to one source or original cause”. Judge Waksman QC determined the proviso was “unquestionably” aggregation wording; indeed it used the words set out by Longmore LJ.

The judge considered the provision made sense in its own terms, being as how it prescribed a consequence for a set of claims of this description ie. that they were all subject to the limit of indemnity in the Schedule.

The Schedule provided a limit of indemnity for medical negligence for “any one claim” of £10 million and £20 million in respect of “all damages costs and expenses arising out of all claims during the Period of Insurance”. Spire submitted that it was not clear which limit should apply and therefore the limit of £20 million should apply, under the contra proferentem rule.

Judge Waksman QC, in rejecting Spire’s arguments, identified three categories of claim: a single claim, a number of non-linked claims and linked claims falling within proviso 5(a). He considered a third financial limit relating to claims arising out of one cause was not necessary, because linked claims were to be treated as a single claim. The lower financial limit would obviously apply since the purpose of aggregation was to reduce cover in the case of linked claims and in the Schedule the lower amount specifically referenced “one claim”.

CASE REFERENCE AND JUDGMENT DATE


19 December 2016
RSA’s interpretation was preferred as better fitting Lord Neuberger’s *indicia* in *Arnold v Britton*, as summarised: (i) the natural and ordinary meaning of the clause was aggregation, (ii) this was consistent with other parts of the Policy and (iii) consistent with the overall purpose of proviso 5(a), i.e. aggregation and the different limits in the applicable Schedule, (iv) although no factual matrix evidence was adduced, aggregation might be expected, objectively, where many different hospitals were insured and where many claims could arise from one cause, and (v) it is certainly consistent with common sense.

**Aggregation for Excess**

The second issue in the case was whether if there was an aggregation provision it applied to the excess as well as the limit of indemnity.

Under the Policy the relevant excess was £25,000 for each and every claim, not to exceed £750,000 in the aggregate in the period of insurance. Spire submitted that if proviso 5(a) operated as an aggregation clause in respect of cover limits, it would be illogical if there was no equivalent aggregation in terms of the excess, limiting it to a single excess of £25,000 for a group of aggregated claims.

Whilst the judge could see the force of that point, he considered achieving that result would amount to rewriting this part of the Policy and declined to do so. He quoted Morison J in *Countrywide Assured Group Plc v Marshall*: “Normally, I accept, the policy will be worded so that the aggregation of the claim will involve an aggregation of the excess in respect of claims so that claims are aggregated both for excess and limit...I am not persuaded that the plain and ordinary meaning of the words in this policy should be corrupted, as I think they would have to be, to make this policy work “normally”.”

Although “Event” was defined as “one occurrence or all occurrences of a series consequent on or attributable to one source or original cause”, “Claim” was not so defined, and therefore it could not be said that the word “Claim” included a group of linked claims.

**COMMENT**

The decision highlights the Court’s willingness to interpret aggregation clauses purposively where it is clear aggregating language is present. However, the Court was not prepared to “corrupt” the wording to read in a complementary aggregation provision for the purpose of the excess.

Insureds and insurers must therefore ensure that where there is a provision purporting to aggregate claims, limits are clearly stated for linked and non-linked claims. If a reciprocal right to aggregate excess is required, this must be expressly stated, as the courts remain reluctant to rewrite the policy to achieve this result.

**ADDITIONAL REFERENCES**

- Arnold v Britton [2015] AC 1619
SLOW OUT OF THE BLOCK (NOTIFICATIONS), COSTLY FOR BROKERS

Ocean Finance is another case in the growing volume of PPI mis-selling litigation and considers a broker’s duties in relation to the notably difficult issue of notifications to insurers. The Commercial Court held a placing broker contributorily negligent for failing to advise an insured of the need to make a block notification with its insurers within the relevant policy period.

BACKGROUND

The Claimants (“Ocean Finance”) sold secured loans and payment protection insurance (“PPI”). Ocean Finance was insured under a professional indemnity policy which covered the period 31 October 2008 to 31 October 2009 (the “Policy”).

The first defendant, Oval Insurance Broking Ltd (“Oval”), was Ocean Finance’s producing broker who in turn retained Senior Wright Limited and Senior Wright Indemnity Limited (together “SWIL”) (joined to the action as third parties) as placing broker because of its connections with the professional indemnity insurance market in London.

The case concerned a failure by Ocean Finance to make a block notification of all its PPI sales to the Policy as a “circumstance that may give rise to a claim” (which was required for reasons explained below). As a result, Ocean Finance failed to recover a full indemnity under the Policy.

Ocean Finance brought proceedings against Oval on the basis that Oval failed to advise it that a block notification should be made. Oval in turn brought a Part 20 claim against SWIL. Prior to trial, Oval settled its claim with Ocean Finance and accepted that a block notification should have been made. The case therefore concerned the extent, if any, of SWIL’s liability.

The relevant background is as follows. In late 2008 there was a steep increase in PPI complaints to the Financial Ombudsman Service (FOS) following a decision of the FOS which criticised the adequacy of information given to a customer during a telephone sale of a PPI policy. Prior to this, Ocean Finance had generally been successful when defending PPI complaints referred to the FOS for adjudication. However, following this decision, the FOS increasingly began to find in favour of the complainant.

In September 2009 the FSA (as it then was) published a Consultation Paper which proposed that all PPI insurers ought to reassess any PPI complaint they had previously rejected and conduct a root cause analysis of PPI complaints to identify any common underlying causes.

During its consideration of the FSA’s proposals, Ocean Finance identified approximately 450 previously rejected complaints. It also established that conducting a root cause analysis would require a review of the 18,000 PPI policies it had issued, 10,000 of which were subject to FSA regulation. Furthermore, Ocean Finance identified that there were deficiencies in its sales script for the PPI policies and so it was likely that 99% of its sales were defective as they failed to tell the customer verbally the price of the PPI policy. This was likely to give rise to the need for redress. Oval was aware of these issues but SWIL was only told about the 450 rejected complaints. It was not told of the likely effect that any root cause analysis would have (i.e. that there were potentially 18,000 PPI policies potentially subject to review) and Oval played down the risks of multiple claims emerging.

The Policy expired on 31 October 2009. Two days prior to this, and without consulting Ocean Finance or Oval, SWIL notified insurers of the 450 complaints which Ocean Finance would be required to reassess if the FSA’s proposals in its Consultation Paper were approved and enforced.

The question for the Court was whether the knowledge that SWIL had or should have had, would have required any competent insurance broker fulfilling its duties to recommend a block notification be made to the Policy.

Oval argued that its liability to Ocean Finance was due to SWIL’s negligence and/or breach of contract as placing broker. Alternatively, Oval argued that SWIL was in breach of direct tortious duties owed to Ocean Finance. Oval contended that it relied on SWIL for specialist advice. In its defence, SWIL argued that Oval (i) never requested advice on a block notification, (ii) did not pass on key information to SWIL that would have alerted it to the need for such a recommendation, and (iii) information given to it on 22 October 2009 was too late for the necessary steps to be taken to make an effective block notification.

DECISION

The key issue for the Court was what SWIL ought to have known and appreciated, and the state of knowledge of the relevant persons at Ocean Finance, Oval and SWIL. Mr Justice Cooke held
that SWIL was under a duty to review the information received by it from Oval in the context of presentation for renewal and to consider any notification of circumstances which was required to the current Policy in order to ensure that the renewed insurance provided effective cover for future claims, with a view to avoiding lack of cover for any liability incurred by the insured.

Cooke J found that a competent broker with the knowledge of SWIL on or around 22 or 23 October 2009 (a week or so prior to the end of the policy period) would have raised the question of a block notification in the same way as it was ultimately raised in 2010 by Oval and that lawyers should subsequently have been consulted and an extension of the 2008/2009 policy claim period be obtained.

Despite SWIL not having the full extent of the knowledge that Oval had, the Court held that a competent broker in the position of SWIL would have concluded that complying with the FSA’s Consultation Paper meant that there was a real risk of a full review of PPI sales which would reveal large numbers of cases affected by script deficiencies and failures in oral disclosure of information to customers. A competent broker would have recognised the risk of multiple claims and considered the issue of block notification.

As to the basis of SWIL’s duty, the Court found that as SWIL had taken upon itself to make the existing notification, without instructions from Oval, it assumed a duty, both in contract and tort to Oval. There was also a suggestion that SWIL may owe a duty in tort to Ocean Finance in relation to making an appropriate notification under the Policy.

The Court ultimately held that SWIL was contributorily negligent and liable for 30% of the settlement figure paid by Oval to Ocean Finance (Oval bore 70% responsibility).

**COMMENT**

This case is a reminder to brokers to consider fully all the information available, particularly as renewal approaches, to ensure that any notifications are made in a timely manner and cover all notifiable issues. As the Court recognised in *Alexander Forbes v SBJ*, a broker should “get a grip” on a proposed notification, appraise it and ensure an appropriate notification is made. The broker should not act simply as a post-box. No doubt SWIL in this case felt that they had done just that by making the notification before the end of the policy period but the Court concluded that this wasn’t sufficient and a wider notification should have been given.

As regards block notifications, the Court acknowledged that insurers may be reluctant to accept these but it was incumbent on the broker to recommend in appropriate circumstances that the insured should take such action.

**ADDITIONAL REFERENCES**

*Alexander Forbes Europe Ltd v SBJ Ltd* [2002] EWHC 3121 (Comm)
COURT OF APPEAL CONFIRMS
CLAIMANTS ENTITLED TO ONLY £250
 DAMAGES HAVING SUCCESSFULLY
MITIGATED OWN LOSS

The Court of Appeal has upheld an award of only £250 in damages for the Defendant solicitors’ failure to identify a relevant planning restriction affecting a residential property purchased by the Claimants, where that was the cost of the Claimants’ successful application to remove the restriction.

Herbert Smith Freehills acted for the Defendant, who was successful both at first instance and on appeal.

BACKGROUND

The Claimants instructed the Defendant solicitors to act on their purchase of a residential property for £600,000. The Defendant failed to advise the Claimants of a planning restriction which meant they could not use the property for residential purposes.

The Claimants subsequently instructed different solicitors who identified the restriction and recommended that the Claimants apply to have it removed. The Claimants lodged a £250 application to remove the restriction, which was successful.

The Claimants brought an action against the Defendant for negligence. They claimed damages of £100,000 plus interest, which they said represented the diminution in value of the property at the time of purchase caused by the restriction. The Defendant admitted negligence but argued that having to make the £250 application to remove the restriction was the only loss suffered by the Claimants. The High Court agreed. It awarded the Claimants only £250 and ordered them to pay the majority of the Defendant’s costs.

DECISION

The Court of Appeal dismissed the appeal, with Lord Justice Davis giving the leading judgment (with which Lloyd Jones and Underhill LJJ agreed). Davis LJ remarked that “there is rather less to this case than possibly first meets the eye”. He succinctly summarised the basis for the Court’s decision, saying:

“By reason of the subsequent removal of the restriction the [Claimants] have suffered no loss and there is nothing in respect of which they require to be compensated. That is the nub of it.”

The Court of Appeal rejected the Claimants’ argument that the loss was “fixed” at the date of purchase of the property. The Claimants sought to rely on the principle in Philips v Ward, that damages will normally be assessed at the date when the damage occurs, which is usually the same day as the cause of action arises - sometimes referred to as the “breach date rule”. In the present case, however, the Court of Appeal said that the principle is Philips v Ward is no more than a “convenient starting point”. The assessment of damages is to be undertaken realistically and not mechanistically.

In the present case, it was necessary to consider the act of mitigation conducted by the Claimants following the purchase (successfully applying to have the restriction removed). Davis LJ held that the Claimants were under an obligation to mitigate their loss in this way. Making such an application was not equivalent to having to engage in lengthy, costly and uncertain litigation. In any event, whether or not the Claimants were under an obligation to mitigate in this way, they did, and therefore avoided their potential loss.

Davis LJ was also not impressed by the Claimants’ argument that they could have purchased the property at a lower price had they known about the restriction, subsequently removed the restriction and sold the property at a profit. The likelihood of success in making an application to remove the restriction was high, even at the time of purchase, so the diminution in value of the property would have been negligible. Irrespective of this, there was no firm evidence that the Claimants would have tried to purchase and sell the property in this way, and no evidence at all as to what stance the vendors would have taken.

COMMENT

The decision emphasises that the so-called “breach date rule” is just a starting point, and the assessment of damages in any given case is to be conducted realistically and not mechanistically.

Where a claimant has successfully taken steps to mitigate its loss after the date of breach, so that no loss has in fact been suffered, that will be highly relevant.

ADDITIONAL REFERENCES

Philips v Ward [1956] 1 WLR 471
Bacciottini & Anor v Gotelee and Goldsmith (A Firm) [2014] EWHC 3527 (Ch)
COURT OF APPEAL GIVES GUIDANCE FOR BANKERS’ REFERENCES

The decision of the Court of Appeal in Playboy Club v Banca Nazionale Del Lavoro is an interesting clarification of the legal principles that apply to bankers’ references.

BACKGROUND

Playboy Club London Ltd (the “Club”) operated a casino in Mayfair called “The Rendezvous”. Customers of the casino were able to obtain gambling credit via a cheque cashing facility, which allowed customers to present a cheque and – before that cheque was cashed – obtain gambling credit of an equivalent value. Before extending credit under such a facility, the Club, through its agent Burlington Street Services Ltd (“Burlington”), would obtain a reference attesting to the customer’s means and trustworthiness to repay the funds. It was the Club’s standard practice to use Burlington to ask for references so as “to preserve confidentiality for customers preferring to keep their gaming activities private.”

In October 2010, Burlington sought and obtained a reference from Banca Nazionale Del Lavoro (the “Bank”) regarding a customer of the Club, Mr Barakat. The reference provided by the Bank was addressed to Burlington c/o its bank, NatWest. The reference stated that Mr Barakat maintained an account with the Bank, was in sound financial health and was able to meet obligations of up to £1.6 million in any one week. The reference indicated that the information provided was strictly confidential.

In fact, Mr Barakat had only begun the process of opening an account with the Bank a little more than a week earlier and his account did not have any funds on deposit. In reliance on the reference, the Club extended £1.25 million of gambling credit to Mr Barakat in exchange for cheques drawn on Mr Barakat’s account with the Bank. After Mr Barakat incurred substantial gambling losses, the Club sought to cash the cheques only to find that the cheques were counterfeit.

Efforts to recover the funds from Mr Barakat were unsuccessful and the Club commenced a negligence claim against the Bank. Burlington was not a claimant to the proceedings, presumably because it had suffered no loss.

At first instance, the Court held that the Bank was responsible for the reference and that in giving the reference, the Bank owed a duty of care not just to Burlington, but also to the Club. The Bank appealed.

DECISION

Overturning the decision of the High Court, the Court of Appeal held that the Bank did not owe a duty of care to the Club and that its obligations were limited to Burlington.

Hedley Byrne distinguished

The Court of Appeal recapped the key principles from Hedley Byrne v Heller, the seminal authority on negligent misstatement which also happens to be a case about a banking reference.

Hedley Byrne was an advertising agency which, before taking on a liability in respect of an advertising contract for a customer (Easipower) had its bank (National Provincial) obtain a reference from Easipower’s bank (Heller & Partners). The reference was to confirm Easipower’s ability to cover the liability. National Provincial’s request to Heller & Partners identified that the reference sought related to an advertising contract but did not identify whether the reference was for National Provincial’s own use or that of a customer.

Similar to the instant appeal, Heller & Partners argued that it only owed a duty to National Provincial and not to its unnamed and unidentified customer, Hedley Byrne. This was rejected by the House of Lords, which held that it was immaterial that the name of the customer (Hedley Byrne) was not mentioned by the inquiring bank (National Provincial). The House of Lords commented that the bank “must have known that the inquiry was being made by someone contemplating doing business with Easipower Ltd and that their answer or the substance of it would in fact be passed on to such person”.

Distinguishing the facts of Hedley Byrne, the Court of Appeal noted that the Bank’s reference expressly named Burlington as the party to whom the reference was being provided. Further, the Bank knew nothing of the purpose for which the reference was sought and received no notice that the reference would be passed on to Burlington’s principal or any other party. The Court of Appeal considered whether these factual differences afforded a relevant legal distinction between the instant case and Hedley Byrne. To answer this question, the Court reviewed the principles for establishing liability for negligent misstatement.

Test to establish a duty of care

The Court noted that there was no single test for determining when a duty of care will arise and set out the general principles established in Caparo v Dickman as applied in Customs and Excise Commissioner v Barclays Bank: 1. Whether the defendant has assumed responsibility to the claimant.
COURT OF APPEAL GIVES GUIDANCE FOR BANKERS’ REFERENCES

2. Whether:
   a. loss was a foreseeable consequence of the defendant’s actions or inactions (the threshold test);
   b. the relationship of the parties was sufficiently proximate; and
   c. it is fair just and reasonable to impose a duty of care on the defendant towards the claimant.

3. Whether the addition to existing categories of duty is incremental rather than indefinable.

Applying these principles, the Court of Appeal held that the factual differences with Hedley Byrne did indeed afford a relevant legal distinction.

The Court of Appeal focused on whether there had been an assumption of responsibility and whether it would be fair, just and reasonable to impose a duty. It held that there could be no assumption of responsibility or “special relationship” between the Bank and the Club, given that the true purpose of the reference was not revealed to the Bank and the Bank did not know of the existence of the Club.

Assumption of responsibility is a sufficient but not a necessary condition for finding a duty of care. The Court of Appeal therefore went on to consider whether it would be fair, just and reasonable to impose liability on the Bank in this case, concluding that it was not. The Club had chosen not to reveal its own interest in the reference to preserve the confidentiality of its customers. The Court held that it was not just and reasonable for the Club to assert a duty of care when it deliberately concealed its existence.

The Court also rejected the Club’s submission that it should be able to sue the Bank as Burlington’s undisclosed principal, on the basis that the Bank had again assumed no responsibility to the Club on the facts. The Court focused in particular on the fact that the requesting bank had named Burlington and so there was no reason for the Bank to think that the reference would be relied on by anyone else (particularly where the reference was given in strict confidence, indicating it would not be passed on).

COMMENT

This decision is an interesting clarification of the Hedley Byrne rule. It suggests that if a party chooses not to reveal its existence to the bank providing a reference, then it will not be able to establish that it is owed a duty of care.

The commercial effect of the judgment is that, if a request for a bank reference:

1. deliberately chooses not to reveal the existence of an underlying customer (naming an intermediary instead); and

2. does not specify the purpose for which the reference is required; then the underlying customer may not be able to rely upon the reference if the subject of the reference defaults.

Financial institutions drafting requests for references should therefore ensure that the above information is included in any request. Any customer who wishes to remain anonymous should be warned that there is a risk they may not be able to rely upon the reference. On the other hand, any financial institutions who are giving references may be able to rely upon this development in order to avoid liability under the reference in an appropriate case.

ADDITIONAL REFERENCES

Hedley Byrne & Co Ltd v Heller & Partners Ltd [1964] A.C. 465
Caparo Industries Plc v Dickman [1990] 2 AC 605
Customs and Excise Commissioners v Barclays Bank plc [2006] UKHL 28
CAUSATION IN VALUERS’ NEGLIGENCE CLAIMS: EXTENT OF LOSS RECOVERABLE FROM NEGligent VALUER IN THE CONTEXT OF A REFINANCING LOAN

In a decision that will be of interest to financial institutions and may have significant implications for the lending industry and for valuers, the Court of Appeal has allowed a lender’s appeal against summary judgment that had been granted in favour of the Defendant valuer in a professional negligence claim.

The Court of Appeal held that where a lender advanced money on the basis of an initial valuation of the proposed security, then refinanced the facility (effectively repaying and replacing the original loan) on the basis of a second negligent valuation, the second loan was entirely independent from the first loan. In that scenario, the valuer may be liable for the whole of the loss flowing from that negligent valuation – that being the loss attributable to the entire amount of the second loan, not just the “top up” amount of any additional lending.

The decision helpfully clarifies:

1. the application of the “but for” test of causation in circumstances where a second refinancing loan (made subject to a negligent valuation) completely repays the amount of the first loan; and
2. the extent of the loss recoverable from a negligent valuer in the context of a refinancing loan.

BACKGROUND

The claim related to a residential development (the “Property”). In early 2011, the Claimant lender (“Tiuta”) advanced funds of £2.2 million to a borrower on the strength of a valuation carried out by the Defendant surveyor (“De Villiers”) in February 2011 (the “February Valuation”). The February Valuation valued the Property (in its then-current state) at £2.3 million, with a gross development value (“GDV”) of some £4.5 million. By December 2011, the sum outstanding had risen to some £2.5 million.

A second valuation of the Property was undertaken by De Villiers in December 2011 (the “December Valuation”) and valued the Property at £3.25 million in its then-current condition, with a GDV of £4.9 million. On the strength of the December Valuation, Tiuta made a new facility of just under £3.1 million available to the borrower and did so by refinancing the original facility (rather than by simply varying the original loan agreement).

By June 2012, the borrower had drawn down £2.84 million of the funds available under the loan facility. The borrower failed to repay the loan and Tiuta appointed receivers to realise the value of the property. It was estimated by the receivers that the property would, in fact, realise only £2.14 million on sale, and Tiuta sought to claim the balance of the loan due and the cost of funding from De Villiers, on the basis that its second December Valuation was negligent. Tiuta made no allegation of negligence in respect of the February Valuation.
CAUSATION IN VALUERS’ NEGLIGENCE CLAIMS: EXTENT OF LOSS RECOVERABLE FROM NEGLIGENT VALUER IN THE CONTEXT OF A REFINANCING LOAN

De Villiers applied for summary judgment on Tiuta’s claim. De Villiers’ case was that by the time the second loan was made to the borrower in January 2012, Tiuta already faced an unavoidable loss of £2.5 million in respect of the sums advanced under the first loan. Given Tiuta had already lent that sum to the borrower at the time of the second December Valuation, it would have been exposed to that indebtedness of Tiuta in any event. Those sums had been advanced on the basis of the first February Valuation, which was not criticised in the claim.

In contrast, Tiuta’s position was that the monies advanced in 2012, on the basis of the December Valuation, were a completely new and separate loan, on different terms and subject to a further facility fee. That second loan was used to discharge in full the existing indebtedness of the borrower, which was replaced with the new loan. Thus, Tiuta claimed that the whole of the money due from the borrower was advanced in reliance on the (impugned) December Valuation.

As the matter had come before the Court by way of a summary judgment application, it had been necessary to proceed on the basis of two fundamental assumptions: (i) that De Villiers was negligent in over-valuing the property in December 2011; and (ii) that the effect of the second transaction was to discharge the debt owing on the original loan.

First Instance Decision

The judge at first instance, Mr Timothy Fancourt QC, found in favour of De Villiers. Fancourt J held that the “but for” test for causation was applicable and that on the facts of the case Tiuta was exposed to a £2.5 million liability even if the second December Valuation had not been negligent. De Villiers was therefore only liable for any loss caused by the additional lending and summary judgment was granted in favour of De Villiers.

Court of Appeal Decision

By a majority of two to one, the Court of Appeal allowed Tiuta’s appeal. The Court of Appeal unanimously agreed that “but for” test should be applied in the circumstances but disagreed as to how it should be applied.

The question before the Court of Appeal in essence was: can Tiuta recover its total loss from De Villiers, or is De Villiers only responsible for the “top up” element of the second refinancing loan because Tiuta would have suffered the loss on the original loan in any event?

Majority Decision

The majority view (Moore-Bick LJ and King LJ) was that, when applying the “but for” test correctly, De Villiers was liable for the whole loss flowing from the negligent December Valuation. To determine what loss had been caused by that valuation, it was necessary to identify correctly the nature of the transaction and the part the valuer played in it. In this regard, the majority considered that first and second loans were both factually and legally separate and that the purpose of the new loan was of no interest or relevance to De Villiers. Moore-Bick LJ delivering the leading judgment noted that the decision at first instance “failed to take into account the fact that the transaction was structured in such a way that the second loan was used to pay off the first”. The fact that the second loan stood alone and was used to repay the first loan in full released De Villiers from any potential liability in respect of the first valuation. On this basis, there was nothing unfair in holding De Villiers liable in accordance with its own valuation for the purposes of the second loan. As a result, Moore-Bick LJ concluded that “the basic comparison for ascertaining the appellant’s loss is between the amount of that second loan and the value of the security”. He further stated that this conclusion would have been the same had different valuers carried out the relevant valuations.

Dissenting Judgment

The dissenting judgment from McCombe LJ supported the more “basic” approach to the “but for” test taken by the judge at first instance, and considered that the proper application of “but for” test meant that it was necessary to compare Tiuta’s actual position with a no-negligence position: if a non-negligent second valuation had been given then the re-financing loan would not have been provided and Tiuta would have still suffered the loss which had already arisen from the original loan.

McCombe LJ also considered:

- It would be inherently unfair if the valuer was “saddled” with the liability referable to the first loan as a consequence of the way the lender chose to structure the second refinancing loan. However, King LJ, who agreed with Moore-Bick LJ, stated that, “the other side of that coin is that it could be said to be inherently unfair that, where both parties are commercial organisations, a negligent valuer could use an attack on the legitimate working practices and systems of the appellant as a means of escaping part of the consequences of his or her negligence.”

- Tiuta’s case as it was argued before him did not accord with facts as they were pleaded and verified as being true.

Suitability for Summary Judgment

Moore-Bick LJ added a postscript (with which McCombe LJ and King LJ each agreed) which stated that the issues raised in the appeal were generally better determined at trial on the basis of findings of fact, rather than on what was inevitably a hypothetical basis due to the two key assumptions the Court was forced to accept (referred to above). For this reason he suggested that, if it had been thought desirable for the issue to be determined in advance of trial, such matters may have been better heard as a preliminary issue.
COMMENT

As stated above, the decision clarifies the application of the “but for” test in circumstances where a negligent valuation supports a second refinancing loan which repays an earlier loan. In such circumstances, the second loan is to be considered entirely independent from the first loan and the valuer may be liable for the entire amount of the second loan.

Some further points to consider:

- The onus is now clearly on valuers to limit their liability in circumstances where its valuation may be relied upon to extinguish an existing loan. With this in mind, valuers may wish to review the steps they take to limit their liability in particular cases, and financial lenders should be aware that valuers (and their professional advisers) may become more active in this regard.

- The majority strongly stated that the purpose of the second loan was of no interest or relevance, either in fact or in law, to De Villiers; regardless of that purpose “the valuer is liable for adverse consequences flowing from the lender’s entering into a transaction insofar as they are attributable to any negligence deficiency in the valuation”.

- Moore-Bick LJ also expressed doubt that the court can or should disregard the way in which commercial parties have chosen to structure a routine business transaction of this kind.

- If the matter proceeds to trial, De Villiers could still avoid liability if it is found that the second valuation was not negligent.

ADDITIONAL REFERENCES

Tiuta International Ltd (In Liquidation) v De Villiers Chartered Surveyors Ltd [2015] EWHC 773 (Ch)
In O’Hare v Coutts, the High Court dismissed a claim alleging that the Defendant, a bank, breached duties in contract and tort to use reasonable care and skill when recommending five investments that the Claimants entered in 2007, 2008 and 2010.

The Court held that the bank’s duties required proper communication and dialogue with the client regarding the proposed investment, in order to ensure the client understood the advice it was given and the risks arising from the recommended course of action. However, the Court found that the relevant approach was not to assess the bank’s actions by reference to what a body of financial advisors would consider acceptable (the “Bolam test”). Rather, the Court would ask whether the bank took reasonable care to ensure the Claimants were aware of any material risks. This approach, the Court said, takes into account the lack of any clear industry consensus about the extent of communication required and the fact the bank’s regulatory duties—which are “strong evidence of what the common law requires”—do not require reference to industry practice.

Another key issue was the extent to which it was appropriate for the bank to persuade the Claimants to take more risks than they otherwise would. The Court could not find anything intrinsically wrong with persuasive salesmanship, provided the products sold were objectively suitable (in which regard the Court said the Bolam test is still applicable). Although with the benefit of hindsight, the investments had not performed as well as the clients had wished, the Court nevertheless found that reasonable practitioners professing the expertise of the bank could properly have given the same advice the bank did. The Court therefore concluded that the investments were suitable and the Claimants should take responsibility for their own investment decisions.

The case is also interesting for the following reasons:

- The bank did not call a pivotal witness, the Claimant’s former relationship manager, but relied on his contemporaneous notes. The Court admitted the notes as hearsay evidence and declined to draw any adverse inferences in respect of the weight to be given to them because there was no procedural failure on the bank’s part.
- The Court said that if the claims in contract and tort had succeeded, the Claimants’ damages would be limited by the more restrictive test of remoteness under contract law.
- The Court found that the bank’s promise to apply discounts in favour of the Claimants as a “gesture of goodwill” in settlement of a separate dispute constituted a binding legal settlement.

BACKGROUND

Mr and Mrs O’Hare (the “Claimants”) were owners of an engineering firm, with a joint net worth in excess of £25 million. Their relationship with the bank began in 2001. Their relationship manager from 2001 to 2008 was Kevin Shone, after which Ray Eugeni took over.

Although Mr O’Hare was an astute businessman, the Court did not accept that he was necessarily an experienced investor. The
Court found that he was willing to accept some – but not too much – risk, provided he was properly informed about how much risk he was taking.

In 2007 and 2008, the Claimants invested over £8 million on the bank’s advice into three products from the bank’s new line of “Novus” funds (the “Novus Investments”). The bank classified these as “wealth generation products” (its most risky investment category). The result was a significant shift in the Claimants’ portfolio towards higher risk investment, concentrated in three untested hedge fund products. The Claimants alleged that the Novus Investments were unsuitable because the bank downscaled the substantial increase in risk, there was no capital protection, and the investments caused the Claimants to expose an unjustifiably high proportion of their wealth to loss.

In 2010, the Claimants invested a further £10 million in two additional products which the bank recommended: RBS International funds called Autopilot and Navigator (the “RBSI Investments”). Unlike the Novus Investments, the RBSI Investments were classified by the bank as “wealth preservation products” (the bank’s least risky investment category). However, the Claimants alleged the RBSI Investments were unsuitable because the bank should have advised against concentrating so much money in one institution and it should have recommended products other than those of it and its parent.

**DECISION**

**The suitability issue: what standard of care is expected of financial advisors?**

The bank undertook to advise the Claimants in their personal capacity, including working with them to understand their “circumstances, objectives and requirements” and to formulate “an investment strategy”. The bank was obliged to give its advice in writing, at such times as it considered appropriate (or otherwise as agreed).

Uncontroversially, the Court found that the bank owed identical duties in tort and contract to use reasonable skill and care when recommending investments, to the standard of a reasonably competent private banker.

**Were the Claimants adequately informed?**

The Court held that in the context of giving investment advice, there must be proper dialogue and communication between adviser and client. The bank submitted that this ought to be assessed in line with the traditional test from *Bolam*: namely, by reference to whether a body of financial advisors would consider the extent of its communications acceptable. The Court noted that the *Bolam* test had recently been overturned in a medical context (so far as the duty to explain is concerned), in favour of a duty to take reasonable steps to ensure the patient is aware of any material risks (see *Montgomery v Lanarkshire Health Board*). In *Montgomery*, the Supreme Court said that a risk is material if, in the circumstances, (1) a reasonable person in the patient’s position would be likely to attach significance to it; or (2) the doctor is aware that the patient would be likely to attach significance to it.

In the context of duties to explain investment risks, the Court also preferred the *Montgomery* approach to *Bolam*, in particular because the expert evidence did not establish any industry consensus delimiting the proper role of a financial adviser in this regard. The Court supported its decision by reference to the regulatory regime, which is “strong evidence of what the common law requires”. In particular, the Conduct of Business Sourcebook (COBS) includes a duty to explain in similar terms to *Montgomery* and, unlike *Bolam*, does not require reference to the opinion of a responsible body within the profession.

Applying the *Montgomery* approach first to the Novus Investments, the Court concluded that the presentations in September and November 2007 “left no room for any suggestion that Mr O’Hare did not fully understand the Novus products”, including “an understanding of their higher risk classification as wealth generation products”.

Similarly, in relation to the RBSI Investments, the Court concluded that Mr O’Hare was “fully aware that the capital would be at risk if RBSI should become insolvent but was happy to run that risk because, he reasoned, RBS was effectively state owned.” Likewise, the Court rejected the allegation that “insufficient information about the products (including costs and charges), and insufficient comparative information about alternatives, was provided”.

**Were the investments objectively suitable?**

Given the Court’s decision that the Claimants were properly informed, the case turned on whether the investments were objectively suitable for the Claimants (the case being one where it was not disputed that advice had been provided by the bank). In this context, the Court accepted that the *Bolam* test applied, the relevant question being whether “reasonable practitioners professing
**HIGH COURT DISMISSES MIS-SELLING CLAIM AND CLARIFIES STANDARD OF CARE REQUIRED OF FINANCIAL ADVISORS**

The expertise of the defendants could properly have given advice in the terms they did.

The key issue was the extent to which it was acceptable for the bank to persuade clients to take more risk than they otherwise would (and conversely, when the bank would be required to step in and “save the clients from themselves”). Perhaps in a welcome recognition of commercial reality, the Court did not find anything intrinsically wrong with a financial adviser using persuasive techniques to induce a client to take risks the client would not take but for the adviser’s powers of persuasion, provided the risks are not so high as to be foolhardy (avoiding the temptation to use hindsight), the client could afford to take the risks, and the client shows themselves willing to take the risks. Critically, the Court said that the duty of care must reflect a balance between the client taking responsibility for investment decisions (even mistaken ones) and the principle that the adviser must sometimes save the client from himself or herself.

In considering the Novus Investments, the Court explicitly applied the Bolam test, ultimately agreeing with the bank’s expert witness that “competent practitioners at the time – avoiding hindsight – would not regard investment in the Novus products as foolhardy for persons in the position of the O’Hares, with their wealth and investment objectives”.

In contrast, the Court did not explicitly invoke the Bolam test in its analysis of the RBSI Investments. This may be because the capital-protected RBSI Investments involved de-risking and consequently, there was less scope for the Claimants to suggest that the products were objectively unsuitable. In any case, Mr Eugeni, in his unchallenged evidence for the O’Hares, said that after the 2010 RBSI Investments, he considered the portfolio suitable and well balanced. As such, the Court’s focus was on whether the O’Hares were properly informed about material risks relating to the RBSI Investments (in light of the fact such a large amount of money was being placed with a single banking institution).

On the evidence before it, the Court held that all of the investments in question were objectively suitable for the Claimants, who should therefore reasonably bear responsibility for their own mistaken investment decisions (even in light of the bank’s salesmanship).

**The absent witness: will courts draw adverse inferences if key witnesses are not called?**

A key factual issue relevant to suitability was the extent to which the Claimants were persuaded by their first relationship manager, Mr Shone to make higher risk investments than would be consistent with their unconditioned risk appetite.

Although he was a material witness, the bank did not call Mr Shone and instead chose to rely on his contemporaneous notes (which were referred to and implicitly adopted as true in the statements of two other Bank witnesses, both called orally). The bank explained that Mr Shone was a former employee and had indicated he was too busy to devote time to the proceedings.

The Court accepted that the hearsay notes were admissible, by virtue of section 1 of the Civil Evidence Act 1995, which abolished the rule against the admissibility of hearsay in civil proceedings. Moreover, because they formed part of the agreed bundle and the Claimants did not give a written notice of objection in respect of them, paragraph 27.2 of Practice Direction 32 confirmed the notes would be admissible as evidence of their contents.

Section 2(4)(b) of the Civil Evidence Act 1995 provides that a failure to comply with the relevant procedural rules may be taken into account as a matter adversely affecting the weight to be given to hearsay evidence. Here, the Court declined to draw an adverse inference in respect of Mr Shone’s notes because it found that the Court had complied with its obligations under CPR 32 and 33 (given that the witnesses who referred to those notes gave oral evidence). It was open to the Claimants under CPR 33.4 to call Mr Shone for cross-examination, but they did not.

In terms of the weight given to those notes, the bank relied on Gestmin v Credit Suisse, in which the High Court said that the best approach for a judge to adopt in a commercial case is “to place little if any reliance at all on witnesses’ recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts.” Whilst the Court agreed that the approach in Gestmin is “very useful”, it did not accept that the effect of Gestmin was to cause Mr Shone’s notes to be admitted unchallenged (their accuracy having been disputed by the Claimants). Nor did it go so far as to mean Mr Shone’s notes should always be preferred to the oral testimony of the Claimants. Indeed, the Court ultimately preferred Mr O’Hare’s testimony that Mr Shone used persuasion on him over Mr Shone’s notes, which repeatedly described the Claimants as “keen”, without mentioning the exertion of persuasion or influence by the bank.

Although the tactical question of which witnesses to call will always be highly fact specific, this case illustrates the importance of complying with the procedural rules for adducing hearsay evidence in the absence of a witness (and the importance of calling a witness if the other side does not).
The settlement agreement: when will "gestures of goodwill" be legally binding?

In 2008 and 2009, the Claimants complained that the bank had not properly explained the risk profile of another product called Orbita Capital Return, which had performed poorly. The bank rejected the Claimants’ complaint and set out reasons why it said the product had not been mis-sold. Nevertheless, the bank recognised the value of the Claimants' business and agreed—"as a gesture of goodwill"—to apply a refund of $250,000 by way of a reduction in fees over a period of time in consideration for the Claimants forbearing to sue. Although Mr O'Hare gave evidence that the agreed currency was pounds sterling, the Court found that Mr O'Hare was genuinely mistaken and that the agreed currency was dollars, reflecting Mr Eugeni’s written notes.

The Claimants sought to exclude discounts that were subsequently negotiated in respect of various investments from the bank’s obligation to bestow $250,000 worth of benefit to the Claimants. The Claimants said that these discounts were separate and distinct from the total of $250,000 which the bank owed.

The bank’s primary argument was that the "settlement agreement" was not binding; rather, it was merely a "gesture of goodwill" made without intention to create legal relations. The bank referred to Clarke v Nationwide in which a refund sent in “full and final settlement”, but described as a “goodwill gesture”, was held not to be binding.

Here, the Court expressly declined to hold that Clarke provided authority for a general proposition that offers made as a gesture of goodwill are not capable, on acceptance, of binding the offeror. The Court noted that this was a question that depended on the circumstances. Unlike Clarke, the bank’s offer was made in the context of a pre-existing contractual relationship. This placed a heavy onus on the bank to show that the parties did not intend to be legally bound, which it failed to discharge. Nevertheless, the Court held that the bank complyed with its side of the bargain by applying $250,000 worth of discounts, despite Mr O’Hare’s genuine belief that some of those discounts that he separately negotiated ought to have been excluded from the sum.

The Court’s approach to this issue highlights the risks in entering into settlements which are not formally documented, given the potential for later disagreement over their terms and the extent to which they have been satisfied. The difficulties here were exacerbated by the absence of evidence from key witnesses (both Mr Shone, who was not called, and Mr Eugeni, who had not given evidence about this point).

The damages issue: concurrent claims in tort and contract

Interestingly, the Court said that if the Claimants were successful, it would have confined damages to the more restrictive contractual test of remoteness (rather than the more generous tortious measure of damages). The Court said that it would have taken this approach even in respect of the Novus Investments, where the Claimants’ contractual claim was time barred but its tortious claim was not. To do otherwise would be to allow the Claimants to benefit from their failure to bring the contractual claim less than six years before the cause of action arose.

This follows the approach in Wellesley v Withers, where the Court of Appeal said that in cases of concurrent liability in tort and contract, the parties are not strangers and should be confined to the contractual measure of damages (since the contract reflects the consensus between the parties which ought to be reflected when dealing with issues of remoteness).

In this case, the Court doubted whether the distinction would make any real difference. However, in other circumstances, it might be relevant whether the financial advisor is liable for all foreseeable consequences of the breach (for instance, unexpected or catastrophic falls in the market) as opposed to merely loss that is within the reasonable contemplation of the parties at the time the contract for the provision of advice is made.

COMMENT

O’Hare v Coutts provides helpful guidance about the extent of financial advisers’ duties to their clients. In particular, the decision erodes the Bolam test in the context of the duty to explain investment risks (as had already happened in cases of medical negligence): in cases where objectively suitable advice has been given, the extent of communications required is simply to take reasonable steps to ensure the client is aware of material risks. On the other hand, the decision affirms that the Bolam test still applies to the assessment of whether the advice given is objectively suitable (which requires reference to whether reasonable practitioners professing the expertise of the Defendant could properly have given the advice the Defendant did).

This adds to the theme of recent cases, which make clear that informed investors must be prepared to accept responsibility for their own investment decisions, even where the adviser has used sales techniques to push a particular product or to encourage the investor to take more risk than they otherwise would.

The decision also serves to reinforce the basic proposition that evidence at trial should generally be given orally by the witness who proves the fact. Where this is not possible, contemporaneous hearsay notes (albeit admissible) may not be preferred to contradictory oral evidence. Parties who intend to adduce hearsay evidence should take steps to protect themselves by complying with the relevant procedures in the CPR. Equally, parties should consider giving written notice of objection to the admissibility of hearsay evidence which the other side seeks to include in agreed bundles.
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Finally, the decision provides clarification of the approach to damages in cases of concurrent liability in tort and contract. While it may not always be relevant, the Court’s approach of limiting damages to the more restrictive contractual test of remoteness could protect a bank in circumstances where investments perform poorly due to unexpected or catastrophic changes in the market.

ADDITIONAL REFERENCES

Civil Evidence Act 1995
Bolam v Friern Barnett Hospital Management Committee [1957] 1 WLR 582
Gestmin v Credit Suisse [2013] EWHC 3560 (Comm)
Montgomery v Lanarkshire Health Board [2015] UKSC 11
Wellesley Partners LLP v Withers LLP [2015] EWCA Civ 1146
**UCTA REASONABLENESS TEST MAY APPLY EVEN WHERE CONTRACT IS ONLY PARTLY ON STANDARD TERMS**

In this case, the High Court found that the requirement of reasonableness imposed by the Unfair Contract Terms Act 1977 (UCTA) can apply in circumstances where a party’s written standard terms and conditions are incorporated only in part and other terms are tailor made.

**BACKGROUND**

The first Defendant (“Mitchell”) was engaged to design and build a warehouse in Kent. Mitchell entered into sub-contracts with the second Defendant (“Regorco”) to carry out vibro compaction and piling works at the site. The Claimant subsequently acquired an interest in the completed warehouse and is the beneficiary of a warranty given by Regorco.

Nearly ten years after the works were completed, the sub-tenant in occupation of the warehouse complained of settlement of the slab beneath the production area.

Regorco’s standard terms and conditions contained a provision, clause 12(d), which required the notification of any claim to be made in writing within 28 days of the appearance of any alleged defect, or of the occurrence of the event complained of, and in any event to be so notified within one calendar year of the date of completion of the works.

The Court tried the following as preliminary issues:
1. whether clause 12(d) had been incorporated into the sub-contracts;
2. if it had, whether it was subject to the provisions of UCTA; and
3. if so, whether it satisfied the test of reasonableness.

**DECISION**

The question of whether clause 12(d) had been incorporated was a difficult one, due to a complex “battle of the forms” style exchange of standard terms and conditions between Mitchell and Regorco. The Court (Mr Justice Edwards-Stuart) held that clause 12(d) had not been successfully incorporated into the sub-contracts, but went on to consider whether UCTA would apply in the event that this conclusion was incorrect.

The Court was satisfied that the terms Regorco sought to be adopted were its “written standard terms of business”. Although Regorco’s group risk manager acknowledged that its standard written terms and conditions were negotiable “for a price”, he said that Regorco did everything that it could to ensure that its terms and conditions were accepted.

Edwards-Stuart J distinguished the present case from his own judgment in *Yuanda* where he held that “[i]f there is any significant difference between the terms proffered and the terms of the contract actually made, then the contract will not have been made on one party’s written standard terms of business.” He said his comments in *Yuanda* must be seen in their own context. In that case the relevant terms came into existence solely for one particular project. It was not a case where a company had a printed set of conditions that it intended to use for every contract, year in year out, as was the case here, and the terms were in fact amended by almost every trade contractor on the project.

Regorco sought to argue that, to be dealing on its written standard terms of business, the entirety of Regorco’s terms and conditions would have to have been incorporated into the sub-contracts, which they hadn’t. Edwards-Stuart J rejected this argument, approving and adopting the obiter reasoning in *Pegler v Wang*. If, therefore, clause 12(d) had been incorporated into the sub-contracts at Regorco’s insistence, then Mitchell would have been required to deal on Regorco’s written standard terms of business and UCTA would have applied.

The Court held that clause 12(d), if it had been incorporated into the sub-contracts, did not satisfy the reasonableness test under UCTA. The Court placed much weight on the fact that, in the context of ground compaction and piling work, there will often be a substantial lapse of time between completion of the works and appearance of any visible defects. Clause 12(d) sought to exclude claims unless they were made both within the 28 day time limit and within the longstop date of one year. The Court held that compliance with these requirements was not “achievable, let alone practicable, save in rare cases”.

**COMMENT**

The UCTA reasonableness test applies to (among other things) any attempt to exclude or restrict liability for breach of contract where one party deals “on the other’s written standard terms of business”. Parties may assume that the test is not engaged in the context of a contract made between two commercial parties where certain of the terms have been negotiated and others are in standard form.
However, this decision makes it clear that it is not necessary for the full suite of a party’s standard written terms and conditions to be incorporated into a contract before UCTA will apply. This means that more exclusion clauses may be open to challenge on grounds of reasonableness than might generally have been assumed.

**ADDITIONAL REFERENCES**

Yuanda (UK) Co Ltd v W W Gear Construction Ltd [2010] EWHC 720 (TCC)

Pegler Ltd v Wang (UK) Ltd (No 1) [2000] BLR 218
HIGH COURT GIVES EFFECT TO CLAIMANT’S PART 36 OFFER FOR 95% OF CLAIM VALUE

In this case, the High Court awarded a Claimant indemnity costs where the Defendant conceded liability shortly before a split trial, having previously refused the Claimant’s Part 36 offer to accept liability for 95% of damages to be assessed.

BACKGROUND

Where a claimant obtains a judgment that is more advantageous than its Part 36 offer, the court must (unless it considers it unjust to do so) order the costs consequences set out in CPR 36.17, including indemnity costs and enhanced interest from the date on which the relevant offer period expired.

In considering whether it would be unjust to order the Part 36 costs consequences, the court must take into account all of the circumstances of the cases, including the factors set out at CPR 36.17(5). As from 1 April 2015, a new factor was added to this list:

“(e) whether the offer was a genuine attempt to settle the proceedings.”

In the present case, the Claimant brought proceedings against the Defendant in relation to the design and construction of a new grandstand at Epsom Race Course. Directions were given for a split trial on liability but by the time of the pre-trial review in December 2015 the Defendant had conceded liability.

The Claimant applied for indemnity costs on the basis of the Defendant’s failure to accept a Part 36 offer made by the Claimant in January 2015. That was an offer to settle the issue of liability on December 2015 the Defendant had conceded liability.

The award of indemnity costs should run from the earliest date made aware that the claim had been increased very significantly.

On the first point, the judge noted that this was a claim where the outcome could only be success or failure for either party; there was no room for apportionment of liability, and so a finding of 95% liability was not an available outcome at trial. However, that did not mean an offer to settle for 95% was not a valid Part 36 offer: cases are frequently settled on the basis of an assessment of risk which combines the risk of failure and uncertainty as to quantum, so that the settlement does not necessarily reflect a likely outcome at trial. That view was supported by the decision in Huck v Robson, where the Court of Appeal said there was no need to measure the offer against the likely outcome.

The Defendant submitted that Huck v Robson could be distinguished because it was decided under the previous version of the rules which did not include the present requirement for the Court to consider whether the offer was a genuine attempt to settle the proceedings. The judge rejected that submission, saying he had no doubt that the Court of Appeal’s view would have been no different if that provision had been included in the rule at the time; the Court had specifically considered whether the offer was a genuine attempt to settle, although it was not an express requirement of the rules.

Accordingly, the judge concluded that the offer in this case was a valid offer within the meaning of Part 36 and that it was a genuine attempt to settle the claim. Although the discount was very modest, it could not be described as derisory.

However, the judge accepted the submission that it would be unjust to award indemnity costs from 21 days after the date of the offer, since at that stage the Defendant had only just been made aware that the claim had been increased very significantly. The award of indemnity costs should run from the earliest date the Defendant could reasonably have put itself in a position to make an informed assessment of the strength of the claim on liability. That date was four months from the date of the offer, so the Claimant was awarded its costs in relation to liability on the standard basis up to that date and thereafter on an indemnity basis.
HIGH COURT GIVES EFFECT TO CLAIMANT’S PART 36 OFFER FOR 95% OF CLAIM VALUE

(Note that although the Part 36 offer in this case was made in January 2015, before the new version of Part 36 took effect in April 2015, the judge proceeded by reference to the new version of the rules.)

COMMENT

When the new version of CPR Part 36 was introduced from April 2015, one of the changes made was to address a perceived difficulty with the previous rules, in that a claimant could obtain the benefits of Part 36 by making an offer for nearly all the relief sought in the action. It was clear from previous case law that there had to be some genuine element of concession, so that a request for total capitulation would not be effective (see AB v CD). However, it was not clear how much of a concession there had to be; in Huck v Robson, for example, a claimant’s offer for 95% of the value of the claim was given effect.

The new rules addressed this issue by adding a further factor the court must take into account in deciding whether it would be unjust to order the Part 36 costs consequences, namely “whether the offer was a genuine attempt to settle the proceedings”. The idea was that a very high claimant offer was unlikely to be a genuine attempt to settle the claim, and so the new factor should mean the court would decline to give effect to a claimant’s offer which contained little in the way of concession.

The present decision suggests, however, that even with this new factor the courts may be prepared to give effect to claimant offers for a very large proportion of the claim value, though of course each case will turn on its facts. In the present case, the judge commented that although the discount was “very modest”, it could not be described as “derisory”.

ADDITIONAL REFERENCES

AB v CD (2011) EWHC 602 (Ch)
Huck v Robson (2002) EWCA Civ 398
COURT OF APPEAL DECISIONS SHOW CONTINUING TOUGH APPROACH TO PROCEDURAL FAILINGS

In case we were all in danger of thinking the courts’ approach to breaches of rules and court orders had relaxed nearly to pre-Jackson levels of tolerance, two Court of Appeal decisions act as a bit of a wake-up call. As these decisions show, there is clearly continuing scope for tough decisions against those who fail to comply, particularly where they do not make a prompt application for relief from sanction. The lesson for litigating parties is obvious.

In British Gas v Oak Cash & Carry, the Court dismissed a Defendant’s appeal against the strike-out of its defence resulting from a two-day delay in filing a listing questionnaire pursuant to an unless order. That means a default judgment entered against the Defendant for some £200,000 will stand.

Significantly, Lord Justice Jackson (who gave the leading judgment) suggested that a prompt application for relief from sanctions would have been granted; however, the delay in applying for relief had led to substantial disruption in the progress of the action, in particular the loss of the trial date, and so it was not appropriate to grant relief.

In Gentry v Miller, the Court of Appeal held that the lower courts should have refused to set aside default judgment, where the Defendant had delayed in making the application, despite evidence that the claim may have been fraudulent. This decision also highlights the fact that the Denton test for relief from sanctions applies equally to an application to set aside default judgment for failure to file an acknowledgement of service or defence.

**British Gas v Oak Cash & Carry**

**BACKGROUND**

The Defendant’s defence was automatically struck out on 19 February 2014 because it failed to comply with an “unless order” requiring its listing questionnaire to be filed by that date.

The day before the deadline expired, a trainee solicitor at the firm representing the Defendant had filed a directions questionnaire (not a listing questionnaire) at the Court. The solicitors filed the correct document two days late (on 21 February) but did not then apply for relief from sanctions.

On 25 February the Claimant applied for judgment in default of defence (on the basis that the defence had been struck out) and default judgment was entered for £211,388 on 18 March. On 24 March the Defendant applied for relief from sanction. It did not apply to set aside the judgment in default.

The district judge granted relief from sanction and set aside the judgment in default. That decision was overturned on appeal to the High Court, so that the default judgment was restored. The Defendant appealed to the Court of Appeal.

**DECISION**

The Court of Appeal dismissed the appeal, with Lord Justice Jackson giving the lead judgment.

In considering whether relief from sanction should have been granted under CPR 3.9, it was necessary to apply the three-stage test established in Denton:

**Stage 1: Was the breach serious or significant?**

In assessing the seriousness or significance of a breach, the Court must ignore historic breaches and look only at the particular breach in respect of which relief is sought. However, where there is a breach of an “unless order”, that breach does not stand on its own; it is necessary to look at the underlying breach which resulted in the unless order being made.

Jackson LJ commented:

“The very fact that X has failed to comply with an unless order (as opposed to an ‘ordinary’ order) is undoubtedly a pointer towards seriousness and significance. This is for two reasons. First, X is in breach of two successive obligations to do the same thing. Secondly, the Court has underlined the importance of doing that thing by specifying an automatic sanction in default (in this case the Draconian sanction of strike out).”

Not every breach of an unless order would be serious or significant - so for example in the Utilise case (heard with Denton), a 45 minute delay in complying with an unless order was held to be trivial, in circumstances were there was no underlying breach of the rules onto which the unless order was attached.

Here, however, the Defendant had had three months to comply with the original order to file the listing questionnaire (which was...
made on 1 November 2013) and had missed the original deadline by 18 days (it expired on 3 February 2014) as well as missing the extended deadline by 2 days. It was not possible to classify the breach as anything other than serious and significant.

**Stage 2: Was there good reason for the default?**

In *Mitchell*, the Court of Appeal gave some examples of good reasons, including that if a party or his solicitor suffered from a debilitating illness or was involved in an accident then, depending on the circumstances, that might constitute a good reason.

Here the fact the Defendant’s solicitor’s wife was suffering from health problems did not constitute a good reason for the default. The health problems had been known for many months. The firm should have provided appropriate cover for the solicitor’s cases and provided appropriate supervision for the trainee dealing with the matter. In addition, the solicitor had in fact attended the office on 17 February and approved submission of the directions questionnaire, when it should have been obvious it was not the correct document.

**Stage 3: All the circumstances, including specific factors set out in CPR 3.9**

At stage 3, the Court must consider all the circumstances of the case, but must attach particular weight to the factors set out in CPR 3.9, namely the need for litigation to be conducted efficiently and at proportionate cost, and to enforce compliance with rules, practice directions and orders.

Here, the Defendant’s lack of promptness in applying for relief was the critical factor that led to the appeal being dismissed. Lord Justice Jackson commented that, if the Defendant had made an immediate application for relief at the same time as, or very soon after, filing its listing questionnaire, he would have been strongly inclined to grant relief. At that point, the late filing of the listing questionnaire had not had any adverse impact on the smooth conduct of the action or the Court’s administrative processes.

However, by the time the Defendant applied for relief, on 24 March, the trial dates of 30 April / 1 May had been lost and so the default had substantially disrupted the progress of the action. Bearing in mind the specific factors set out in rule 3.9 (which under *Denton* must be given particular weight) the Court was required to refuse the application for relief.

**Gentry v Miller**

**BACKGROUND**

The underlying claim arose out of a road traffic accident. The facts are complex, but in essence the Defendant’s insurer failed to engage properly with the claim, despite being notified that the Claimant was incurring charges for a replacement vehicle under a credit hire facility and would continue to do so until the insurer paid the claim.

Ultimately the Claimant entered judgment in default of acknowledgement of service against the Defendant on 8 August 2013. The Claimant was awarded damages of £75,089 plus costs at a disposal hearing on 17 October 2013, which neither the Defendant nor its insurer attended.

On being notified of the award of damages and costs, the insurers instructed solicitors who, on 25 November, applied to set aside the judgment in default alleging that the claim was in fact fraudulent and that the Claimant and Defendant had known each other before the accident. The district judge set aside the judgment and the recorder dismissed the appeal. The Claimant appealed to the Court of Appeal.

**DECISION**

The Court of Appeal allowed the appeal, Lord Justice Vos giving the leading judgment.

It was accepted that the application to set aside the default judgment under CPR 13.3 was to be treated as an application for relief from sanctions under CPR 3.9. It was also accepted that the principles established in *Denton* applied regardless of the allegations of fraud.

The appropriate course was first to apply the express requirements under CPR 13.3, namely whether the Defendant had a real prospect of successfully defending the claim or there was some other reason the judgment should be set aside, taking into account the promptness of the application to set aside. After that, the *Denton* tests came into play.

The Court of Appeal noted that there must be finality to litigation and the rules of court must be obeyed, so a default judgment could not be set aside as a matter of course just because an arguable fraud was alleged, however long the delay in making the application. At some point, the Court must leave the applicant to vindicate its rights by bringing an action based on the fraud. When that point arose could be resolved by the application of the relevant tests under CPR 13.3 and the *Denton* criteria.

Here, the Court found that the insurer had not made the application promptly. It delayed inexcusably from the point when it could reasonably have obtained a sufficient knowledge of the default judgment to enable it to apply to set aside, which was by at least 19 September (even though it was not immediately served with the default judgment, as it ought to have been).
Applying the Denton tests: (1) the breach which allowed default judgment to be entered was serious or significant; (2) there was some explanation for the failure, though not a complete one; (3) taking into account all the circumstances, and in particular the need for litigation to be conducted efficiently and to enforce compliance with rules and order, the application to set aside ought to have been refused.

Vos LJ concluded with comments on what he recognised might seem a harsh decision:

“In my judgment, Mitchell and Denton represented a turning point in the need for litigation to be undertaken efficiently and at proportionate cost, and for the rules and orders of the Court to be obeyed. Professional litigants are particularly qualified to respect this change and must do so. Allegations of fraud may in some cases excuse an insurer from taking steps to protect itself, but here this insurer missed every opportunity to do so. … The insurer must in these circumstances face the consequences of its own actions.”

**ADDITIONAL REFERENCES**

Andrew Mitchell MP v News Group Newspapers Ltd (Practice Note) [2013] EWCA Civ 1537
Denton v TH White Ltd, Decadent Vapours Ltd v Bevan and others, Utilise TDS Ltd v Davies and others [2014] 1 EWCA Civ 906
DECISION HIGHLIGHTS COSTS RISK IN ISSUING A CLAIM FORM WHICH IS NOT THEN SERVED

Significant costs can be incurred in the pre-action period while parties investigate a claim and follow pre-action protocols. At the same time, it is not uncommon for settlement discussions to be on-going. Where discussions stall, a claimant may be tempted to issue a claim form without serving it immediately, in an attempt to convince the defendant it is serious about its claim in order to advance settlement discussions. It has the added advantage of stopping the limitation clock from running, where that is an issue.

BACKGROUND
The Defendant valued a residential property in August 2007 at £117,000. In reliance on that valuation, a loan of £105,301 was advanced to a couple secured on the property. The Claimant then purchased that loan in July 2009.

By January 2010 the couple had defaulted on their loan repayments and the property had been repossessed and sold for a sum significantly lower than the 2007 valuation.

In May 2011 the Claimant sent a letter of claim to the Defendant alleging that the Defendant had negligently or in breach of contract overvalued the property. The Claimant claimed losses of £31,148. The Defendant responded in full in June 2011. There then followed two years of settlement discussions, during which costs were incurred which, the Court said, were disproportionate to the value of the claim – the Claimant incurred costs of over £62,000 against its initial claim of £31,148 and against its final offer to settle of £12,500 (plus costs).

In August 2013, with the expiry of the limitation period looming, the Claimant issued a claim form but did not serve it. The Claimant brought to the Defendant’s attention the fact it had issued a claim form, made one last attempt at settlement – which was unsuccessful – and then allowed the claim form to lapse, thereby abandoning its claim.

The Defendant applied to recover from the Claimant the costs which it had incurred during the two year pre-action period and in the period after the claim form was issued.

DECISION
The Deputy Master said that it was clear from the Civil Procedure Rules and the authorities that issuing a claim form fundamentally changes the position on costs. If a claim form is not issued, a defendant cannot seek an order for its pre-action costs. However, when a claim form is issued, the Court has discretion to award to a defendant its costs “of and incidental to” the litigation (which will ordinarily include pre-action costs) if that claim is subsequently abandoned. This is the case whether a claimant formally discontinues the claim or, as in the present case, simply allows the issued claim form to lapse. The fact that a claim form has not been served is only a factor to be taken into account when the Court’s discretion is exercised.

In this case, the Deputy Master held that the Defendant was entitled to its costs, including its pre-action costs, “of and incidental to” the claim, which included all the expense that followed as a direct consequence of the letter of claim. Factors he took into account included that the costs incurred by the Defendant dealing with the abandoned claim were significant, that the Claimant had been aware throughout of the disproportionate expense of the course it was on and that the cost consequences of a Claimant issuing a claim form are clearly spelled out in the relevant statute and the Civil Procedure Rules.

COMMENT
Webb v Countrywide demonstrates the risk inherent in such a tactic if the claimant is not genuinely committed to pursuing its claim if settlement discussions fail: as soon as the claim form is issued the claimant may become liable for all of the defendant’s (potentially very significant) pre-action costs, and not only those which were incurred after the claim form was issued.
USE OF PREDICTIVE CODING FOR E-DISCLOSURE ENDORSED BY HIGH COURT

The High Court has ordered disclosure to be carried out using predictive coding despite a party’s objections to the use of the technology.

This is understood to be the first reported decision in which the English Courts have approved the use of predictive coding following a contested application. A decision in February 2016 had endorsed the use of the technology for a large disclosure exercise, but in circumstances where the parties had already agreed on its use (Pyrho Investments v MWB).

BACKGROUND
The underlying case is an “unfair prejudice” petition under section 994 of the Companies Act 2006. It was agreed that disclosure should be on a standard basis but there was a dispute as to whether the exercise should be conducted using predictive coding or a more traditional keyword approach. The majority of the relevant documents were in the hands of the respondents, who sought the order for predictive coding.

Predictive coding uses a combination of technology and manual document review. The document review software applies algorithms to human reviewers’ coding decisions to suggest similar documents for review. In doing so, the system prioritises those documents which it believes are most likely to be relevant, which are then reviewed by human reviewers. The purpose of the process is to identify the documents relevant to the case while reducing the time and cost of the review by reducing the number of irrelevant documents. Predictive coding is seen as potentially beneficial in large-scale disclosure exercises where linear review of documents, using only keyword searches to limit the volume, may not be feasible or proportionate.

DECISION
The Court (Mr Registrar Jones in the Companies Court) made an order for predictive coding. The fact that most documents were in the hands of the respondents was not determinative, but it was relevant to take into account when considering their assertion that predictive coding would be the most reasonable and proportionate method of disclosure.

The registrar described it as “extremely significant” that the estimated costs for predictive coding were in the region of £132,000 compared to costs for a keyword search of at least £250,000 and possibly as much as £338,000 on a worst case scenario.

That was only persuasive to the extent that predictive coding would be effective and achieve the disclosure required. However, there was nothing to suggest that predictive coding would not be able to identify the documents that would otherwise be identified through, for example, keyword searches – and predictive coding would be considerably cheaper.

The registrar referred to Pyrrho and the factors considered by Master Matthews in that case to favour predictive coding. The registrar said that all of those factors effectively applied to the present case, save that one factor (that there was nothing in the CPR or practice directions to prohibit the use of such software) was neutral and that (unlike in Pyrrho) the parties had not agreed to the use of the software. The other factors from Pyrrho, which the registrar said applied here, include:

- Experience in other jurisdictions has been that predictive coding software can be useful in appropriate cases.
- There is no evidence to show that it leads to less accurate disclosure being given than manual review/keyword searches, and some evidence to the contrary.
- There were no factors of any weight pointing against its use.

The registrar also made directions aimed at narrowing down the issues and the scope of disclosure before the predictive coding exercise took place. Essentially, the parties would have to identify relevant issues, the documents relating to them, their source and location, following which there would be discussions between the parties regarding the criteria to adopt and the general process of disclosure.
USE OF PREDICTIVE CODING FOR E-DISCLOSURE ENDORSED BY HIGH COURT

COMMENT
The present decision illustrates that the comparative costs between predictive coding and keyword searching are likely to be a significant factor in determining whether it should be ordered. It also suggests that, where there is a dispute as to whether predictive coding is appropriate, the court may take particular account of the views of the party who holds the lion’s share of the documents and therefore will have the greater burden on disclosure.

ADDITIONAL REFERENCES
Pyrrho Investments v MWB Property [2016] EWHC 256 (Ch)
The Court of Appeal has overturned a decision of the Central London County Court as to the effect of a clause requiring amendments to be in writing, finding that the autonomy of contracting parties to amend the terms of their agreement is paramount.

This decision confirms the non-binding view expressed by the Court of Appeal earlier this year in Globe Motors thereby settling an issue on which there was previously conflicting Court of Appeal authority.

BACKGROUND
The Claimant (MWB) operated and managed office space in central London. The Defendant (Rock) was a provider of marketing services and had occupied premises managed by MWB for a number of years. Rock entered into a written agreement with MWB to take on larger premises (at an increased fee) for 12 months from 1 November 2011. However, Rock's business did not expand as expected and it was unable to meet the increased fee payments, incurring arrears and other charges of over £12,000 by late February 2012. MWB exercised its contractual right to exclude Rock from the premises and sought to terminate the agreement.

In this action, MWB claimed the arrears and other charges and damages in respect of the unpaid licence fees while Rock counterclaimed for loss and damage suffered as a result of being, in its view, wrongfully excluded from the premises. Central to Rock's case was the claim that, on 27 February 2012, an oral agreement was made between the parties to reschedule the licence fee payments due under the original agreement. On the same day, Rock paid £3,500 to MWB on the basis that this was the first instalment due under the revised payment schedule. However, just two days later, MWB purported to reject what it characterised as Rock's "proposed payment schedules".

In the County Court, HHJ Moloney found that an oral variation had been agreed but could not take effect due to a clear clause in the agreement precluding any oral variations. He also held that MWB was not prevented, or 'estopped', from enforcing its strict rights under the licence agreement by reason of accepting the £3,500 payment from Rock. Rock appealed against both of these findings.

The judge also found that, if the oral variation was effective, the £3,500 payment and agreement to comply with the other terms of the revised payment schedule amounted to good consideration for it. MWB challenged that finding on appeal.

DECISION
The Court of Appeal unanimously allowed Rock's appeal on the first ground, holding that the oral amendment to the licence contract was effective despite the express contractual provision requiring amendments to be in writing.

The Court considered the ruling in Globe Motors and decided that it would require "a powerful reason" to come to a different conclusion in this case, which had not been shown. The autonomy of commercial parties was the most important consideration. This demanded that parties be able to amend their contracts even in situations where they had previously agreed only to do so by specific means.

On Kitchin LJ's analysis, with which McCombe LJ agreed, the oral variation agreement was binding on MWB so long as Rock continued to meet its obligations thereunder. Arden LJ accepted that this was a possible interpretation of the contractual position but added that her provisional view was that the parties had entered into a "collateral, unilateral contract" by which MWB was bound on receiving the £3,500 payment to accept the rescheduling of licence payments, so long as Rock occupied the premises and paid the licence fee as renegotiated. However, Arden LJ acknowledged that the question of a 'collateral, unilateral contract' was not raised by the parties and Kitchin and McCombe LJ said they preferred not to base their decision on that issue.

Having established that the terms of the licence agreement did not preclude an oral variation of the payment schedule, the Court of Appeal determined that the trial judge had been entitled to find that parties had reached an oral agreement. The next question for the Court was whether there was adequate consideration to make this agreement binding.
The Court considered the authorities on adequacy of consideration and concluded that, although part payment of a sum already due is not normally good consideration, MWB obtained an additional practical benefit in this case, namely that Rock’s continued occupation of the property would mean that it did not lie vacant. On that basis, the Court of Appeal was satisfied that there was adequate consideration.

Having concluded that the parties had validly agreed to reschedule the licence payments, the Court did not need to rule on Rock’s second ground of appeal with regard to the alleged unfairness of MWB enforcing its contractual rights. Nevertheless, Kitchin and Arden LJJ set out their views of this element of the case, concluding that Rock had not suffered any prejudice in paying an amount to MWB that it was already due to pay. Accordingly there would have been no basis in promissory estoppel, waiver or proprietary estoppel to prevent MWB enforcing its rights under the contract.

COMMENT

In light of this decision, commercial parties should note that including a clause requiring amendments to be in writing will not always prevent oral amendments taking effect. However, the Court acknowledged that such a clause can make it more difficult to demonstrate that the parties intended to vary the contract through oral discussions.

The Court of Appeal also found that, in the circumstances of this case, an agreement to accept payment of an existing debt by instalments was supported by consideration as the creditor received a practical benefit beyond merely accommodating the debtor. Although the Court expressly did not depart from the established rule that part payment of a debt is not good consideration for the release of the whole, the decision may indicate an increasingly flexible view as to what will amount to additional consideration so as to result in a binding variation.

ADDITIONAL REFERENCES

Globe Motors Inc v TRW Lucas Varity Electric Steering Ltd [2016] EWCA Civ 396
SUPREME COURT HOLDS THAT A SETTLEMENT MAY BE SET ASIDE FOR FRAUD EVEN IF FRAUD WAS SUSPECTED

The Supreme Court has held unanimously that, where a party seeks to set aside a settlement agreement on the grounds that it was induced to enter into it by its opponent’s fraudulent misrepresentations, it will not necessarily be a bar to the claim that the party did not fully believe the representations.

Overturning the Court of Appeal’s ruling on this point, the Supreme Court identified the appropriate question as whether the party was “influenced by” its opponent’s representations in entering the agreement. There is no independent requirement that the defrauded party actually believed the representations to be true. The fact that it had doubts or suspicions may be highly relevant to the court’s assessment of whether it was influenced, but it will not be determinative. In particular, in the specific context of an agreement to settle court proceedings, a party may have been influenced in the sense that it took into account the risk that the court hearing the claim would believe the representations, even if the party itself did not. Each case will however turn on its facts.

The Supreme Court’s decision clarifies an uncertain area of the law regarding misrepresentation and deceit in a settlement context and will be particularly welcomed by insurers and other parties involved in proceedings where an element of fraud is suspected.

BACKGROUND

An employee brought proceedings against his employers in respect of a workplace injury. The employers’ insurer conducting the defence admitted liability but disputed quantum, primarily based on the insurer’s pleaded case that the employee was exaggerating the extent of his ongoing condition (supported to some extent by video surveillance evidence). The claim settled before the quantum trial, with the terms recorded in a settlement agreement.

Two years later, the insurer received from the Claimant’s neighbours further evidence that the claim had been dishonestly exaggerated. This evidence indicated, in particular, that the Claimant had fully recovered from his injuries over a year prior to the settlement. The insurer sought rescission of the settlement agreement (or damages for deceit in the alternative) on the basis that it had been induced to enter into the agreement by the employee’s fraudulent misrepresentations, in the form of statements as to his condition in his pleadings and witness statements.
SUPREME COURT HOLDS THAT A SETTLEMENT MAY BE SET ASIDE FOR FRAUD EVEN IF FRAUD WAS SUSPECTED

LOWER COURT DECISIONS

In the County Court, Judge Maloney QC (in a judgment subsequently broadly endorsed by the Supreme Court), set aside the settlement agreement on that basis. Following a review of the relevant authorities, the Court concluded that it was not essential for a party to show that it subjectively believed a representation in order to establish that it relied on it in entering into a contract. Rather, the law only required a party to have been “influenced by” a representation. This requirement was satisfied here in the sense that the insurer undoubtedly took into account in its decision to settle for the amount it did the fact that the claimant’s assertions would be put before the Court and the risk that they would be believed, given that it had been unable to secure adequate evidence in this regard.

The Court of Appeal overturned Judge Maloney’s ruling and held the insurer to the settlement, albeit with some regret at the employee benefitting from his dishonesty. It disagreed with the lower court’s analysis of the relevant law, holding that the authorities clearly indicated that, while a party need not have had “blind faith” in the truth of a representation in order to establish reliance, it “must have given some credit to its truth, and been induced into making the contract by a perception that it was true rather than false”. Further, in the present circumstances where the statements being relied on as misrepresentations were among the very matters alleged by the employee in the proceedings settled by the agreement, the Court considered there was no reason in principle to rescind an agreement purely on the basis that a defendant could subsequently show that the allegations were unfounded. It considered that to hold otherwise would seriously undermine the finality of settlement agreements and run counter to the public policy in favour of encouraging settlement.

SUPREME COURT DECISION

In judgments delivered by Lords Clarke and Toulson (with which the other Justices agreed), the Supreme Court allowed the insurer’s appeal, restoring the County Court ruling that the settlement agreement should be set aside. The Supreme Court’s reasoning largely endorses the approach adopted by Judge Maloney.

The Supreme Court confirmed that the correct test is whether a defendant could subsequently show that the allegations were unfounded. It considered that to hold otherwise would seriously undermine the finality of settlement agreements and run counter to the public policy in favour of encouraging settlement.

The Supreme Court expressed the view that, where there is an intention to induce by means of fraud, it is very difficult to rebut the presumption that the innocent party has in fact been induced. Lord Clarke noted that the authorities are not entirely consistent as to what is required to rebut the presumption (which is an inference of fact rather than a presumption of law) – whether what must be proved is that the misrepresentation played “no part at all”, or did not play a “determinative part”, or did not play a “real and substantial part”. It was not necessary to resolve the matter, however, as the presumption was clearly not rebutted on the facts of this case; on the judge’s findings of fact it was clear that, if the insurer had known the true position, it would not have agreed the settlement it did.

The fact that the insurer had carried out its own investigations into the veracity of the claims did not preclude a finding that it had been induced by the representations. The Court accepted that “Qualified belief or disbelief does not rule out inducement, particularly where those investigations were never going to find out the evidence that subsequently came to light.”

It is also important to note that in this case, although the insurer had suspected exaggeration of the claim to some extent, it did not know the full extent of the fraud subsequently uncovered. In Lord Clarke’s view, the Court of Appeal had put it too highly in suggesting that the fraud now relied on had been positively pleaded in the insurer’s defence.

A question therefore also arises as to what the position would have been if the full extent of the fraud had been known at the time of settlement (whether or not pleaded). The insurer appears to have conceded that, as a matter of law, where the innocent party knows that a representation is false, it cannot succeed. However, Lord Clarke, without expressing a final view, doubted this was correct as a blanket rule, given that the question of inducement will be a factual question in each case. He thought there could be circumstances in which a party might know that a representation is false but nevertheless be held to rely upon it. He referred to the judge’s example of a staged road traffic “accident”, where the innocent party might know for a fact that the claim was fraudulent but still have to take into account the risk that a court would believe the lie. In such a case, he said, the claimant “may well” establish inducement on the facts.
COMMENT

Whereas the Court of Appeal’s decision could clearly be seen as driven by a desire to avoid undermining the finality of settlement agreements, even if it resulted in fraudsters receiving a windfall, the Supreme Court judgment represents a move back from that position. While not amounting to an unqualified approach of “fraud unravels all”, it certainly illustrates the Court’s unwillingness to tolerate fraud.

It might be argued that the concern about discouraging settlement by undermining the finality of agreements has less force in the context of fraudulent claims, given that the party who might theoretically be discouraged from entering a settlement (out of concern that it could be unwound) would be the party receiving the settlement – that is, the fraudster. It seems unlikely that such parties would refuse settlements on this basis and opt for the far riskier strategy of having their claims tested in court.

ADDITIONAL REFERENCES

Hayward v Zurich Insurance Co Plc [2015] EWCA Civ 327
FINAL REPORT IN LORD JUSTICE BRIGGS’ CIVIL COURTS STRUCTURE REVIEW

The final report of Lord Justice Briggs in his Civil Courts Structure Review was published on 27 July 2016. Key recommendations relevant to commercial parties include:

- establishing an Online Court, initially for money claims up to £25,000;
- a substantial increase in the minimum claim value threshold for commencing claims in the High Court – initially to £250,000 and subsequently to £500,000;
- transferring some of judges’ more routine and non-contentious work to case officers, under judicial training and supervision;
- there should not be a move to a unified civil court (ie combining the High Court and County Court) but the time has come for a debate about the future of the High Court Divisions (beyond the scope of this review); and
- the County Court should become the single default court for the enforcement of judgments and orders of all the civil courts, with enforcement procedures to be unified and digitised.

BACKGROUND

The review was commissioned by the Lord Chief Justice and the Master of the Rolls in July 2015. It is intimately linked with the HMCTS (Her Majesty’s Courts and Tribunals Service) Reform Programme, which was launched in March 2015 and focuses on three main areas: using IT to improve the issue, handling, management and resolution of cases; reducing reliance on buildings and rationalising the court estate; and allocating aspects of the work currently done by judges to court officials under judicial supervision.

In relation to the use of IT, a key assumption underlying both the Reform Programme and the Civil Courts Structure Review is that it will be possible to move to a completely digital (ie as far as possible paperless) court structure. In his final report, Briggs LJ observes that he now regards it as “practically inevitable” that the Reform Programme will include the creation of a single online Portal for the issue and conduct of all court proceedings (at least within the boundaries of Civil, Family and Tribunals).

Briggs LJ’s interim report on his review was published in January 2016 setting out provisional recommendations, following which he engaged in further consultation with the legal profession and other stakeholders. The final report was published on 27 July 2016.

Notably, Briggs LJ observes in the final report that the responses he obtained in the further rounds of consultation have remedied what he had identified as an inadequate period for consultation prior to the interim report. He also confirms that, for the most part, the subsequent consultation reinforced his provisional analysis of the civil courts structure’s strengths, weaknesses, opportunities and threats, which has informed his recommendations.
KEY FINAL RECOMMENDATIONS

Amongst the various recommendations and proposals addressed (listed together in Chapter 12 of the report), key conclusions relevant to commercial parties include the following.

Online Court

One of the key findings in the interim report was that there is a clear and pressing need for the establishment of an Online Court, to give effective access to justice in more straightforward and modest value disputes without disproportionate costs and delay.

The final report notes Briggs LJ’s understanding that the Ministry of Justice has already agreed to implement the concept of the Online Court. Legislation is being prepared and the design and development of the system is now the subject of a specific work-project within the Reform Programme (although it is yet to be decided whether it should be separate from the County Court, as recommended by Briggs LJ). The proposed timing for the launch of the system is April 2020, although Briggs LJ acknowledges that this will represent “a real challenge”.

It is proposed that cases in the Online Court would progress through three main stages: (i) a largely automated, inter-active online triage process to enable users to articulate their case and to identify documentary evidence; (ii) conciliation and case management by case officers; (iii) resolution by judges (either on the documents, by face-to-face trial or by video or telephone hearing, as considered appropriate). In response to concerns expressed in the consultation about ensuring accessibility by individuals who are challenged by IT, the final report stresses the need for the system to include assistance for such individuals and also concludes that the new court be governed by its own “user-friendly” set of dedicated rules, rather than the Civil Procedure Rules.

The recommended jurisdiction of the Online Court remains as originally proposed, being money claims up to the value of £25,000 (with substantial exceptions including most personal injury and professional negligence claims). However, it is suggested that an initial ceiling of £10,000 could be adopted as part of a “soft launch” of the new court. In any event, the report clearly anticipates that the Online Court will eventually become the compulsory forum for resolving cases within its jurisdiction, although always with provision for complex and important cases to be transferred upwards to higher courts. Appeals from case determinations in the Online Court will lie initially to the Circuit judge in the County Court and then to the Court of Appeal.

In Briggs LJ’s view, the new court, if successful, “may pave the way for fundamental changes in the conduct of civil litigation over much wider ground than is currently contemplated by its first stage ambition”.

County Court and High Court thresholds

In line with the report’s conclusion that a substantial proportion of cases currently being commenced in the High Court do not actually need to be heard there, Briggs LJ recommends that (i) all remaining financial limits on the jurisdiction of the County Court should be removed and (ii) the minimum claim value threshold for commencing claims in the High Court be increased immediately to £250,000, with a view to a second increase to £500,000 (applicable to all types of claim, with no lower limit for personal injury claims as at present).

Case officers

The final report confirms Briggs LJ’s provisional recommendation (echoing the similar proposal within the Reform Programme) that some of the more routine and non-contentious work currently carried out by judges should be transferred to case officers, being a senior body of court officials who will receive judicial training and supervision. This is likely to include matters that are not actively disputed, and some routine case management of less complex cases, but not decisions affecting substantive rights and duties.

The final report stresses that judicial “supervision” in this regard should involve not merely a reporting line but a relationship of close physical proximity and regular contact between the case officer and the judge. It also accepts (taking a more strict view than the interim report) that case officers should all have legal qualifications and experience.

The report confirms that there should be an unfettered right for a party to have a case officer’s decision reconsidered by a judge.

Proposals for a unified civil court

The interim report considered the question of whether there should be a move to a unified civil court (ie combining at least the High Court and County Court) but reached only the conclusion that any such unification should not be pursued ahead of completion of the Reform Programme.

In the final report, Briggs LJ notes that a clear benefit of such unification would be the more efficient allocation of cases between the High Court and County Court (with the court, rather than the parties, determining the allocation). However, the report reaches the conclusion that, on balance, this advantage is insufficient to justify the creation of a unified court and that the benefits of improved allocation can be achieved substantially as well by other means (including the proposed changes in claim value thresholds, discussed above).
The future of the High Court divisions

The interim report had suggested that the review would consider possible changes to the current divisional structure of the High Court and in particular the “sensitive subject” of whether there should be a merger of the Rolls Building courts (ie Chancery, the Commercial Court and the Technology and Construction Court). However, the final report does not make any specific recommendations in this regard, due to the fact that the issue has implications well beyond the civil courts.

Nonetheless, Briggs LJ does express the view that “the time has come for a decision about the future of the Divisions” and recommends that the question be dealt with as a major part of a wider debate by the Judicial Executive Board. In doing so, he notes that no change should risk undermining the international reputation of the Commercial Court or the other specialist courts in the Rolls Building.

Enforcement

The report confirms Briggs LJ’s provisional recommendation that various identified shortcomings in the quality of the enforcement of civil orders and judgments would be best addressed by a unification of those processes within a single court, which should be the County Court (with provision for transfer of certain enforcement issues to the High Court where necessary and special provision for the enforcement of arbitration awards).

In his view, this is an “entirely uncontentious objective”. However, if the necessary legislative amendments to effect such unification cannot be given sufficient Parliamentary and Ministry of Justice attention, a ‘second best solution’ would be to achieve as much of that as is possible by the centralisation, rationalisation, harmonisation and digitisation of the processes of enforcement in the separate courts.
HIGH COURT APPLIES NARROW INTERPRETATION OF “CLIENT” FOR PURPOSES OF LEGAL ADVICE PRIVILEGE

The High Court has applied the much-criticised Court of Appeal decision in Three Rivers No 5 to find that interviews conducted by a bank’s solicitors with its employees were not covered by legal advice privilege, as the employees in question did not form part of the “client” for privilege purposes.

BACKGROUND

The present decision was given in the context of group litigation brought against RBS relating to a rights issue of shares in the bank announced in April 2008.

RBS claimed privilege in “transcripts, notes or other records” of interviews conducted by or on behalf of the bank with its employees and ex-employees as part of certain internal investigations.

It was not contended by RBS that the documents were subject to litigation privilege (which applies where documents are prepared for the dominant purpose of litigation that is pending or in reasonable prospect). The only ground of privilege relied on was legal advice privilege, which applies to lawyer/client communications for the purpose of giving or obtaining legal advice.

RBS contended that the documents were privileged because:

1. If English law applied, the documents were privileged as a record of lawyer/client communications for the purposes of giving or obtaining legal advice - ie. the interviewees were part of the “client” on a proper interpretation of Three Rivers No 5.
2. Even if the interviewees were not part of the “client”, the documents were privileged as part of the lawyers’ working papers.
3. In the event that the Court found the documents not to be privileged under English law, the English court should apply US law (not English law) to the question of whether the documents were privileged (because there were close connections with the US, including that one of the investigations was undertaken as part of RBS’s response to subpoenas issued by the US Securities and Exchange Commission) and the documents were clearly privileged under that law.
4. Even if English law applied, and if the documents were not privileged under English law, the English court should exercise its discretion to order that disclosure or inspection could be withheld because of RBS’s rights under US law.

DECISION

The judge (Hildyard J) rejected the claim to privilege on all grounds, and refused to exercise his discretion to prevent disclosure and inspection. The arguments and the judge’s conclusions on each of the issues identified above are considered in more detail below.

1. Three Rivers No 5

As noted above, the Three Rivers No 5 decision led to significant uncertainty over the question of who is a lawyer’s “client” for the purposes of legal advice privilege.

In that case, creditors of BCCI sued the Bank of England for misfeasance in public office. The Bank asserted privilege in documents prepared by its employees which were to be provided to its external solicitors to assist in preparing the Bank’s submissions to the Bingham Inquiry on the collapse of BCCI.

The Court of Appeal held that, for the purpose of assessing privilege, the “client” did not encompass all employees of the Bank but was limited to a particular group of three individuals (the Bingham Inquiry Unit or “BIU”) who had been given responsibility for coordinating communications with the Bank’s solicitors. Everyone else at the Bank was a third party to the lawyer-client relationship, so legal advice privilege did not apply.

In the present case, RBS argued that Three Rivers No 5 was an unusual case which should be confined to its own particular facts. RBS justified that approach, in part, by reference to the extensive academic criticism of the decision and its disapproval in other jurisdictions including Singapore.

In particular, RBS argued that the application of Three Rivers No 5 should be confined to the particular context where a special unit (in that case the BIU) had been established as the exclusive conduit for communications between the client organisation and its lawyers, and internal documents were prepared by other employees (who were not authorised to communicate with the lawyers) to assist that unit in the preparation of communications with the lawyers. In other words, the decision did not apply to communications directly between a company’s
HIGH COURT APPLIES NARROW INTERPRETATION OF “CLIENT” FOR PURPOSES OF LEGAL ADVICE PRIVILEGE

lawyers and its employees who were authorised to communicate with the lawyers.

Hildyard J recognised that there was force in these criticisms and attempts to confine the application of Three Rivers No 5, saying: “It may be that in a suitable case the Supreme Court will have to revisit the decision…”. However, he considered the decision to be binding authority that legal advice privilege is limited to communications between lawyer and client and “the fact that an employee may be authorised to communicate with the corporation’s lawyers does not constitute that employee the client or a recognised emanation of the client”.

In what the judge referred to as “the fundamental and most powerful part of RBS’s case”, RBS submitted that it was not contrary to Three Rivers No 5 that an individual who was authorised by the client corporation to communicate either instructions or factual information to the corporation’s lawyers, to enable the corporation to seek legal advice, should be treated as part of the client and protected by legal advice privilege.

The judge however rejected that submission, finding (in essence) that the effect of Three Rivers No 5 is to limit the “client” to those who are authorised to seek and receive legal advice on behalf of a client corporation, and that authority to provide information is not sufficient for these purposes.

The judge said he did not think it necessary to determine whether a further implication of Three Rivers No 5 was to restrict the “client” to those who are the “directing mind and will” of the organisation. However, he added:

“I suspect that such a restriction will often reflect reality: a corporation is unlikely to authorise an individual to seek and receive legal advice on its behalf to an individual or body which is not its directing mind and will. Further, in my view, there are good reasons for it not doing so, and for the law not extending privilege if it does. So I do incline to the view that only communications with an individual capable in law of seeking and receiving legal advice as a duly authorised organ of the corporation should be given the protection of legal advice privilege.”

2. Lawyers’ working papers

As noted above, RBS submitted that even if the interviewees were not part of the “client”, and therefore the interviews themselves were not privileged, the lawyers’ notes of those interviews were privileged as part of the lawyers’ working papers.

It was common ground that lawyers’ working papers are privileged. The judge explained the basis for this principle, by reference to previous authority, as being that disclosure of lawyers’ working papers may betray or at least give a clue to the trend of the advice being given to the client.

It followed (and was not disputed) that a verbatim transcript of an unprivileged interview would not be privileged; there had to be some attribute of the notes which distinguished them from verbatim transcripts and triggered their protection as lawyers’ working papers.

The burden of demonstrating this was on RBS. The judge concluded that the burden was not satisfied on the evidence. He pointed out that any notes of an interview, as opposed to a bare transcript, are likely to reflect to some extent the note taker’s particular interests, lines of inquiry and perception of the relative importance of various points.

Here, RBS’s evidence indicated that the notes included “mental impressions”, and reflected preparation which revealed the lawyers’ train of enquiry, but the judge held this was not sufficient. There was, he said, a real difference between reflecting a “train of enquiry” and giving a clue as to the trend of legal advice.

3. Which law applies?

RBS submitted that the Court should depart from the old established rule that it is the lex fori (or law of the forum) which governs issues of privilege because:

- the modern concept of legal professional privilege as a fundamental human right, rather than as an aspect of the law of evidence, rendered it inappropriate and obsolete; and
- the previous case law could be distinguished as it invariably concerned the position where the foreign right was more limited or had been waived, rather than (as here) where a party has sought to rely on a broader foreign right to privilege.

RBS proposed a new choice of law rule, which would apply the law of the place with which the relevant engagement or instructions had their closest connection (unless that would be contrary to English public policy). Here, RBS said, that would result in the application of US law.

The judge said it appeared likely, and he was prepared to assume, that the interview notes would be privileged under US law. However, he rejected the submission that US law should apply to the question, including on the basis that the English court’s application of the lex fori to questions of privilege had been well settled since the mid-19th century, he did not think there was sufficient basis for applying a different rule where the foreign law gave broader protection, and there were practical difficulties in applying some other law.

4. Discretion to prevent disclosure/inspection

Finally, RBS contended that (even if English law applied and the documents were not privileged), the Court should exercise its discretion to order that disclosure or inspection could be withheld.
The judge did not think it was necessary to determine whether the effect of *Three Rivers No 5* goes further, so that the "client" comprises only those who are the "directing mind and will" of the organisation – which RBS argued would impose an undesirable restriction on the scope of legal advice privilege available to corporates, go beyond the findings in *Three Rivers No 5* and undermine the policy underlying legal advice privilege. The judge did suggest, however, that he inclined to that view.

The decision also contains interesting discussion of when a lawyer’s notes of a non-privileged discussion will be subject to privilege, the law the English courts will apply to determine questions of privilege, and when the court will exercise its discretion to allow a party to withhold disclosure or inspection.

That was (in summary) because RBS had a right to withhold inspection under US law, and a reasonable expectation that the interview notes would be and remain privileged.

The judge accepted that the Court had a discretion to prevent disclosure or inspection notwithstanding that a document is disclosable. He described the discretion as a “salutary one”, not least where legitimate expectations may need to be taken into account in striking a balance, but said the Court was likely to lean heavily in favour of disclosure unless there were compelling grounds to do otherwise.

The judge concluded that this was not a special case where the general public policy in favour of disclosure should yield to the foreign law right.

The *Three Rivers No 5* decision has caused difficulties for corporates since it was handed down in 2003. It has led to a risk that in any given case the “client” might be restricted to some limited group of employees, so that communications or documents prepared by anyone else in the organisation would not be privileged, unless they were prepared for the purposes of contemplated litigation. That is because, as is well-established, legal advice privilege (unlike litigation privilege) does not apply to communications with third parties; it only covers lawyer/client communications.

RBS has indicated an intention to seek permission to appeal.

**COMMENT**

Significantly in the 13 years since the *Three Rivers No 5* decision was handed down, there has not (to our knowledge) been any reported English case in which the decision was applied to restrict the identity of the “client” for privilege purposes. Not, that is, until now when we have seen two judgments in quick succession, the first being *Astex v Astrazeneca* in which Chief Master Marsh held that certain employees were not part of the “client” for privilege purposes, but with only brief analysis on the point.

In the present decision, Mr Justice Hildyard considers the question in much greater detail. In doing so, he reaches a conclusion which narrowly interprets the definition of “client” and which will require careful consideration by corporates seeking legal advice. In essence, although the judge could see force in the criticisms of *Three Rivers No 5*, and recognised that these may need to be considered by the Supreme Court in due course, he concluded that the effect of the decision (which is of course binding on him) is to limit the “client” to those who are authorised to seek and receive legal advice on behalf of a client corporation. Importantly, he concluded that authority to provide information to the lawyers is not sufficient for these purposes.

**ADDITIONAL REFERENCES**

*Three Rivers No 5* [2003] EWCA Civ 474

*Astex Therapeutics Ltd v Astrazeneca AB* [2016] EWHC 2759 (Ch)
ENGLISH LAW CONTRACTS POST-BREXIT: WHAT CHANGES SHOULD COMMERCIAL PARTIES EXPECT?

The core principles of English contract law, such as interpretation of contracts and remedies for breach, will not be affected by Brexit and the key attractions of English law will remain.

Brexit may, however, have implications for particular aspects of parties’ contractual relationships, including how certain terms may be interpreted and whether any termination rights may be triggered, and on questions relating to jurisdiction and enforcement of judgments.

INTRODUCTION

English law has long been a popular choice for international parties entering into commercial contracts. It is viewed as stable and predictable, while also being flexible enough to adapt to new developments in commercial practice. It respects “freedom of contract”, generally giving effect to the parties’ contractual bargain with only limited scope for implied terms or the influence of public policy.

These key attractions will not be diminished as a result of Brexit. The core principles of English contract law come from the common law (ie judge-made case law) and as such are unaffected by Brexit; only in specific spheres, such as consumer contracts, has English contract law been significantly affected by EU law.

Nor will Brexit have any impact on the effectiveness of a choice of English law to govern commercial contracts. EU rules require Member States to respect a choice of law, regardless of whether any contracting party is EU-domiciled or whether the chosen law is that of a Member State.

Although Brexit will not affect the principles governing interpretation of contracts, it may lead to questions as to how particular terms should be interpreted or whether one party is entitled to terminate in light of changes resulting from Brexit. It also has implications for issues relating to jurisdiction and enforcement of judgments.

BREXIT – TOP TIPS FOR ENGLISH LAW CONTRACTS

- **DO** consider whether there may be a basis to terminate onerous contracts in light of Brexit-related events
- **DON’T** be hasty in terminating – if you get it wrong, you may be liable for significant damages
- **DO** consider addressing Brexit expressly in new contracts, eg to allow for termination on Brexit or to make it clear there is no such right, or to make appropriate amendments to reflect Brexit
- **DO** consider dispute resolution options carefully, particularly if it is important to be able to enforce judgments in the EU or avoid proceedings being brought in the EU

INTERPRETATION

It is not possible to list every contract term that might conceivably give rise to issues of interpretation following Brexit. However, obvious candidates include references to the European Union, or the EU, and references to legislation which originates from the EU.

Under English law, the court’s aim in interpreting a contract term is to determine the meaning it would convey to a reasonable person with all the background knowledge available to the parties at the time the contract was made. As well as the words used and the relevant background, the court will take into account how the clause fits within the contract as a whole and considerations of commercial common sense – though recently the trend has been for the courts to place greater emphasis on the language used and downplay considerations of commercial common sense, unless there is some ambiguity or lack of clarity.

The court may also imply a term that the parties have not expressly included in their contract, but the bar for doing so is set high. In general, the term either must be so obvious as to go without saying or must be necessary to give business efficacy to the contract. These are not easy hurdles to meet.
**References to legislation**

Where a contract refers to directly applicable EU legislation which no longer applies to the UK following Brexit (ie treaty provisions or EU Regulations), questions may arise as to whether this means the relevant legislation as it existed at the time, or any legislation enacted to replace it. The question may be resolved by an express interpretation clause.

Where there is no such clause, section 17(2) of the Interpretation Act 1978 provides that a reference to legislation that has been repealed and re-enacted is construed as a reference to the re-enacted version (unless the new statute makes a contrary provision). But section 17(2) may not be relevant where EU legislation ceases to apply as a result of Brexit, rather than being expressly repealed. Given the uncertainty, it is better to include an express interpretation clause in contracts.

Where a contract refers to UK legislation which implements non-directly applicable EU legislation (ie an implemented EU Directive), and which is amended post-Brexit, ordinary principles of contractual interpretation will apply to determine which version is meant. (Section 20(2) of the Interpretation Act 1978 deals with references to amended legislation but, unlike section 17(2), it applies only to references in legislation, not in contracts.) Again, therefore, it is better to have an express clause.

There may also be questions as to how the UK legislation itself will be interpreted post-Brexit. Currently, English courts endeavour to interpret UK legislation in such a way that it complies with EU law. There will be no obligation to do so post-Brexit. However, EU law may continue to be persuasive, particularly where the relevant UK legislation was intended to implement EU legislation.

**References to the EU**

A contract may refer to the EU in a variety of contexts. For example, a distribution contract may define the distributor’s territory as the whole of the EU. Or a business sale agreement may prohibit the seller becoming involved in a competing business throughout the EU.

Once the UK leaves the EU, questions may arise as to whether such references should be interpreted to mean the territory of the EU at the time the contract was entered into, so that the UK is included, or the territory of the EU from time to time, so that the UK is excluded.

Since the exercise of interpretation depends on the commercial context and the background knowledge available to the parties, the answer may well be different in different contracts. English courts are likely to take a sensible view and to favour commercial interpretations.

So for example in the context of an ongoing distribution agreement, if the UK forms an important part of the distributor’s operation, a court might readily conclude that the territory was not intended to change in the event of the UK’s exit from the EU. All will depend on the facts and circumstances of the contract.

For new contracts, if referring to the EU, it would obviously be better to cover the point expressly.

**TERMINATION**

Recent events have inevitably prompted many commercial parties to reassess their contractual arrangements. In some cases, parties may wish to exit certain arrangements or may wish to make changes, eg to exclude the UK from an EU-wide agreement so that separate arrangements may be made.

Some parties may already have put in place express rights to terminate or amend their agreements if and when the UK leaves the EU as part of an attempt to “Brexit-proof” the arrangements. Other contracts may contain a right for one or both parties to terminate on notice and without cause. In such cases, the position should be relatively straightforward.

Where a contract contains no such provisions, there are three main routes a party wishing to end its contractual obligations might seek to rely on:

a. **Frustration:** Excuses the parties from performance where something has happened to make performance impossible or to render the obligation radically different from what was contracted for.

b. **Force majeure clause:** A contract term which excuses one or both parties from performing the contract if prevented by circumstances outside the party’s control.

c. **Material adverse change (or “MAC”) clause:** A term found in some agreements which allows a party (for example a buyer or lender) to refuse to proceed if certain events occur after the contract date.

**FRUSTRATION**

The effect of frustration is to bring the contract to an end automatically. This common law doctrine will only apply, however, where an event occurs after the contract has been entered into, which is not due to the fault of either party, and which renders further performance impossible or illegal, or makes the relevant obligations radically different from those contemplated by the parties at the time of contracting.

The courts have tended to apply the doctrine of frustration narrowly, emphasising that it is not lightly to be invoked to allow a contracting party to escape from what has turned out to be a bad bargain. In determining whether the doctrine applies, the court will
ENGLISH LAW CONTRACTS POST-BREXIT: WHAT CHANGES SHOULD COMMERCIAL PARTIES EXPECT?

Consider multiple factors including the parties’ knowledge and expectations at the time of contracting, as objectively ascertained. Events which make performance more onerous or more expensive will not necessarily be sufficient to frustrate the contract.

The fact that an event is foreseeable, or even that it is the subject of express contractual provision, will not necessarily preclude a finding of frustration, eg if an event such as a strike lasts so long as to render performance radically different from that contracted for. However, the less an event is foreseeable, the more likely it is to lead to frustration.

The scope for the doctrine of frustration to apply as a result of Brexit-related events seems likely to be limited, particularly where contracts were entered into in the run-up to (or since) the referendum so that Brexit was foreseeable or expected. An argument based on frustration may, however, be available in some limited circumstances; all will depend on the facts.

**Edwinton Commercial v Tsavliris Russ** concerned whether a 20 day time charter had been frustrated by a delay of 108 days in redelivery of the vessel due to its detention by port authorities. The Court of Appeal held that it had not. The critical question was whether, at the relevant point, the existing and prospective delay would have led the parties to have reasonably concluded that the charter was frustrated.

Applying the doctrine of frustration required a “multi-factorial approach”, taking into account for instance the terms of the contract, its context, the parties’ (objectively determined) assumptions in particular as to risk, the nature of the supervening event, and the parties’ “reasonable and objectively ascertainable calculations as to the possibilities of future performance in the new circumstances”.

Here the Court based its conclusion on a number of factors, including that the delay came at the very end of the charter, rather than interrupting “the heart of the adventure”, and that the contractual risk of such delay was, in the Court’s view, firmly on the charterers. It was also relevant that the risk of detention was foreseeable, in general terms, even if the actual circumstances of the detention were unusual.

This conclusion was consistent with the dictates of justice, which provided a “reality check” as to the Court’s assessment of the issue of frustration.

**FORCE MAJEURE**

Whether Brexit-related events might constitute force majeure will depend on how the particular clause is drafted. In most clauses, force majeure is defined by reference to a non-exhaustive list of events, together with a general “wrap-up” provision to include other events which are not within a party’s reasonable control. The clause may also exclude specific categories of event which the parties agree will not constitute force majeure.

In the run-up to the referendum, parties may have expressly included (or excluded) Brexit-related events in defining force majeure. Absent an express term, categories of event which are commonly included in the definition and which might occur in connection with Brexit include: acts of governments; restriction, suspension or withdrawal of any licenses etc; and changes in law or regulation.

However, it is not enough to have an event falling within the definition of force majeure. The clause will generally be triggered only if the event prevents, hinders or delays a party performing its obligations. Typically, in that event, the obligations are suspended without liability while the impact of the force majeure event continues (subject to obligations to notify the counterparty of the force majeure event and to seek to mitigate its effects). Most force majeure clauses will also give a right to terminate the contract if the force majeure event continues for a specified period of time.

A change in economic or market circumstances which makes the contract less profitable or performance more onerous is not generally regarded as sufficient to trigger a force majeure clause. Parties wishing to rely on Brexit-related events as force majeure are therefore likely to have to point to something beyond mere economic hardship. For new contracts, the best route is to include an express termination right.

In **Thames Valley Power v Total Gas** the High Court found that a force majeure clause in a gas supply contract was not triggered by a sharp rise in the market price of gas, making it uneconomic for the seller to supply the gas.

The Court agreed with the buyer that the increased cost of gas did not mean the seller was unable to carry out its obligations under the agreement; it merely made the contract less profitable. This was not sufficient. The fact that a contract has become expensive to perform, or even dramatically more expensive, is not a ground to relieve a party from performance on the grounds of force majeure (or indeed frustration).

Similarly, in **Tandrín v Aero Toy Store**, the High Court found there was no triable argument that a force maejure clause in an aircraft sale agreement was triggered by the “unanticipated, unforeseeable and cataclysmic downward spiral of the world’s financial markets”.

The Court referred to the well-established position under English law that a change in economic or market circumstances which affects the profitability of a contract or the ease with which the parties’ obligations can be performed is not regarded as being a force majeure event.
MATERIAL ADVERSE CHANGE (MAC)

The drafting of MAC clauses varies greatly. They may be drafted widely, subject to specific carve-outs of events that will not qualify, or they may be drafted more narrowly to specify particular events that will qualify as a MAC.

As with any contract term, the interpretation of a MAC clause will depend on the language used in the context of the contract as a whole, the background facts and commercial context.

The party seeking to terminate the contract under a MAC clause has the burden of proving that a MAC has occurred. In general, a court will not be easily persuaded that a party should be released from its obligations under a concluded contract, and so there is a heavy evidential burden on the party seeking to rely on the clause.

A MAC clause cannot be triggered on the basis of circumstances known to the relevant party on entering into the agreement, although it may be possible to invoke the clause where conditions worsen in a way that makes them materially different in nature. The change relied on must also be material, in the sense that it must be sufficiently significant or substantial, and it must not be merely a temporary blip.

Whether Brexit-related events may amount to a MAC will depend on the terms of the clause and the specific circumstances. In general, however, it may not be straightforward to argue that a MAC clause is triggered by Brexit unless events have taken an unexpected turn after the contract is entered into which has a dramatic impact in the particular circumstances of the transaction. Again, for new contracts, the best route is to include an express termination right.

JURISDICTION AND ENFORCEMENT OF JUDGMENTS

It is highly likely that, after Brexit, Member State courts will continue to respect an English jurisdiction clause and enforce English judgments. Whether there are any changes to the current position, however, depends on the arrangements put in place. The main options are set out in the box entitled “Possible Brexit outcomes”.

Brexit will not have any impact on arbitration clauses or enforcement of arbitral awards. The regime for the recognition of an agreement to arbitrate and enforcement of an arbitral award is the 1958 New York Convention, an international treaty to which 156 states worldwide are party, including the UK and all other EU Member States.

If a party would have chosen an English court jurisdiction clause absent any considerations relating to Brexit, then whether it may want to consider the matter further will depend on two principal questions:

a. Is it important that any judgment can be enforced in an EU Member State? If the possibility of having to take steps to enforce is remote, or if the counterparty has sufficient assets within the UK (or some other country known to enforce English judgments), and assuming that is unlikely to change, there may be no need to consider this aspect further.

b. Is there a risk of the counterparty bringing proceedings in an EU Member State court that needs to be avoided? If neither the parties nor the contract have any connection with another Member State which would allow the courts of that Member State to accept jurisdiction over the claim (either under the Brussels regime or its own domestic rules), there may be no need to consider this aspect further.

If a party considers it important to be able to enforce any judgment against assets in an EU Member State, or to prevent the risk of proceedings being brought in an EU Member State court, it may wish to take local law advice in the relevant Member State(s) as to what would happen if, following Brexit, there were to be no applicable agreement or convention with the UK (though this is highly unlikely).

If there is uncertainty as to the relevant Member State’s approach to an English jurisdiction clause or English judgment in such an event, then that would be a factor to consider. However, the party would have to weigh up the advantages and risks of a choice of English jurisdiction as against the available alternatives.

These include English-seated arbitration, either as the sole dispute resolution mechanism or as an optional clause. For example, with an optional clause, the English court might have exclusive jurisdiction save that one or more parties would have an option to refer disputes to arbitration in particular circumstances, such as if the UK has left the EU.

Commonly recognised attractions of English court jurisdiction include the quality of the judiciary, the possibility of appeal and the ready availability of summary procedures. Conversely, arbitration may be favoured for various reasons including ease of enforcement, ability to choose the tribunal, party autonomy in determining the process, and relative confidentiality.
POSSIBLE BREXIT OUTCOMES

1. An agreement with the EU on similar lines to the recast Brussels Regulation: In this case little if anything would change, depending on precisely what was agreed.

2. An agreement to join the 2007 Lugano Convention: In this case the position would be as it was before the recast Brussels Regulation took effect in January 2015. The most significant difference is that certain improvements under the recast Brussels Regulation, to prevent parties delaying proceedings in the chosen court by launching so-called “torpedo actions”, would not apply.

3. Joining the 2005 Hague Convention on Choice of Court Agreements: In this case there would probably be relatively little change where an exclusive English jurisdiction clause has been agreed. The Convention does not apply, however, where there is a one-way or non-exclusive jurisdiction clause. For such cases, the position would be the same as if no agreement were put in place (see below).

4. No agreement or convention with the EU on jurisdiction and enforcement of judgments (though this is highly unlikely): It is likely that the question of whether an EU Member State court would respect an English jurisdiction clause or enforce English judgments would largely depend on its own domestic law. Local law advice would therefore be needed, but the domestic law in many Member States does provide for the recognition of jurisdiction agreements and enforcement of foreign judgments.

COURT VS ARBITRATION: SOME FACTORS

ADDITIONAL REFERENCES

Thames Valley Power v Total Gas & Power [2005] EWHC 2208 (Comm)
Edwinton Commercial Corp v Tsavliris Russ (Worldwide Salvage & Towage) Ltd (The Sea Angel) [2007] EWCA Civ 547
Tandrin Aviation Holdings Ltd v Aero Toy Store LLC [2010] EWHC 40 (Comm)
BREXIT: OVERVIEW OF IMPLICATIONS FOR THE INSURANCE SECTOR

In terms of scale and importance, the UK’s insurance and long-term savings industry is the biggest in Europe and the fourth largest in the world.

The insurance market developed in the UK over the last 200 years depends for its success upon, among other things, efficient regulation, access to world-class talent and the ability to underwrite risk around the world, including in EU markets.

Brexit brings with it the prospect of restricted access to talent and European markets but the opportunity for progressive regulatory reform.

RISKS AND OPPORTUNITIES OF BREXIT

Access to world-class talent:
Given the complexity and bespoke nature of much of the business written in the UK, our market attracts some of the world’s top insurance talent.

In the short term, at least, much of the existing insurance expertise is expected to stay. Lloyd’s of London, for example, has confirmed that its central operations will remain in London, even if some of its business moves elsewhere after Brexit.

Longer term, the challenge will be in reconciling the need for high-quality insurance staff with the Government’s policy on immigration controls. The UK risks losing its talent and its reputation in insurance to other EU countries with less rigid border controls.

Restricted access to the free market:
‘Passporting’ currently allows UK insurers and reinsurers to conduct cross-border business in the EU relying on a single home state licence (and, EU insurers can conduct business in the UK on the same basis). If, post Brexit, the Government fails to negotiate terms close to ‘free access’, UK firms might be forced to shift some of their business to Europe. Meanwhile, international insurers, whose European operations are headquartered in the UK, may have to rethink the location of their European hubs.

For UK insurers with policyholders in EU states, the risk, post Brexit, is that they will no longer be licensed to deliver services in those countries unless they go through the onerous process of establishing an authorised branch in each country. Not doing this may leave insurers unable to pay out on claims, and EU policyholders without valid insurance.

UK and EU insurers’ freedom to operate in the other’s territories hinges on future reciprocal agreements between the UK and EU.

Freedom to set own rules:
The UK, under Brexit, should be able to reduce some of the burdens that UK insurers encounter with the EU’s Solvency II Directive. As Andrew Tyrie, chairman of the House of Commons Treasury Select Committee, puts it Brexit allows the UK to “assume greater control of insurance regulation”.

Some argue that changing the UK regime would allow UK-headquartered groups to become more competitive outside the EU. In practice, however, there are other considerations:

- The UK was behind much of the content of Solvency II and is unlikely to reform the current regime radically. UK insurance companies also incurred massive upheaval and expenditure to comply with the directive and are not likely to welcome a significant rewriting of the rules.
- The UK is renowned internationally as a regulator and supervisor of the highest standard. Putting that reputation at risk to further the competitiveness of UK groups in overseas markets is unlikely to be in the UK’s long-term interests.
- For the UK to be assessed as “equivalent”, it will undoubtedly need to follow Solvency II closely. The benefits of an equivalence determination under Solvency II are, however, limited. Some UK insurers, at least, would favour a less onerous regulatory regime over equivalence.

PREPARE FOR THE UNKNOWN

Despite the uncertainty, insurers must prepare for life outside the EU and keep a close watch on the shifting political landscape.
For now at least, many firms are making plans on the assumption that passporting rights will be lost and that exit terms agreed by the Government will fall short of providing free access to the single market. Some are considering moving some or all of their business outside the UK, possibly setting up a new European subsidiary as a hub for their European affairs. Given that there may be no transitional period once the UK extricates itself from the EU, and as insurance firms can take a year or more to restructure, few are prepared to wait and see what the Government’s negotiations might deliver.

Our technical and industry experts, experienced in shaping legislative and regulatory reform, began preparing for Brexit 18 months before the referendum. They are working with insurance clients on the following questions:

- What business do we do now and where do we do it?
- Who are our customers and where are they located?
- What licences are needed to carry on that business and how will that change if passporting rights are lost?
- How can we best reorganise our operations to meet the challenges presented by the loss of passporting rights?
- How much time do we need to ensure that any reorganisation is implemented in time for the UK’s withdrawal from the EU?

Upfront planning can help insurers to prioritise their mitigation strategies. It can also inform lobbying to Government and industry bodies in the lead-up to exit negotiations.
BREXIT: IMPACT ON EEA INSURERS AND NON-EEA HEADQUARTERED GROUPS

Following the UK referendum on EU membership, businesses have no alternative but to prepare for the UK’s exit from the EU. The precise timing of the UK’s withdrawal remains unclear and even greater uncertainty surrounds the relationship between the UK and the EU that will follow. Nonetheless, there is broad agreement that it is not too early for firms to look at the implications of the vote and to understand the range of actions that could be taken to mitigate the risks to their business.

For UK insurers and reinsurers, withdrawal from the EU does not of itself mean that they will be excluded from doing business in EEA states. Their ability to access EEA insurance markets will depend in part on rules applying under the Solvency II Directive (“Solvency II”) to so-called “third country” insurers and reinsurers. Otherwise, and subject to the outcome of negotiations regarding the new relationship between the UK and the EU, it will be a matter for individual states to determine the basis on which UK firms can access their insurance markets.

By the same token, it seems inconceivable that EEA insurers will be denied access to the UK insurance market post-exit. The precise terms on which they will be able to conduct cross-border activities will depend on the outcome of negotiations between the UK and the EU and on requirements for reciprocity agreed in that context. As the UK will no longer be bound to follow Solvency II, in the absence of exit negotiations providing a specific regime, the UK can decide which rules should apply. Its ability to change the current regime will in practice be limited if the UK wishes to establish its status as an “equivalent” jurisdiction.

We consider some of the issues for EEA insurers below. We also look at issues raised by the UK’s exit from the EU for non-EEA headquartered groups that currently passport into the EEA from a UK subsidiary.

In this note, the terms “insurers” and “insurance companies” should be read as including both insurance and reinsurance companies, unless otherwise specified. The term “pure reinsurer” refers to a firm that only carries on reinsurance business. References to “EU” and “EEA” should be taken to exclude the UK.

THE FUTURE UK/EU RELATIONSHIP

As stated above, rules on access to overseas markets applying to UK and EEA insurers post-exit will depend on the outcome of negotiations. There are a number of possible structural outcomes, apart from any bilateral arrangements arising from the secession negotiations. The main options which have precedents in the EU’s relations with other countries are:

- EEA (European Economic Area)
- EFTA (European Free Trade Association)
- EU/UK FTA (Free Trade Agreement)
- Customs Union
- EU/UK CETA (Comprehensive Economic and Trade Agreement)
- WTO (World Trade Organisation)
The diagram below illustrates the implications of each approach for the UK.

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<th>CONTRIBUTE TO EU BUDGET</th>
<th>FREE MOVEMENT OF PEOPLE</th>
<th>SCHENGEN OPEN BORDERS</th>
<th>PARTICIPATE IN EU LAW MAKING</th>
<th>EU MARKET ACCESS – GOODS</th>
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**EEA insurers – accessing the UK insurance market**

There are three approaches that an EEA insurer may adopt to carry on cross-border business into the UK once the UK leaves the EU. The preferred approach is likely to depend on a combination of the nature of the business being written and on arrangements agreed between the UK and the EU for continued access to the UK market:

- Carry on business through a UK branch
- Provide insurance services into the UK without establishing a permanent presence here
- Write business through a newly established (or existing) UK subsidiary

**EEA insurer establishing UK branch**

Without the help of a crystal ball, it is impossible to know what rules will govern the establishment of a UK branch by EEA insurers post-exit. Current UK requirements applying to UK branches of non-EEA insurers meet the requirements of Articles 162-175, Solvency II. The same rules would apply, absent further change to the UK regime, to UK branches of EEA insurers once they can no longer passport into the UK (see discussion of these requirements in our recent publication “Access to the single market” – an explanation for the (re)initiation sector).

Once the UK leaves the EU it will no longer be bound by Solvency II. The UK could, in theory at least, make it considerably harder for an EEA insurer to establish a UK branch.

In practice, this is unlikely to happen. In the context of broader Brexit negotiations, the UK government can be expected to seek to maintain, as close as is possible, access to EU markets for UK businesses. If anything, to secure the best reciprocal access of UK insurers into the EEA, the UK might be expected to take a more lenient approach to the authorisation and supervision of UK branches of EEA insurers than it takes to branches of non-EEA insurers.

**EEA insurer providing services into the UK**

The position for EEA insurers wishing to provide insurance into the UK on a services basis (ie without having a presence in the UK) is also unclear. The UK has historically taken the view that authorisation is only needed by third country insurers, which will include EEA insurers post-Brexit, if they are actually carrying on insurance business here. In other words, they must be effecting or carrying out contracts of insurance by way of business “in the UK” under the Financial Services and Markets Act 2000 (“FSMA”). If an overseas
insurer’s activities are not caught by this definition, it does not require authorisation for its activities. It can access the UK market on what is commonly described as a “non-admitted” basis.

There is a significant amount of case law that considers when an insurer’s activities in the UK are sufficient for it to be caught by FSMA. Particular points arising from the case law are as follows:

- Whether or not an insurer is carrying on insurance business in the UK comes down to a question of fact and the specifics of any particular arrangement.
- The greater a firm’s connection with the UK, the more likely it is to be carrying on activities in the UK.
- As a general rule, any presence in the UK, whether this is a branch, an office or establishment, a permanent employee or an agent or representative is a strong indication that the activity is carried on in the UK.
- However, an overseas insurer’s lack of a presence in the UK will not, of itself, prevent the insurance activity from being carried on in the UK.
- The location of the risk is a factor in ascertaining where the insurance activity is carried on, although for overseas insurers may not necessarily be determinative.

One such case is Secretary of State for Trade and Industry v Great Western Assurance Co SA, which confirmed that the general approach of the Insurance Companies Act 1982 (pre-FSMA legislation) did not prohibit the placing of UK risks with insurers who were not authorised in the UK. It did, however, prohibit the effecting and carrying out of any insurance business in the UK by such insurers. In other words, insuring risks based in the UK is not the same as carrying on insurance business in the UK and the location of the risk is not necessarily the place in which the insurance activity is carried on.

Absent any change to FSMA (other than changes that inevitably flow from the loss of passporting rights), the rules described above should apply following Brexit to EEA insurers in the same way as they apply today to, for example, US insurers.

Recent indications are, however, that some EU Member States, including Germany, are moving towards heavier regulation of non-admitted business than has been the case to date. In addition, in July 2015 the EU Commission (“Commission”) expressed the view that “a third-country insurance undertaking may only insure risks located in a Member State through a branch authorised by the competent supervisory authority of that Member State”. This is the Commission’s view of the effect of Article 162, Solvency II which is grandfathered almost word for word from Solvency I.

If the Commission’s view is adopted by EEA states, it will affect UK insurers’ ability post-exit to write new business in EEA states on a non-admitted basis, ie without establishing a branch. If this turns out to be the case, the UK may decide to take the same approach, for reasons of reciprocity, to EEA insurers wishing to access the UK market. We do not envisage that the same change would be extended to non-EEA insurers as it would have significant implications for those insurers that currently access the UK market on a non-admitted basis.

**EEA insurer establishing UK subsidiary**

If the passport becomes unavailable for activities carried on in the UK by an EEA insurer, the preferred solution may be to conduct those activities through a UK subsidiary. That subsidiary would be subject to UK rules on the authorisation and supervision of a UK insurer which may, or may not, be the same as they are today. This will depend on whether the UK decides to keep its current, Solvency II, regime or whether it decides to adopt a new approach. In practice, it seems likely that the UK regime will be broadly the same as under Solvency II, albeit that over time some changes may be made.

A number of issues are raised by this option for EEA-headquartered groups. These include the following:

- To obtain authorisation in the UK, the UK subsidiary will be expected to have its head office here (assuming the rules stay the same as they are now). This may mean moving aspects of the business and its governance to the UK that have previously been located elsewhere.
- Any proposed restructuring of the group needs to take full account of the time that it would take to obtain a new authorisation in the UK and to allow for the transfer of business to reflect the new corporate structure. This may be difficult when so much uncertainty remains about the future of the UK’s relationship with the EU.
- The creation of an additional insurer within the group is likely to bring with it increased capital costs for the group as well as the additional administrative costs associated with UK supervision of the UK subsidiary.
- UK subsidiaries within EEA-headquartered groups would need to be brought into account for group capital purposes on a Solvency II basis (unless the UK has been assessed as equivalent for the purposes of Article 227, Solvency II, in which case UK rules would apply). In practice, even if the UK is not given equivalence status, it is doubtful whether this would have much significance while the UK regime reflects Solvency II standards because there would be little difference in the calculation. Nonetheless, affected EEA firms may wish to lobby for the UK to be given equivalence status from the date of its exit from the EU.
BREXIT: IMPACT ON EEA INSURERS AND NON-EEA HEADQUARTERED GROUPS

NON-EEA HEADQUARTERED GROUPS – ACCESSING EEA MARKETS

For a group that is headquartered outside the EEA, loss of the ability to passport into the EEA may make the UK less attractive as a “hub” for its European business. Groups in this position may prefer to transfer their sub-group headquarters to a different EEA jurisdiction and then consider the various options described above for the conduct of their UK business. How attractive this option is would depend, amongst other things, on how far across the EEA the group’s business extends. For example, it is difficult to see what benefits, if any, would accrue to a group that currently only has operations in the UK and one other EEA state. The position may be very different, however, for a group that passes its business from the UK throughout the EEA.

Otherwise, many of the issues for non-EEA headquartered groups with a sub-group operating from the UK are the same as for UK-headquartered groups. For example, where a group or sub-group decides to move its headquarters out of the UK, it may prefer to retain the bulk of its operations in the UK on an outsourced basis. The extent to which this can be achieved will depend upon the regulatory regime in both the UK and in the jurisdiction to which it is moving, and in particular any local substance requirements in that jurisdiction. If other aspects of the UK regulatory regime diverge from the EEA, particularly in relation to the protection of personal data, this may also have a bearing on the extent to which such an outsourcing model is viable.

Typically, this type of sub-group will be headed by an insurance holding company, not an authorised insurer (see diagram below), which in principle makes the transfer of the sub-group (including relevant insurance subsidiaries) to another jurisdiction relatively easy to achieve.

However, a simple transfer of shares in the insurance holding company to a new insurance holding company established in an EEA state does not overcome the loss of passporting rights by the UK insurer.

To achieve this, it would be necessary to transfer some or all of the business of the UK insurer to an EEA insurer (any UK business may be retained in the UK carrier). Whilst some operational functions may need to be transferred to the EEA, the headquarters of the holding company need not necessarily also be transferred out of the UK. An alternative approach to restructuring the group may be to convert the UK insurer to a Societas Europaea (“SE”) so that it can subsequently redomicile (ie transfer its registered office, its assets, rights and obligations and the identity of its “home state” for regulatory purposes) anywhere within the EEA.

In deciding on a new jurisdiction for the headquarters of the business, important factors will include:

- willingness of key staff to move to the new jurisdiction and post-exit rules determining their ability to work there;
- availability of local expertise (both in terms of staff for the insurance business and for service providers to support the business) in sufficient numbers;
- possible language barriers;
- availability of expertise and capacity within the regulator in the new jurisdiction; and
- quality and extent of office accommodation.

The group may also wish to consider the likely approach of its new group supervisor to supervision of the group outside the EEA. Solvency II confers considerable discretion on group supervisors of non-EEA headquartered groups to decide on the appropriate level of supervision and practice may vary across EEA states (see Article 262, which allows the group supervisor to supervise the group by way of “other methods” instead of applying Solvency II standards to the entire group). Should a group supervisor wish to take a particularly intrusive approach to supervision of the group at worldwide level, this may cause the group to look again at its options for relocation.

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ADDITIONAL REFERENCES

Globe Motors Inc v TRW Lucas Varity Electric Steering Ltd [2016] EWCA Civ 396
Secretary of State for Trade and Industry v Great Western Assurance Co SA [1997] 2 BCLC 685
POST-BREXIT ACCESS TO THE SINGLE MARKET: AN EXPLANATION FOR UK (RE)INSURERS

The UK has voted to leave the European Union ("EU"). Since the result became known, there has been much discussion of the wish to preserve "access to the single market" so far as possible. This article seeks to explain the issues which arise in this context for the insurance and reinsurance sector and suggests some issues to be brought to the attention of those negotiating the terms of the UK exit. For this purpose, the briefing assumes that the UK does not join the European Economic Area ("EEA") on exit or negotiate a bespoke form of access to EEA insurance markets (the "EEA Market") in a manner that substantially replicates that which it has today.

Withdrawal from the EU does not of itself mean that UK insurers and reinsurers will not be able to do business in EEA states. What it does mean is that they will not be able to carry on insurance activities on an EEA-wide basis as a matter of right (albeit subject to the necessary formalities), flowing from the UK’s membership of the EU. Instead, how they are able to access the EEA Market will depend in part on rules contained in the Solvency II Directive ("Solvency II"). To the extent not addressed under Solvency II, it will be up to individual EEA states to determine the conditions on which access is given to UK insurers and reinsurers.

This note does not cover the position under national law in individual EEA states. That must form the subject of legal due diligence performed by financial services specialists in the relevant national law.

For any business to determine the impact of losing its right to access the EEA Market on withdrawal of the UK from the EU, it will need to ask the following questions:

a) What activities are carried on prior to exit in the EEA and can those activities continue to be carried on as a matter of the national law of each relevant state?

b) If not, can those activities be carried on under third country access provisions of the specific EU law regulating the conduct of those activities within the EEA?

c) If so:

(i) How likely is it that the firm will be able to make use of such third country access provisions, taking into account the taxation, capital and other costs of doing so (i.e. how ‘achievable’ are they)?

(ii) Is there some aspect of national law in the relevant EEA state that negates the effect of the third country access in that EEA state?

For insurance companies, Solvency II rules on third country access are the starting point for determining how UK insurers might continue to access the EEA Market once withdrawal has taken place.

In this note, the terms “insurers” and “insurance companies” should be read as including both insurance and reinsurance companies, unless otherwise specified. The term “pure reinsurer” refers to a firm that only carries on reinsurance business.

SOLVENCY II – BACKGROUND

Solvency II establishes a framework for the prudential regulation of insurers and the corporate groups of which they are members. The new regime has applied throughout the EEA since 1 January 2016. As with the predecessor EU legislation, one of the cornerstones of Solvency II is the insurance “passport”. Provided certain formalities, involving the giving of notice to use the passport to the home state regulator, are followed, insurance companies which have their head office in the EEA are able to carry on business throughout the EEA on the basis of a single home state authorisation. Such cross-border business can be carried on in one of two ways:

a) through an establishment in the host EEA state; or

b) on a services basis without having a presence in the host EEA state.

Once the UK leaves the EU (and, as envisaged above, on the assumption it neither joins the EEA nor succeeds in entering into
POST-BREXIT ACCESS TO THE SINGLE MARKET: AN EXPLANATION FOR UK (RE)INSURERS

bespoke arrangements which preserve the passport), the passport will no longer apply to cross-border activities between the UK and remaining member states of the EEA. The UK becomes a non-EEA state, or “third country”, for Solvency II purposes.

A secondary focus of the Solvency II regime is on firms whose head office is outside the EEA, but which carry on business in the EEA. Solvency II provides for the authorisation of branches of non-EEA insurers that meet certain specified requirements. As will be shown below, however, the rights of such companies to conduct business within the EEA fall significantly short of passporting rights afforded to insurers which have their head office within the EEA.

CARRYING ON CROSS-BORDER BUSINESS POST-“BREXIT”

Third country insurer establishing EEA branch

A separate set of rules apply under Solvency II (beginning at Article 162) to EEA branches of third country insurers (but not to pure reinsurers).

The starting point for conducting business through a branch is that a third country insurer must obtain authorisation in the EEA state in which the branch is located. EEA states may grant an authorisation where the relevant insurer meets certain specified conditions, which include:

a) being entitled to carry on insurance business under its national law;

b) keeping at the place of management of the branch (i) accounts specific to the business pursued there; and (ii) all the records related to the business transacted;

c) possessing assets up to a certain value in the EEA state in which authorisation is sought;

d) undertaking to meet the Solvency Capital Requirement (“SCR”) and Minimum Capital Requirement (“MCR”) in respect of business carried on through the branch;

e) submitting a scheme of operations that meets specified requirements; and

f) fulfilling Solvency II governance requirements.

Where a third country insurer has more than one branch in the EEA, with the approval of the supervisory authorities in all the states concerned, the required assets may be localised in just one of the EEA jurisdictions and the SCR may be calculated in relation to the entirety of its EEA business.

Once authorisation has been obtained for a branch, rules to which it must be made subject include requirements to:

a) establish adequate technical provisions in respect of business written through the branch, applying Solvency II rules;

b) establish eligible own funds in accordance with Solvency II rules;

c) calculate the SCR and MCR in accordance with Solvency II rules, but only in respect of the business of the branch; and

d) maintain assets representing the SCR within the EEA state in which the branch is established up to the amount of the MCR and the excess either within that state or elsewhere within the EEA.

There appears to be no obligation for the EEA state to grant authorisation to an insurer that meets these requirements, which would suggest that more onerous obligations could be imposed at individual EEA state level.

If the UK wishes to achieve a different outcome for UK insurers than that set out above, it may seek to use Article 171, Solvency II. Article 171 allows the EU to conclude agreements with third countries that deviate from the requirements described above. The purpose of such an agreement must, however, be to ensure “under conditions of reciprocity” that EEA policyholders are properly protected. The circumstances in which this provision might be used are not clear and we are not aware of any guidance on its application. EIOPA guidelines on the supervision of branches of third-country insurance undertakings contain extensive guidance on the application of Articles 162-170, Solvency II but do not discuss the possible use of Article 171.

Third country pure reinsurer establishing EEA branch

The provisions described above do not apply to pure reinsurers. Article 174, Solvency II simply requires that rules in an EEA state applying to branches of third country pure reinsurers should not result in the third country reinsurer being treated more favourably than home state reinsurers. Other than that, the EEA state is free to do as it wishes in relation to third country pure reinsurers wishing to set up a branch within its jurisdiction.

Article 175, Solvency II applies in a similar way to Article 171 (discussed above). It allows the EU Commission to submit proposals to the Council of the EU for the negotiation of agreements with a third country regarding the supervision of:

(a) third country pure reinsurers which conduct reinsurance business in the EEA; and

(b) EEA pure reinsurers which conduct reinsurance business in the relevant third country.

The purpose of such an agreement would be to secure effective market access for both types of reinsurer on the basis of mutual recognition of the respective parties’ supervisory regimes. Recital (89), Solvency II refers to the international nature of reinsurance markets and calls for the use of a “flexible” approach to determining the prudential equivalence of third countries “so as to improve liberalisation of reinsurance services in third countries”. It
EQUIVALENCE UNDER SOLVENCY II AS A SUBSTITUTE FOR THE INSURANCE PASSPORT?

“Equivalence” means different things in different contexts in EU financial services legislation. At the broadest level, having a regime in the UK that is broadly aligned with that applying throughout the EU may make it easier to negotiate a more beneficial deal for the UK on exit.

In the context of Solvency II, “equivalence” has a more technical meaning. It applies a test of “equivalence” to the regulatory regimes of jurisdictions outside the EEA in three contexts:

- **Article 172 – Reinsurance provided by a non-EEA reinsurer**: Contracts between an EEA cedant and a non-EEA reinsurer which is located in a jurisdiction whose solvency regime is assessed to be “equivalent” for the purpose of this Article must be treated in the same manner as if that contract were concluded with an EEA reinsurer.

- **Article 227 – Group solvency – related companies located in a non-EEA jurisdiction**: Where a Solvency II group contains a non-EEA insurer which is located in a jurisdiction whose solvency regime is assessed to be “equivalent” for the purpose of this Article, the group may apply to use local rules in capital calculations carried out under the deduction and aggregation method. Such an application may or may not be granted.

- **Article 260 – Group supervision**: Where a Solvency II group is headquartered in a non-EEA jurisdiction which is assessed as having a system of group supervision that is “equivalent” to that operated under Solvency II, EEA supervisors must rely on supervision of that group by the national supervisor in that jurisdiction.

It is clear from this list that determination that the post-Brexit UK regulatory regime is “equivalent” under any of these heads does not mean that UK insurers would “retain access” to the EEA Market. The benefits UK insurers would gain from a finding of equivalence in each case fall considerably short of offsetting the loss of the passport that would result from a UK Brexit. This is in contrast to the position under some other financial services directives, where a finding of equivalence would be considerably more meaningful in maintaining UK access to the EEA single market.

Should the UK seek equivalence status?

Despite the shortcomings attaching to equivalence under Solvency II, it seems likely that the UK would seek to be assessed as being equivalent under all three heads described above. As an alternative to seeking full equivalence status from the start (which would take some time to be given), the UK may prefer to seek temporary or provisional equivalence status:

a) Countries may be afforded “temporary” equivalence status for a period ending in December 2020 for the purposes of
Articles 172 and Article 260 if they satisfy certain specified criteria (see below for details). These include making a commitment to put in place a regime that can be assessed as equivalent before the end of the transitional period.

b) Countries may be granted “provisional” equivalence status for ten years for the purposes of Article 227. This is seemingly capable of renewal any number of times (for a further ten years in each case). Again, specified criteria must be met (see below for details). Significantly, however, the country concerned need not have made any commitment to put in place an equivalent regime by the end of the transitional period, or at all.

As Solvency II is drafted (and consistent with the point made earlier that the legislation makes no provision for a country leaving the EU), the UK cannot initiate a formal application for equivalence status (whether on a full, temporary or provisional basis) until after it leaves the EU. Even then, there would inevitably be some delay whilst the assessment process was carried out, however self-evident it might be that the UK regime was still the same as the pre-Brexit Solvency II-compliant regime (if this is the position which the UK adopts – the possibility of some differences being proposed by the PRA cannot be ruled out). This would be unhelpful for UK insurers and groups because, for a short time at least:

a) reinsurance taken out by EEA insurers with a UK reinsurer may not be given full recognition, which may make UK reinsurers less attractive as providers of reinsurance to EEA cedants;

b) groups headed by a UK-headquartered entity with an EEA insurance subsidiary would be subject to EEA group supervision unless “other methods” could be agreed with the relevant group supervisor under Article 262, Solvency II; and
c) UK subsidiaries within groups headed by a EEA-headquartered entity would need to be brought into account for group capital purposes on a Solvency II basis instead of under local, UK rules (although it is doubtful whether this would have much significance while the UK regime is heavily based on Solvency II standards).

Insurers may wish to lobby for “equivalence” status to be granted to the UK immediately on exit, rather than having to wait for the formal process to be initiated once its withdrawal from the EU is complete. Without such a concession, it seems that a gap is inevitable.

Of course, any negotiations over expediting equivalence decisions needs to be seen in the context of reciprocal arrangements that the UK may grant to EEA supervisory regimes. This raises a number of interesting dynamics. For example, reinsurers that have their head office in the EEA will wish to preserve their competitive position when it comes to providing protection to the UK insurance market. This position is likely to be undermined if their home state supervisory regimes are not given the same recognition by the UK that they have under the current regime.

Finally, this is, of course, the first time that a Member State has left the EU at a time when its domestic regime is, effectively, fully equivalent. Given this, there may be some merit in exploring whether, if the UK adopts the Solvency II regime in full on exit, it could achieve something more than just equivalence status, perhaps through use of Article 171, Solvency II (see discussion above). This may improve the position for both EEA and UK insurers in terms of retaining the access to insurance markets across the EEA that they currently hold.
CASS COMPLIANCE FOR INSURANCE INTERMEDIARIES – SOME ENFORCEMENT LEARNING POINTS

The FCA has published separate Final Notices against Towergate Underwriting Group Limited (“TUGL”) and its Director Timothy Philip. The FCA has fined TUGL £2,632,000 for breaches of CASS 5 and related Principle 3 and Principle 10 breaches between 2005 and 2013; Mr Philip was fined £60,000, and banned from having any responsibility for client and/or insurer money in relation to any regulated activity in future.

Enforcement by the FCA has previously focused on CASS 6 and 7, which apply to investment firms, rather than the specific CASS 5 rules for insurance intermediaries. This Final Notice may suggest that the FCA has increased its focus on insurance intermediaries. The FCA has chosen to take this action despite its lack of progress on issuing a Policy Statement following closure of the (then) FSA’s August 2012 consultation (CP12/20) on proposals to clarify and simplify the CASS 5 rules.

This article sets out the factual content of the FCA’s Final Notices, the areas of CASS 5 that the FCA considered had been breached and key learning points for firms to consider.

This case represents an opportunity for insurance intermediaries to consider their process and procedures around CASS 5 in light of the shortcomings identified by the FCA, and to select target areas for review and enhancements. Similarly, insurers may want to consider their contracts with intermediaries and consider additional oversight or checking their client money arrangements.

SOME QUESTIONS TO CONSIDER:

- Are your client money calculations and reconciliations accurate and effective?
- Do your client money calculations take account of bank account ‘sweep’ arrangements?
- Do you reconcile your calculations to the actual bank account balances?
- How would your process operate if you became aware of a client money shortfall?
- How quickly could you identify/correct any shortfall?

KEY BREACHES AND THEIR CAUSES

TUGL is an insurance intermediary which, during the relevant period, had made a large number of acquisitions of other insurance intermediary firms (“Business Units”). In total, between January 2007 and December 2013, it acquired 70 Business Units. In integrating these formerly separate businesses, which had conducted separate client and insurer money reconciliations, TUGL operated an automated daily system in which funds in the client and insurer bank accounts of the Business Units were transferred into central client and insurer bank accounts (“Central Bank Accounts”). It was in the course of managing this process that some of the breaches arose.
Below we explain the key areas of weakness identified, and then provide some suggestions of specific areas to check compliance at your firm.

1. Client money calculations and reconciliation

CASS 5.5.63 requires an insurance intermediary to:

- carry out client money calculations at least every 25 business days by comparing the amount of client money actually segregated in its client money bank account (“Client Money Resource”) against the amount of money that is needed to be segregated for the firm to meet its obligations to clients. Any shortfall or excess identified must be replaced or withdrawn accordingly on the same day (with some exceptions); and
- within 10 days of the client money calculation, reconcile the balance on each client bank account as recorded by the firm (typically in a ledger), against the external bank account statement (external reconciliation).

These obligations differ from those for CASS 7 investment firms, which require a daily client money calculation. TUGL operated CASS 5.4 non-statutory trust accounts in respect of much of its client money. This meant that client money and insurer money could be comingled, provided that the relevant insurers agreed that their claims on that money would be subordinated to claims by clients. This comingling feature is unique to CASS 5, and offers insurance intermediaries flexibility in circumstances where they receive premium to arrange insurance cover for clients, receive money on behalf of insurers in respect of each policy, retain commission on a portion of premium, and pay the balance over to insurers; as well as receiving payments on claims from insurers and administering them back to clients. This flexibility does however bring with it some complexity: as client money calculations are only required to be undertaken relatively infrequently, this can make it harder to identify any errors.

TUGL performed client and insurer money calculations over the individual Business Unit bank accounts, with the figures being recorded internally before the balances were swept into the Central Bank Accounts. As such, the figures used for Client Money Resource in its client money calculation were (usually) the sums recorded prior to the sweep and not the actual sum present in the Central Bank Accounts.

In addition, when TUGL carried out its external reconciliation (required within 10 days of the client money reconciliation), this was also done at Business Unit level. TUGL therefore compared the Business Unit’s ledger against the relevant bank account statement. Due to the sweep arrangement, however, both of these balances would typically show nil at the time the reconciliation was performed. As such, the processes in place did not achieve the requirements of the CASS rules on external reconciliations.

The core purpose of the client money calculation and external reconciliation is to ensure that the money sitting in the relevant bank account is enough to meet client entitlements in the event of insolvency. To substitute that actual figure with an internal record of how much money was in several other bank accounts before they were swept did not allow for the possibility of intervening movements which may affect the actual central bank balance.

2. Commission payments/shortfall

TUGL was also found not to have adequately managed removal of its commission from the client money bank accounts. Under CASS 5.5.17(1)G, firms must withdraw commission as soon as it becomes due to the firm. This will generally be, as set out in CASS 5.5.16, when it has received premium from the client; and when it is consistent with the firm’s terms of business. In order to meet business expenses TUGL transferred a total of £10.5 million from the Central Bank Accounts, over four separate tranches, which it believed was due to it as commission. These transfers were based on a review of the Business Units’ client and insurer money calculations prepared by the Business Units did not reflect this removal of £10.5 million. As a result, subsequent client and insurer money calculations prepared by the Business Units did not take into account the ‘surplus’ withdrawn from the Central Bank Accounts, which was therefore aggregated and removed by TUGL from the Central Bank Accounts as four lump sums.

TUGL did not, however, allocate the withdrawal of monies back to the relevant Business Units and they were not informed that the surplus had been removed. As a result, subsequent client and insurer money calculations prepared by the Business Units did not reflect this removal of £10.5 million. Had the client money calculation been reconciled against the actual bank account balances in the Central Bank Accounts, this discrepancy would likely have been identified and any top-ups caused by the lower Client Money Resource would have been made.

3. Commission drawdown adjustment

A shortfall was also identified as being caused by the Business Units not operating in accordance with their agreements with relevant insurers. Under these agreements TUGL was entitled to withdraw commission on receipt of premium from clients. In practice, the Business Units would withdraw commission on the inception of the policy. This caused a shortfall of £3.62 million compared to the balance that would have arisen had commission been removed at the right time. In relation to this, the FCA noted that no single team or individual was responsible for monitoring compliance with the agreements and the interplay between different aspects of the CASS 5 rules was not understood.
CASS COMPLIANCE FOR INSURANCE INTERMEDIARIES – SOME ENFORCEMENT LEARNING POINTS

4. Treatment of interest

TUGL clients were not entitled to earn interest on balances, and therefore interest should have been removed to a separate firm bank account. TUGL thought that it had set up its sweep accounts such that no interest would accrue, however this was found to be ineffective in some cases. As TUGL did not allocate responsibility for the monitoring of transactions and removal of interest credited in error, a total of £1.45 million interest was not removed from the client bank accounts. TUGL’s reconciliations did not identify this excess money and it was therefore not removed from the client bank accounts.

The total effect of the excess of £1.45 million interest and the shortfall of £10.5m relating to commission, in addition to several other smaller breaches was that the client bank accounts were £9.04m short of the client requirement meaning that insufficient client money had been held in the client money bank account. This was rectified in October 2013, but had been identified in May 2013. TUGL was criticised for not immediately rectifying the shortfall in May 2013 and notifying the FCA it was unable to perform its client money calculations.

5. Learning points to consider

This case offers useful prompts for insurance intermediaries to select some key areas of their client bank account reconciliations and related processes for a health-check. In particular:

- **Business changes:** Merging or acquiring businesses can be a difficult process and an area of exposure for compliance with CASS: operations and processes can be difficult to align when a firm is buying new businesses. If your firm has acquired other businesses which operate client money bank accounts, a review of how those accounts have been factored into the firm’s client money calculation and reconciliation, or of how that process has been recorded and audited for CASS 5 compliance in the past, could be worthwhile.

- **Removal of Commission:** Review arrangements and controls around the removal of commission and the timing of removal. Check the process for how commission is removed and consider that process by reference to CASS 5.5.

- **Interest:** Check that interest on client bank accounts is treated in a way that is consistent with the client terms and conditions: review procedures in place for verifying that interest is being removed. Check that erroneous credits are caught.

- **Contractual arrangements:** Consider reviewing contracts with clients and with insurers, and ensure that their terms reflect how you manage commission, mixed remittances, interest and premium. Although firms are often aware and sensitive to this in the context of retail customers, corporate clients can present more complex arrangements. Check that negotiated arrangements are consistent with your obligations under the CASS rules, and that those arrangements are reflected in contractual terms. The FCA’s focus on TUGL’s failure to abide by its agreements with insurers emphasises the importance of these agreements reflecting operational reality.

- **Senior management responsibility:** The action against an individual in this case is another example of the FCA’s continuing focus on individual accountability and responsibility. With the advent of SIMR and SMR, and their forthcoming extension to all firms, this focus is likely to continue. Consideration of how to support the responsible senior manager at your firm, such as enhancements to the MI he/she receives about CASS compliance, can further support them in their role.
As many businesses have discovered to their cost in recent years, the consequences of placing an unsafe or defective product on the market can be devastating. In addition to the potential criminal penalties and civil claims (including group actions), the business will face the often significant costs of recalling the products and inevitable damage to its reputation and brand.

Product liability and product recall insurance can provide some protection against the financial consequences of placing an unsafe or defective product on the market. In this article we set out the legal framework of product liability in the UK and then explain the scope and nature of product liability and recall insurance.

This article was first published in the International Comparative Legal Guide to: Product Liability 2016

REGULATORY/CRIMINAL POSITION

The main statutory rules on product safety in the UK are set out in the General Product Safety Regulations 2005 (“GPSR”) and in the Consumer Protection Act 1987 (“CPA”). The GPSR implement the EC General Product Safety Directive (2001/95/EC) and apply to all products to the extent they are not covered by a sector specific regime. The CPA has been superseded in part by the GPSR but remains relevant in particular as an umbrella under which various sector specific regimes have been enacted (e.g. for electrical products, toys and cosmetics). Some products (notably food and drink) are covered by sector specific safety regimes outside the CPA. Where any relevant matter is not addressed by a sector specific regime the GPSR apply to ‘fill the gap’.

The GPSR cover a wide range of products. “Product” is defined broadly and covers items which are sold or provided freely to consumers, as well as items not intended for consumers but which are likely to be used by them. New, used and reconditioned items are all included.

The GPSR impose the following principal obligations on producers and distributors of products:

- to place only safe products on the market;
- to ensure that products are identifiable and traceable;
- to monitor the safety of products; and
- to take appropriate and speedy action (including notifying the relevant authority and potentially instigating a recall) in circumstances where an unsafe product is placed on the market.

These obligations are backed up by criminal penalties.

The “general safety requirement” is the conceptual bedrock of the GPSR. This prohibits producers and distributors from placing on the market or supplying (or offering or agreeing to offer) an unsafe product. A producer or distributor can place a product on the market in a number of ways including by:

- selling, leasing, hiring out or lending it;
- entering into a hire purchase or other credit agreement for it;
- exchanging it for any consideration other than money;
- giving it as a prize or gift; and
- providing it in the course of the delivery of a service.

The GPSR identify a number of factors that will be relevant in determining whether or not a product is safe. These include:

1. its characteristics (including its composition, packaging, instructions for assembly);
2. maintenance;
3. its effect on other products;
4. presentation of the product (such as labelling, instructions for use or warnings); and
5. any consumers who are particularly at risk when using it (e.g. children and the elderly).
European Commission has published guidance which sets out a detailed methodology for the assessment of risks associated with a product.

Producers and distributors who contravene the general safety requirement by placing an unsafe product on the market can be served with a notice by an enforcement authority. This notice can require them to suspend or halt the offending action, to withdraw or recall the product in question, label the product or otherwise warn consumers who are at risk of the dangers posed by it.

It is a criminal offence for a producer or distributor (i) to fail to notify the relevant authority on discovery that an unsafe product has been placed on the market; (ii) to fail to comply with a notice issued under the GPSR; (iii) to fail to keep documentation necessary to trace products; and (iv) to fail to cooperate with the enforcement authority to avoid the risk posed by an unsafe product. Persons found guilty of these offences will face a custodial sentence and/or a fine.

In February 2013, the European Commission adopted a package of reform (known as the Product Safety and Market Surveillance Package) which intended to simplify and make more uniform the safety rules applying to non-food products, to streamline market surveillance procedures and to better co-ordinate and monitor the carrying out of market surveillance activities in the EU.

The Package includes a proposed new Regulation on Consumer Product Safety (which will repeal and replace the EC General Product Safety Directive and apply automatically in qualifying member states) and a proposed new single Regulation on Market Surveillance of Products (intended to simplify the EU market surveillance framework in the field of non-food products).

Three years on, the proposed new Regulations have still not been enacted. The intention remains, however, that they will be enacted and come into force this year.

**CIVIL POSITION**

A product manufacturer or retailer may also be exposed to civil claims by businesses and consumers who have purchased defective or dangerous products. The various forms of civil liability under English law include, in particular: (i) liability for breach of contract (including breach of statutory implied terms); (ii) liability in tort; and (iii) strict liability pursuant to the Consumer Protection Act.

**Contractual liability**

Contractual liability may arise in a number of ways. A contract for sale or supply may include express terms as to the nature or character of the product (i.e. in the form of a warranty or a guarantee). Failure of the product to comply with those express terms will generally give rise to a claim for breach of contract.

Statutory terms will also be implied into contracts for the sale or supply of products. Until last year these implied terms derived from one statutory regime that covered both business to business (B2B) and business to consumer (B2C) sales. Following the coming into force of the Consumer Rights Act 2015 there are now two parallel regimes (with B2C sales covered by the Consumer Rights Act and B2B sales continuing to be covered by the Sale of Goods Act 1979 and the Supply of Goods and Services Act 1982).

In practice, however, the statutory terms implied under the two regimes are much the same and include in particular requirements that products should be of satisfactory quality and fit for purpose and that they should match any description.

The implication of the implied terms can turn on whether the product supplied is a standard or bespoke product. In Trebor Bassett v ADT the Court of Appeal held that the design and installation of a bespoke fire suppression system could not be equated with a supply of goods that attracted the statutory implied terms of satisfactory quality and fitness for purpose.

The statutory implied terms give rise to strict liability. It is not necessary for the buyer to demonstrate fault on the part of the seller. The buyer need only show that the product did not accord with its description, or was of unsatisfactory quality or was otherwise unfit for its purpose.

Contractual liability may also attach to pre-contractual statements which refer to the qualities of the product. Such statements can be incorporated into contracts as terms or, alternatively, form the basis of a separate contract between the buyer and seller or the buyer and a third party. Under the new Consumer Rights Act, certain pre-contractual statements will now automatically become terms of the contract (on which the consumer can rely).

For breach of contract claims the buyer will be able to claim damages. In some cases a buyer will be able to reject the goods and terminate the contract.

**Liability in tort**

The tortious liability upon a manufacturer under English law was established in the landmark decision of Donoghue v Stevenson. That case imposed a duty of care on manufacturers of defective products to a class of persons to whom damage (personal injury or property damage) is foreseeable if that product is defective.

The standard is tested objectively and the manufacturer will not be at fault if a particular danger could not have been anticipated. Damage to the defective product itself (or the cost of a replacement product) will not be recoverable in a claim in tort for negligence.
Statutory liability

The UK (in common with other EU Member States) also imposes a strict liability regime on certain parties involved in the manufacture and supply chain in respect of consumers who have suffered damage as a result of a defective product. The CPA (which transposes the Product Liability Directive (85/374/EEC and 1999/34/EC) into UK law) imposes strict liability on producers (including persons holding themselves out as producers by selling products under their brand and importers into the EU) for harm caused by defective products. The CPA allows consumers who suffer injury or damage as a result of defective products to sue for compensation without having to prove that the producer was negligent, provided that it can be demonstrated that the product was defective and the defect in the product caused the damage. A person can sue for death, personal injury or damage to property. There are a number of available defences, including where the state of scientific and technical knowledge at the relevant time was such that the producer could not have been expected to discover the defect.

PRODUCT LIABILITY INSURANCE

Policy forms

There is no standard form of product liability insurance policy wording in the UK, unlike in the US which has the Combined General Liability Policy wording. Despite this, the form of many product liability policy wordings is similar and regularly combined with public liability insurance.

Proposal form/insured’s duty of disclosure

When a product manufacturer or distributor decides to take out a product liability insurance policy, it will be required to complete a proposal form. This form provides key information to the insurer about the insured’s business, the type of products it sells/distributes and the countries where the products are sold/distributed.

The business seeking insurance cover will also be required to disclose to the prospective insurer any other material facts which it knows or ought to know, and which are relevant to the products being insured. This obligation forms part of the general duty of good faith imposed by law in respect of contracts of insurance (which are based on the principle of utmost good faith). If the insured fails to disclose a material fact and if the insurer can show that such non-disclosure induced it to enter into the policy, it can avoid the contract in its entirety.

The Insurance Act 2015 changes a number of aspects of the existing law, including in particular the consequences of breach by the insured of its duty of disclosure. The Act provides remedies for breach which are more flexible and proportionate than those currently in force:

- The insurer can still treat the policy as void from the outset if:
  (i) the insured’s breach of its disclosure duty was deliberate or reckless (with no return of premium); or
  (ii) the insurer would not have entered into the policy at all if proper disclosure had been given (but must return the premium).
- However, if the insurer would still have entered into the policy but on different terms the policy may be treated as if it included those terms from the outset; and if the insurer would have entered into the policy but at a higher premium, the amount paid on claims may be reduced proportionately.

The changes are not retrospective and so the old regime will continue to apply to policies entered into before 12 August 2016.

Scope of cover

The basic indemnity provided by product liability insurance policies is for protection of the insured against legal liability for or in respect of bodily injury, illness or disease or physical damage to property not in the custody or control of the insured which is caused by the product. Damage to the product itself is not, therefore, normally covered. This scope of cover effectively matches the liability imposed in tort for negligence.

The “product(s)” covered by the policy will not normally be defined as a specific item (or items). The definition will instead normally include any goods or products after they have ceased to be in the insured’s possession or control, including packaging materials and containers. Disputes have arisen from the question of whether or not an item that has given rise to a loss is a “product” for the purposes of the policy.

In Aspen Insurance v Adana, judge Mackie QC considered whether a concrete base of a tower crane, constructed by the insured defendant which collapsed causing serious injury and property damage, constituted a “product” within the meaning of the product liability insuring clause of a building services combined contractors’ liability insurance policy. The judge held that the base of the crane was not a “product” for the purposes of the policy: it was created on site (concrete poured in situ) not at the factory and came into existence as a lump of concrete and was not one of the insured’s range of products (it could not be bought). The Court of Appeal subsequently confirmed this analysis although it did find that dowels (iron rods connecting the crane base to the supporting piles) supplied and installed by the insured were themselves “products” notwithstanding the fact that they were incorporated into the overall crane support structure. This did not affect the outcome of the case since the dowels did not fail. The Court of Appeal commented that whilst the term product “may elude precise definition” it was “a hallmark of a product ... that it was something which, at least originally, was a tangible and moveable item which can...
be transferred from one person to another; and not something whichonly came into existence to form part of the land on which it wascreated”.

The use of the words ‘for or in respect of [bodily injury, property damage etc.]’ in the insuring clause is of significance and has a limiting effect on the extent of the insurance cover, carrying with it the requirement that the liability relate to the loss or damage. It is not sufficient that the liability should simply have had some connection with the loss or damage (Rodan v Commercial Union). These words are generally taken as excluding pure economic losses from the scope of the indemnity.

**Trigger and notification**

Product liability insurance policies are written either on an occurrence basis (i.e. the damage must occur in the period of cover for the policy to be triggered) or on a claims made basis, meaning cover will apply to all claims made against the insured by a third party during the policy period.

Insureds will need to pay close attention to the notification provisions in the policy and consider these carefully whenever a product safety/defect situation arises. The notification requirements under a product liability policy written on a claims made basis will invariably include provisions relating to notification of claims and of circumstances which may or are likely to give rise to a claim. The requirement for notification of circumstances will usually also include a ‘deeming’ provision under which claims which arise after the expiry of the policy period but out of circumstances previously notified to insurers are deemed to attach to the policy under which notification of circumstances was given.

Insureds should take care to ensure that notifications are made strictly in accordance with the notification provisions in the policy and are always carried out in a timely manner. The importance of avoiding unnecessary delay was illustrated in the case of HLB Kidsons v Lloyd’s Underwriters in which the Court of Appeal confirmed that failure to make a timely notification of circumstances could mean that claims arising out of those circumstances after expiry of the policy would not be covered.

**External damage**

A product liability policy is principally concerned with damage caused to persons and other property by a defective product that is supplied by the insured. In this regard, the policy reflects the law of tort which generally requires some form of external physical loss or damage to trigger liability.

In English law, “damage” usually refers to a changed physical state to external property in circumstances where the relevant alteration is harmful in the commercial context. A defect or deterioration in the commodity or product itself is not “damage”.

Some product liability policies may, however, contain express provision that damage caused by a defective part to another part or other parts of a larger item which is not defective or inadequate will be covered (again, this akin to the position in tort for negligence).

The application of the requirement for physical damage can give rise to difficulties where the product supplied by the insured is to be installed in a larger item for use or onward sale by a third party. There will be a distinction between cases where the product causes damage to the larger item (covered) and where the defect in the product itself becomes manifest but without causing any damage beyond itself (not covered).

The test is whether there has been any physical change to the larger item as a result of the incorporation or inclusion of the defective product. If the defective product causes harm to the larger product, such that its value is diminished, physical damage will have occurred. In Tioxide v CGU, a defective whitening pigment used in the manufacture of PVC doors which had caused the PVC to turn pink was found to have caused physical damage to the PVC for the purposes of the insurance cover. In Omega Proteins v Aspen, although the question of whether there had been damage to property within the meaning of the product liability policy was not in issue, the judge proceeded on the basis that the mixing of contaminated material (fit only for disposal) with other materials caused damage to those other materials (by rendering them unusable).

The principle will not, however, apply where a product is installed or fitted alongside the property of a third party where no physical harm is caused and the harmful effects are confined to the product itself. In Pilkington v CGU, glass panels supplied by Pilkington were installed in the roof and vertical panelling of the Eurostar Terminal at Waterloo in London. A small number of the panels were defective and fractured on installation, although no physical damage was caused to the building. The insurance policy excluded cover for products which were defective at the time when installed and, as the Court held that the only damage was to the glass panels themselves (and not to third party property), the claim failed.

Extensions are sometimes available which extend the scope of cover under a standard product liability insurance policy to sums for which the insured becomes legally liable in respect of claims for the diminution in value of a product arising from any defect in any ingredient or substance supplied by the insured which is mixed or blended with other ingredients or substances for the purposes of creating an end product and which results in that end product being defective or harmful. These are often referred to as mixing or blending losses extensions. Such extensions can be extremely valuable for manufacturers or retailers of ingredients and other substances which are mixed or blended in a finished product.
Pure economic loss
As product liability policies are principally directed to damage caused to persons and other property by a defective product supplied by the insured, the English courts tend to construe cover under such policies in accordance with the law of tort. Accordingly, product liability cover will not normally extend to liability for pure economic financial losses which are not consequential upon the damage.

This is exemplified by Horbury v Hampden, where the insurance claim related to the costs associated with the collapse of a suspended ceiling installed in a cinema auditorium. The cause of the collapse was initially unknown and the whole cinema complex was closed for several weeks although it was accepted by the parties that the damage caused by the collapsed ceiling had not physically prevented the use of the rest of the complex. The Court held that the insurer was not liable to indemnify the insured subcontractor in respect of loss of profit arising from the closure of the entire cinema complex; the policy only covered liability for the physical consequences of the damage in the auditorium where the ceiling collapsed and the economic losses caused by that physical damage. The policy did not extend to matters such as the cost of the investigations or precautions taken to avoid physical damage.

Some policies contain financial loss extensions which cover liability for third party financial losses in the absence of injury or damage. Such coverage tends to be limited but can be particularly valuable as liability for pure economic loss can freely arise in contract and in some jurisdictions in tort as well. These extensions can also be combined with product guarantee insurance, which provides protection against an insured’s legal liability for claims arising out of the failure of its product to fulfil its intended purpose or function (discussed further below).

Exclusions
There are a number of exclusions generally included in product liability insurance policy wordings which can operate to exclude liability otherwise falling within the scope of the cover. The most common exclusions include:

- The costs of recalling, replacing or repairing the product itself. Plainly, these costs fall outside of the general ambit of a product liability policy which is principally concerned with liability for damage caused to persons and other property. Insureds can protect themselves against the costs of a product recall by obtaining product recall insurance (discussed below).
- Liability assumed by contract or agreement. This exclusion reflects the fact that product liability coverage is designed to cover the insured’s liability for injury to persons or damage to physical property. It is not ordinarily intended to cover those types of losses which might be recoverable in a claim for breach of contract unless such liability would have arisen in tort in any event. Such exclusions do not always make it clear, however, whether the test is: (i) liability in tort as if no contract between the claimant and the insured had existed; or (ii) liability in tort assuming the existence of a contract. In Omega Proteins v Aspen, the judge considered that an exclusion for "any liability arising ..., under any contract or agreement unless such liability would have attached in the absence of such contract or agreement" invited consideration as to what liability would have attached in the absence of a contract (but the facts were otherwise as they were), not whether there was a liability in tort, as well as contract.

It is possible to obtain contractual liability extensions but care must be taken with the way these are drafted to ensure that they do not simply cover contractual liability which is concurrent with that in tort (which is normally covered in any event). Issues can arise where a policy extension provides cover for liability assumed under contract but the extension remains subject to the insuring clause under which cover is restricted to liability ‘for or in respect of [bodily injury, property damage etc.]’. In such cases, pure economic losses (i.e. financial losses which do not arise directly from bodily injury or property damage) would not be covered by the policy even though they may be recoverable from the insured under contract.

- Liabilities which arise from the failure of an insured product to perform its function (so-called “product efficacy” exclusions). Product functionality is only relevant where the failure of product function may give rise to liability. The functionality failure of certain products (such as clothing, electrical goods or toys) will not necessarily cause liability for loss or damage. However, failure of other products to perform effectively (such as medicines or fire extinguishers) will almost certainly give rise to loss and/or damage.
- The insured’s deliberate acts or omissions which can reasonably be expected to cause harm, loss or damage which is the subject of the claim. Where an insured fails to carry out adequate due diligence in respect of a product or reacts poorly in the wake of a product liability issue, insurers may seek to deny cover on this basis.

Care should be taken to ensure that the wording of the policy and the exclusions reflects the nature of the insured’s business, particularly where there may be technical reasons for a product’s failure/defect. If the policy terms are inappropriate or poorly drafted, there may be grounds for dispute. In John Reilly v National Insurance & Guarantee Corporation the Court was unable to determine whether a product efficacy exclusion applied, as there was a lack of clarity about how the clause applied to insured’s products. As a result, it was ultimately unable to determine policy coverage.
OUR GUIDE TO PRODUCT LIABILITY AND PRODUCT RECALL INSURANCE

PRODUCT RECALL INSURANCE

The costs of a product recall can be substantial, particularly where the products are distributed internationally, and can include:
(i) costs in the supply chain (such as manufacturing plant cleaning costs and material write offs); (ii) the handling costs of the recall (which can include customer returns, call centre costs, trade claims, costs relating to the storage and disposal of the recalled products and advisory fees); and (iii) loss of profit (including both immediate trading losses and damage to reputation and goodwill).

In the current climate many manufacturers and distributors now seek to protect themselves against the consequences of an expensive product recall through insurance cover.

This form of insurance used to be something of a speciality but has become increasingly popular in recent years. A wider array of coverage options has become available although the number of insurers active in the field remains relatively small.

Scope of cover

Product recall policies are often arranged as part of or as an extension to products liability insurance but can be purchased on a stand-alone basis. Such policies generally cover the following types of risk:

- The insured’s legal liability for:
  - the costs of removing, recovering, repairing or replacing a product which is defective or dysfunctional; and/or
  - financial losses incurred by customers or third parties which arise as a result of product impairment (i.e. a product failing to perform the function for which it was manufactured, designed or sold).

- The costs and expenses incurred by the insured which are associated with the cost of recalling its own products which may include:
  - business interruption losses;
  - the costs of the additional communications and media outputs required for the recall;
  - additional staffing to cover the recall operation;
  - brand restoration costs (such as consultants and advisors to assist in loss mitigation);
  - legal costs and expenses incurred in mitigation of a loss or potential loss; and
  - rehabilitation costs involved in re-establishing the product affected to the projected level of sales or anticipated market share prior to the recall.

Product recall policies may also provide cover for the costs and expenses of a product recall which are caused by malicious contamination of a product (although some policies will expressly exclude cover for such losses).

Event triggering the recall cover

The nature of the event that is necessary to trigger the insurance cover will normally depend upon the form of indemnity. Indemnities for legal liability tend to be written on a claims made basis requiring notification of a claim (or circumstances which may or are likely to give rise to a claim) during the policy period. Indemnities for the costs and expenses of a recall, by contrast, are normally triggered by the insured’s decision to recall the product being taken (and notified to insurers) during the period of insurance.

Where the cover is for the costs and expenses incurred by the insured in respect of a product recall, the policy will often stipulate that the recall must be necessary in order to prevent or mitigate the prospects of legal liability arising from the use or consumption of the product. Some product recall insurance policies will contain more stringent limitations which specify that there must be an actual or imminent threat of danger, injury or harm associated with the product’s use. The regulatory regime in the UK encourages pro-active steps (including recall) when an unsafe product may have been placed on the market. Insureds may, therefore, find that they are potentially exposed to uninsured losses where a precautionary recall was carried out in the absence of actual or imminent danger of injury or harm (if such was required by their policy). Similarly product recall cover may not be available where a business decided to carry out a recall voluntarily for commercial reasons (e.g. due to a quality defect only in order to protect the brand).

Exclusions

Product recall policies will also contain a number of exclusions, the most common of which include the following:

- Where a product recall is necessitated by a product defect which has arisen solely due to:
  - exposure to weather or the deterioration or decomposition of a product (e.g. fresh food items);
  - the fact that a product does not accomplish its intended purpose or comply with other implied statutory warranties or has passed its shelf life;
  - contamination or other defect arising out of bioengineering or GM treatment; or
  - the failure of any third party to store or consume the product in the prescribed manner.
Prototypical or experimental products which, by their very nature, are expected to experience problems in the nascent stages of development are also generally excluded.

Product recalls which are forced upon the insured by the government or a public authority in circumstances where the insured would not have conducted the recall but for the said intervention.

### Practical considerations

Insureds should establish and shock-test the product recall planning procedures which are in place and ensure that they accord with the requirements of any product insurance held (particularly in terms of notifications to insurers). Such requirements may include:

- Notifying insurers as soon as it becomes apparent that expenditure will need to be incurred in respect of a product recall.
- Maintaining detailed records of any expenses incurred and actions taken in a product recall situation, including steps taken to mitigate or minimise the costs involved.
- Submitting proof that such costs were reasonably and properly incurred.

### ADDITIONAL REFERENCES

- Donoghue v Stevenson [1932] AC 562
- Rodan v Commercial Union [1999] Lloyds Rep IR 495
- Horbury Building Systems Ltd v Hampden Insurance NV [2004] 2 CLC 453
- Pilkington United Kingdom Ltd v CGU Insurance Plc [2004] EWCA Civ 23
- Tioxide Europe Ltd v CGU International Insurance Plc [2004] EWHC 2116 (Comm)
- HLB Kidsons (a firm) v Lloyd’s Underwriters and Others [2008] EWCA Civ 1206
- John Reilly v National Insurance & Guarantee Corporation Ltd [2008] EWHC 722 (Comm)
- Omega Proteins v Aspen Insurance UK Ltd [2010] EWHC 2280 (Comm)
- Trebor Bassett Holdings Ltd v ADT Fire & Security Plc [2012] EWCA Civ 1158
- Aspen Insurance UK Ltd v Adana Construction Ltd [2013] EWHC 1568
- Aspen Insurance UK Ltd v Adana Construction Ltd [2015] EWCA Civ 176
- Sale of Goods Act 1979
- Supply of Goods and Services Act 1982
- Consumer Protection Act 1987
- EC General Product Safety Directive 2001/95/EC
- General Product Safety Regulations 2005/1803
3D PRINTING: THE LEGAL IMPLICATIONS OF AN EMERGING NEW TECHNOLOGY

3D printing, additive manufacturing, direct digital manufacturing and rapid prototyping are just some of the terms used to describe a new form of printing where a 3D object can be created using successive layers of material.

The technology is generating significant attention in the consumer technology sector in particular. For now, while basic 3D printers are available for less than £500, limitations in the strength and choice of materials (mainly plastics) mean that the technology is not an appropriate alternative to many ready-manufactured products. But as the technology becomes more advanced, the popularity of home production as an alternative to home delivery may rise, making it important for both businesses and consumers to understand the legal implications of the technology. For industry too, 3D printing will offer new ways to manufacture complex products.

It is too early to say whether sectoral specific legislation for 3D-printed products will be needed but it is clear that, as 3D printing technology develops, businesses will need to anticipate developments and act proactively, rather than waiting for the law to catch up to a fast-moving area.

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HOW DOES 3D PRINTING WORK?

The item to be printed first needs to be represented in a computer-readable format, by using computer-aided design (CAD) software. The 3D design is uploaded to the printer, which prints the 3D object by laying down successive layers of plastic or by heating powdered metal to solidify it into a particular shape. 3D designs can be created from scratch using CAD software or they can be obtained from a third party, for example from one of the many online platforms that provide printable designs. 3D scanners also allow 3D design files to be created from physical objects, allowing their external faces to be copied. Since the 3D designs are simply computer files, they are easily reproduced and disseminated.

INTELLECTUAL PROPERTY

Copying an object protected by intellectual property (IP) laws without permission will usually be an infringement. The method by which the infringing item is produced does not affect the way that IP laws apply; conventional manufacture in a traditional factory and manufacture by a 3D printer using a computer-aided design (CAD) file both produce a copy of an object.
However, if the items are being produced for non-commercial purposes by individuals for personal use, they could fall within the personal use exceptions to infringement. These personal use exceptions could cause problems for IP rights owners where consumers are printing goods rather than buying them through traditional pathways.

**Spare parts and personal use**

An obvious attraction of 3D printing is the production of spare parts for other products. IP law generally treats the production of spare parts leniently; exceptions to infringement exist under:

- Patent law, provided that the spare part is not itself part of the inventive concept of the patent (Schutz v Werit).
- Design law, to replace a component part where the design is solely dictated by function or must fit or match another product (section 7A(5), Registered Designs Act 1949 (as amended) (“1949 Act”); Copyright, Designs and Patents Act 1988 (“CDPA”)).

In addition, acts done privately and for non-commercial purposes are excepted from infringement under registered design and patent law. A lot of 3D printing that is done at home, whether or not for spare parts, may fall within this exception.

This combination of legislative provisions excepting private, non-commercial use of IP from infringement and allowing reasonable repair of a purchased item through the creation of spare parts was designed to avoid abuse of consumers by rights owners and to allow personal use and repair at a reasonable cost, rather than forcing consumers to replace the whole product whenever a component breaks or to buy replacement parts only from the original manufacturer.

However, these provisions may pose significant problems for those seeking to protect their rights in the context of 3D printing. Manufacturers will surely be grateful that the personal use copyright exception in the Copyright and Rights in Performances (Personal Copies for Private Use) Regulations 2014 was quashed by the High Court in 2015 and does not look like being reintroduced in any form, at least in the short term (R (British Academy of Songwriters, Composers and Authors and others)).

**Commercial infringers**

In relation to largescale commercial infringers, rights owners will much more readily be able to protect their IP.

A patent is a monopoly right, so any independent creation of a product protected by a patent will be an infringement. Patent protection of spare parts was considered in Schutz where the Court held that various factors are relevant when considering whether a spare part can be manufactured without infringing a patent, including whether the part is included within the inventive concept of the patent, whether the item is free-standing, and what its life expectancy is likely to be. The rise of 3D printing may result in manufacturers being more keen to register patents that are specifically directed to spare parts and potential spare parts for their products.

Trade marks may also be infringed if 3D-printed goods are printed with a brand name or logo on them, just as they would be had the goods been manufactured using conventional methods. This would also apply to individuals applying trade marks to items for their personal use.

Scanning items to create a 3D-printed version can be a copyright infringement in some circumstances, although protection of manufactured items under UK copyright law is far from straightforward. It is not a breach of copyright to make an article using a particular design, unless the design is an artistic work (section 51, CDPA). Instead, protection is given under UK unregistered design, which also arise.

Whether the original from which the manufacturer produces its stock is an artistic work is therefore significant in the long-term protection of a design. In Lucasfilm Ltd v Ainsworth, the Supreme Court found that Star Wars Stormtrooper helmets were functional and were not works of artistic craftsmanship, so the copyright was not enforceable and the design right had already elapsed.

It is likely, therefore, that many objects replicated on a 3D printer will be held to be functional objects and so will not gain copyright protection; only those objects created for a truly artistic purpose may retain copyright. Instead, the design could receive the shorter term UK unregistered design rights protection, along with Community unregistered design rights, which also arise automatically and co-exist with UK unregistered design, providing some limited, short-term (three-year) protection across the EU.

The current reduction in the term of copyright protection from the life of the author plus 70 years to 25 years only for items manufactured in numbers greater than 50 set out in section 52 of the CDPA was repealed in July 2016. This will assist in restricting the 3D printing of artistic works, even where these have been produced in significant numbers. The Intellectual Property Office has produced guidance to assist businesses and individuals affected by the repeal. Registered design protects the appearance of the whole or a part of a product resulting from the features of the product or its ornamentation (section 1(2), 1949 Act). Community-registered designs are also available providing EU-wide rights. These rights are likely to provide some protection for designers against 3D printing, as they do against traditional methods of manufacture.
However, design protection is difficult to enforce where even small changes are made to a design, so protecting against copies adapted using 3D printing may prove difficult. This is the implication of a recent series of cases in which design right owners have failed to prevent similar designs being marketed by competitors (Procter & Gamble v Reckitt Benckiser, Dyson v Vax).

**Online CAD file-sharing**

An obvious challenge to rights owners is the online sharing of CAD design files, in much the same way that MP3 music files raised concerns for the music industry. These files could be unofficial designs produced by enthusiastic amateurs. Equally though, given the ease with which CAD files can be copied, they could be official design files that have leaked from the rights owner, for example through a cyber attack.

It may be possible to stop the supply of infringing CAD files by seeking orders requiring internet service providers to block file-sharing platforms, in a similar way that this is already done in relation to MP3 music files and film files in relation to the likes of The Pirate Bay, which already has a CAD file-sharing section.

Specific requests to, or legal action against, websites inviting them to remove infringing content is also a possibility. This might be easy to establish where the CAD files are official files that have been illegitimately copied. However, it will be more difficult where it is necessary to show that the CAD file infringes the IP right owner’s 3D object, particularly if there are material differences. Reliance on trade marks or common law passing off may be an alternative if, for example, the look and feel of a product had been copied, or infringement of a registered design or patent might be available. Designers should therefore obtain patent rights where possible and register their designs, rather than relying on copyright, although unregistered designs will provide some limited term protection.

**Commercial alternatives**

3D printing can represent an opportunity for rights owners as well as a threat. If consumers wish to 3D-print their own products, rights owners may choose to issue their own legitimate official CAD files instead. Design owners will need to consider how to license use of their design files. It is possible to sell a download of the file for limited use, for example, with digital rights management, but as with most software, the limitations on re-use are hard to enforce and are often circumvented. An ideal option would seem to be a one-print sale, where the design is sent direct to the printer, rather than a copy of the design being held on the buyer’s computer. With the advent of the internet of things, this may become a possibility.

**ENFORCEMENT DIFFICULTIES**

Manufacturers of counterfeit goods often use jurisdictions where intellectual property rights (IPR) are not rigorously enforced or where the IPR are not registered or do not exist. Rights owners therefore rely on the customs authorities seizing counterfeit goods when they are imported to ensure that the goods do not get onto the market in the jurisdictions where the rights owners sell their products normally. The use of 3D printing may mean that the routes to market of counterfeit goods are more direct. 3D computer-aided design files can easily be emailed across borders without detection and all that is needed within a jurisdiction is a suitable 3D printer. A greater use of search and seizure orders in the UK and of trading standards authorities, where appropriate, may become necessary if 3D printing of counterfeits becomes more prevalent in the UK.

**PRODUCT LIABILITY**

English law imposes a range of criminal and civil liabilities for those involved in manufacturing and distributing products that are defective, dangerous, or both. This includes products manufactured by 3D printing. The challenge in the case of 3D printing arises not so much from the technology but more from the way in which it is used; that is, the new business models and supply chains involving 3D printing.

It is a criminal offence to place on the market a product that is unsafe (General Product Safety Regulations 2005 (“2005 Regulations”)). “Product” is defined broadly and includes products created by 3D printing and products involved in the printing process itself, including the printer and the materials involved.

Contracts for the sale of goods, including 3D-printed products, include implied terms as to quality and fitness for purpose under the Consumer Rights Act 2015 for business to consumer sales, and under the Sale of Goods Act 1979 in other cases. Product manufacturers will owe a tortious duty of care to end users, which may give rise to a cause of action in the event that a defective or dangerous product causes personal injury or damage to property.

The Consumer Protection Act 1987 (1987 Act) also allows consumers to recover damages for civil liability from the producer of a product that causes personal injury or property damage. The 1987 Act imposes strict liability, subject to certain statutory defences.

How this framework applies in the field of 3D printing will vary depending on the relevant circumstances. This may be best illustrated by two examples:

- A company uses 3D-printing technology to manufacture products for sale that prove to be defective. If the defect means that the products are unsafe, the company will face criminal liability under the 2005 Regulations. If end users...
suffer personal injury or property damage, they may recover damages in tort and, in the case of consumers, under the 1987 Act. Buyers of the product will have a potential contractual claim against the seller, and the seller may, in turn, have recourse down the supply chain and ultimately against the manufacturer, depending on the contractual arrangements. In this scenario, the law applies just as it would to a product manufactured through a traditional process.

- A consumer with a home 3D printer prints a product based on a digital design template that he has downloaded. If the product proves to be defective, the consumer’s recourse is much less straightforward. It may be difficult to argue that he has bought the printed product and so the implied terms as to quality and fitness for purpose in contract may not assist. If he can show that the defect arose from a fault in the printer, from an error in the digital design or from a defect in the printing material, he may have a claim against the relevant supplier but proving this is unlikely to be straightforward. If the product is unsafe, it may be difficult for the authorities to determine who, if anyone, is criminally liable as the producer.

**ADDITIONAL REFERENCES**

Procter & Gamble Co v Reckitt Benckiser (UK) Ltd [2007] EWCA Civ 936
Dyson Ltd v Vax Ltd [2011] EWCA Civ 1206
Lucasfilm Ltd v Ainsworth [2011] UKSC 39
Samsung Electronics (UK) Ltd v Apple Inc [2012] EWCA Civ 1339
Schutz (UK) Limited v Werit UK Limited [2013] UKSC 16
R (British Academy of Songwriters, Composers and Authors and others) v Secretary of State for Business, Innovation and Skills [2015] EWHC 2041 (Admin)
Registered Designs Act 1949
Consumer Protection Act 1987
Copyright, Designs and Patents Act 1988
General Product Safety Regulations 2005/1803
END-USER OF DEFECTIVE PRODUCT PREVENTED FROM BRINGING A CLAIM WHEN IT HAS KNOWLEDGE OF THE DEFECTS

The Court of Appeal has confirmed that where an end user has knowledge of the defects in a product, it is not able to bring a claim for any subsequent loss resulting from that defect. It held that an end user company would be deemed to have knowledge even where its senior managers were not aware. It is sufficient that employees entrusted with the task of maintaining and operating the defective equipment in a safe manner had such knowledge.

BACKGROUND

The Appellant, Howmet, is a company which manufactures turbine aerofoils and other precision components for the aerospace industry. As part of the manufacturing process, metal castings are dipped into a series of heated tanks. The Respondent, EDL, was engaged to provide a number of “thermolevel” devices which were fitted to the tanks. Operating correctly, the device automatically switches off the heater when the level sensor detects that the liquid in the tank has dropped below a specified level. This function is designed to prevent the risk of the tank catching fire, which was the likely outcome of the heater remaining on when the tank was empty or nearly empty. On two occasions prior to the incident giving rise to the claim, the thermolevel failed to function resulting in a fire. On both of these occasions, the fires were extinguished by members of staff on site at the time. The thermolevel device fitted to the same tank then failed for a third time. On this occasion, there was no one present to witness the chemicals within the tank catching fire and the blaze spread, causing £20 million of loss.

Howmet brought the following claims:

1. EDL had breached its duty to exercise reasonable care and skill in the manufacture and design of the thermolevel devices
2. That EDL had breached its statutory duties under the Electrical Equipment (Safety) Regulations 1994 (the “1994 Regulations”) in failing to affix CE markings and ensure the product was “safe”

FIRST INSTANCE DECISION

At first instance, it was held that EDL had not implemented any satisfactory testing regime and the manufacture of the devices was deficient. In addition, EDL provided inadequate instructions to accompany its product demonstrating a lack of reasonable care. The same reasoning also meant that the product was unsafe under the 1994 Regulations. Had Howmet reasonably relied on the thermolevel as protection against fire at the relevant time, the failure of the device to operate properly would have been within the scope of the duty of care and the claim to recover losses caused by the fire would have been successful. It was held, however, that this was not the case; Howmet had knowledge that there had been at least one occasion upon which the thermolevel had not operated as it should have done. The evidence also suggested Howmet might have been prepared to accept vigilance of the operators as a suitable safeguard. There was therefore no such reliance.

COURT OF APPEAL DECISION

Upholding the judgment at first instance, the Court of Appeal discussed in greater detail whether Howmet did possess the relevant knowledge of the defect, and whether EDL could remain liable for some part of the loss nonetheless.

Attribution

The Court of Appeal noted that the law imposes restrictions on a manufacturer’s liability to an end user, noting that the manufacturer will have no control over how the product is used. It is well established that a claim for negligence cannot be brought successfully if a hidden defect in the product was discovered before the damage was caused. A claimant cannot recover losses caused by a faulty product if it continued to use the product after becoming aware of the fault.

The Court of Appeal considered in more detail the question as to who within a company would have to make or have knowledge of such a discovery before the company itself would be deemed to have the relevant knowledge. Jackson LJ confirmed that if one relevant employee in the corporate hierarchy becomes aware of a defect and fails to comply with a duty to report the defect up the line, the company in question will not be able to rely on the ignorance of more senior managers. This would be the case even if it would only be within the power of those senior managers to take steps to deal with the problem. The relevant employees for the purpose of attribution of knowledge in this case were those employees to whom the directors of Howmet had entrusted the task of maintaining and operating the equipment in a safe manner.

CASE REFERENCE AND JUDGMENT DATE

Howmet Ltd v Economy Devices Ltd
[2016] EWCA Civ 847
31 August 2016
Apportionment of Liability

Counsel for Howmet argued that the effect of such a discovery should not defeat a tortious claim in its entirety. Instead, there should be an apportionment of liability under the Contributory Negligence Act 1945. The Court of Appeal rejected this argument. Once an end user is alerted to the dangerous condition of a chattel, it continues to use it entirely at its own risk except in exceptional circumstances where there is no choice but to continue usage.

COMMENT

The Court of Appeal decision represents a confirmation of the law as it was previously understood.

When a defective product has been supplied to a company as end user, relatively junior employees of the company who discover the defect may possess knowledge which will be attributed to the company. It would be prudent to put in place policies which encourage systematic reporting up the line in order to identify defects and raise these with the supplier as soon as possible, considering carefully whether to continue usage of the product at the company’s own risk.

ADDITIONAL REFERENCES

Howmet Ltd v Economy Devices Ltd (2014) EWHC 3933 (TCC)
Law Reform (Contributory Negligence) Act 1945
Electrical Equipment (Safety) Regulations 1994/3260
The Sentencing Council has published guidelines to be used by judges when sentencing corporate manslaughter, health and safety offences and food safety and hygiene offences.

The guidelines will apply to all sentences passed on or after 1 February 2016 irrespective of when the relevant offence was committed. They are expected to result in significantly larger fines being paid, particularly by large corporate defendants.

THE DEFINITIVE GUIDELINE

The final guidelines are almost identical to the draft version issued in November 2014 as the basis for a consultation which ran until February 2015. The guidelines were produced following a review of sentences passed over a number of years in corporate manslaughter and health and safety cases. They reflected the Sentencing Council’s conclusion that there was a lack of consistency in the approach to sentencing and a perception that the fines imposed on large corporate defendants were often too low to satisfy the public policy requirements that fines should be proportionate and should deter future wrongdoing. The guidelines followed a line of cases in which the financial means of corporate offenders were considered increasingly closely when passing sentence, for example the Court of Appeal ruling in *R v Sellafield*, *R v Network Rail*.

The guidelines represent a more structured and mathematical approach to setting fines for corporate offenders than has previously been applied although uncertainty still exists when it comes to sentencing the largest corporate entities.

The guidelines require a judge to determine the appropriate fine via a multi-stage approach which is summarised below.

1. Determine the category of offence by reference to the level of the offender’s culpability and the risk of harm created by the relevant breach

The level of culpability ranges from “low” to “very high” and is assessed by reference to a range of objective factors. For example, where a company’s breach arose from its failure to put in place safety measures that are considered to be industry standard, that would point towards a high level of culpability. Where, by contrast, a company has made significant efforts to mitigate the relevant risk that would point to a lower level of culpability in cases where its efforts proved inadequate.

The court will then consider the risk of harm created by the breach. It is important to bear in mind that health and safety offences focus on the creation of a material risk of harm, not on causing actual harm. The guidelines do acknowledge, however, that an offence resulting in actual harm should lead to a larger fine than one which merely creates a risk. The court will determine a ‘Harm Category’ by assessing (i) the seriousness of the harm that could have (or did) eventuate (from minor injury up to serious injury/death); and (ii) the likelihood of that harm eventuating. The lowest Harm Category (4) will be appropriate where, for example, the breach could only ever lead to a minor injury and there was a low chance of even that happening. The highest Category (1) will be appropriate where there is a high probability of death or serious injury.

The above relates primarily to health and safety offences. Considering relative levels of culpability and harm is much less relevant in the context of corporate manslaughter (where both culpability and harm must by definition be of the most serious nature). Nonetheless, the guidelines do provide a mechanism for distinguishing between more and less serious instances of corporate manslaughter (referred to as Categories A and B) by considering factors such as the level of foreseeability and the number of people killed (or put at risk of death or serious injury).

2. Identify the appropriate starting point and range of fine (by reference to the category of offence and the financial means of the offender)

The court will then consider financial information concerning the corporate offender and classify it based on annual turnover:

- “micro” (up to £2 million turnover);
- “small” (£2 million – £10 million);
- “medium” (£10 million – £50 million); or
- “large” (more than £50 million).

The guidelines accept that in some instances it will be necessary to look beyond turnover (e.g. where a company has a large turnover but very small – or non-existent – profits, that may be a relevant consideration). The onus will be on the company to show that turnover alone does not properly reflect its financial position.
The guidelines include matrices specifying appropriate ranges and starting points for fines by reference to the category of offence and size of company. So, for example:

- where a “small” company commits a health and safety offence within Harm Category 1 (i.e. where there is a high likelihood of death or serious injury eventuating) and its culpability is found to be “high”, the starting point is £250,000 and the range is £170,000 - £1 million. Where a “large” company commits an equivalent offence the starting point is £2.4 million and the range is £1.5 million - £6 million.
- where a “micro” company is found guilty of Category A corporate manslaughter the starting point is £450,000 and the range is £270,000 - £800,000. For a “large” company the starting point is £7.5 million and the range is £4.8 million - £20 million.

The guidelines also refer to a fifth category of “very large” companies and provide that “where an offending organisation’s turnover…very greatly exceeds the threshold for large organisations [i.e. £50 million], it may be necessary to move outside the suggested range to achieve a proportionate sentence”. Neither the draft guidelines nor the final version provide any clarity as to how much more than £50 million turnover would make a company “very large”.

3. Set the fine within the range

Having identified the applicable starting point and range, the court will consider relevant aggravating and mitigating factors in order to determine where within the range a fine should be set. Aggravating factors include previous convictions and cost cutting at the expense of safety. Mitigating factors include self-reporting and evidence of steps having been taken to remedy the problem.

4. Adjustments

Finally, the court will (i) consider whether the level of fine arrived at via steps 1 to 3 needs to be adjusted to ensure it is proportionate to the overall means of the offender; and (ii) apply any reductions that are appropriate for, for example, an early guilty plea or assistance provided to the prosecution.

The guidelines provide a similar approach to be followed for individuals who commit health and safety offences. Appropriate starting points and ranges of sentences (including both fines and imprisonment for up to 2 years) are set by reference to the offender’s culpability and the nature of the risk created by their offence.

**AMENDMENTS TO THE GUIDELINE FOLLOWING CONSULTATION**

As noted at the outset, the final Definitive Guideline is virtually identical to the draft issued in November 2014. There has been no change to the overall approach to sentencing nor to the specified levels of fines.

The minor changes to the text include the following:

- “Targeting vulnerable victims” has been included as a new aggravating factor (to be considered at step 3 in the sentencing process). According to the Sentencing Council’s response to consultation document, this factor is intended to apply where, for example, an employer uses workers who are unable to challenge unsafe practices due to limited language skills.
- As noted above, one mitigating factor to be considered at step 3 is the extent to which a company has sought to remedy the problem after the offence has been committed. The word “voluntarily” has been added to the final text to reflect that fact that offenders are frequently required (by the HSE or other regulators) to remedy unsafe practices or replace unsafe equipment and no credit should be given for complying with these requirements.
- The terminology used to describe the extent of an individual offender’s culpability has been amended to mirror the terminology used for companies. Previously an individual’s culpability would be “low”, “reckless”, “negligent” or “deliberate”. Now it will be “low”, “medium”, “high” or “very high”.

Several responses to the consultation highlighted the lack of clarity as to (i) what level of turnover will lead to a company being classified as “very large”; and (ii) how this will impact on the level of fine imposed. The Sentencing Council declined to make any amendment to address this. This is consistent with the approach taken by the Court of Appeal in **R v Thames Water**.

**R v Thames Water** was the first case in which the Court of Appeal applied sentencing guidelines for environmental offences which are very similar to the new guidelines for health and safety offences and corporate manslaughter. In that case there was no doubt that Thames Water was “very large” (with turnover of £1.9 billion and profits of £346 million). The question was how this should impact on the level of fine. At first instance the Recorder took a mechanistic approach and multiplied by five the fine she would have imposed on a “large” company. The Court of Appeal upheld the fine but rejected the approach and indicated that it would have upheld a much higher fine. The judgment stated that (i) there should not be a mechanistic approach to calculating fines for “very large” companies – the exercise involved complex issues and such an approach would hinder the sentencing judge’s ability to properly reflect such issues; and (ii) in serious cases, fines imposed on “very large” companies may be measured as a percentage of pre-tax profits (up to 100% in the most serious cases, even if that leads to fines of over £100 million). The
NEW SENTENCING GUIDELINES FOR CORPORATE MANSLAUGHTER AND HEALTH AND SAFETY OFFENCES COME INTO FORCE

Sentencing Council cites the judgment in its consultation response document and suggests that this will provide guidance for judges required to assess fines for “very large” companies.

COMMENT

When the draft guidelines were published, we suggested that if they were implemented they would lead to larger (and potentially much larger) fines for larger companies and great uncertainty for companies that could be deemed to be “very large”. This remains our view.

It is inevitable that discussion of the new guidelines tends to focus on the potentially huge fines for corporate manslaughter and the most serious health and safety offences. However, it will also be the case that there will be a significant increase in fines for less serious offences. Consider, for example, the case of a “large” company that commits a health and safety offence by creating a ‘medium risk’ of ‘Level B’ injuries (i.e. injuries that are serious but not life-threatening). If the company is found to have ‘medium culpability’ (the second lowest category) it will face a fine of up to £750,000. This is very significantly higher than the level of fine that would previously have been imposed for such an offence. Indeed, £750,000 is more than the largest fine imposed to date for corporate manslaughter (a fine of £700,000 passed in December 2015) despite corporate manslaughter being a very substantially more serious offence in terms of both culpability and harm. Again, it remains to be seen how sentencing judges will apply the new guidelines.

ADDITIONAL REFERENCES

R v Sellafield Ltd R v Network Rail Infrastructure Ltd [2014] EWCA Crim 49
R v Thames Water Utilities Ltd [2015] EWCA Crim 960
ALTON TOWERS OWNER FINED £5,000,000 FOLLOWING ‘THE SMILER’ CRASH

In September 2016 Merlin Attractions Operations Limited was fined £5,000,000 following an accident on the Smiler rollercoaster at Alton Towers which left a number of people seriously injured. This reflects the continuing trend of very significant fines being imposed on large corporate defendants following the introduction of new sentencing guidelines earlier this year. The judgment provides a helpful insight into the way the courts are applying these guidelines.

BACKGROUND

On 2 June 2015 a number of people were injured (some of them very seriously) when two trains collided on the Smiler rollercoaster at Alton Towers amusement park (owned and operated by Merlin Attractions Operations Limited (“Merlin”)). Merlin was prosecuted for failing to ensure, so far as reasonably practicable, the safety of visitors to the park (in breach of the Health and Safety at Work etc. Act 1974). Having pleaded guilty Merlin was sentenced following a two day hearing in September 2016.

The Smiler rollercoaster was designed so that multiple passenger-carrying trains could travel around the track at once. Its automated operating system blocked trains from moving into a part of the track that was occupied by another train. The Court heard that on the day of the incident the Smiler was halted whilst a fault was repaired. Having completed their repairs, Merlin engineers sent two empty trains around the track to ensure it was operating properly. One of these trains did not complete its circuit and remained halted on the track. The rollercoaster was then re-opened and a passenger-carrying train began to travel around it. The automatic operating system stopped the passenger train as it approached the area where the empty train was halted. This was then overridden by the engineers who believed, mistakenly, that the automatic stop related to the fault they had repaired. The passenger train then collided at high speed with the empty train causing very serious injuries to a number of passengers. The passengers were left suspended for several hours before being rescued by emergency services.

DECISION

Merlin was severely criticised by the judge for (i) failing to conduct an adequate risk assessment; (ii) failing to have in place a safe system of work; and (iii) failing to properly train and supervise its staff in relation to health and safety (in particular, failing to train them in procedures to be followed in the event of the ride being stopped automatically). The judge found that the company fell far short of the standards expected.

The failure to provide the emergency services with proper and timely access to the site was an important aggravating factor. So too was the conviction of Merlin in 2012 for what the judge described as a similar failure to carry out proper risk assessments which led to a fatal accident at its Warwick Castle site.

Sentencing

The judge applied the new Sentencing Guidelines (applicable to all corporate manslaughter and health and safety offences) which came into force in February 2016. These guidelines set out a systematic approach to sentencing under which the judge must:

1. first determine the category of offence by reference to the level of the offender’s culpability and the risk of harm created by the relevant breach;
2. then identify the appropriate starting point and range of fine (by reference to the category of offence and the financial means of the offender);
3. then set a fine within the appropriate range; and
4. finally, adjust the fine if necessary (i) to take account of any aggravating or mitigating factors; (ii) to reflect an early guilty plea; and (iii) to ensure that the fine is proportionate.

These guidelines were widely expected to lead to a significant increase in the size of fines imposed (particularly on large companies) and this has proved to be the case.

In Merlin’s case, the company pleaded guilty and there was relatively little dispute in respect of the factors relevant to sentencing. It was agreed that the risk of harm created by the breach was at the most serious level (Level A – risk of death or serious physical impairment). Merlin argued that its level of culpability was “borderline high/medium”. It appears to have accepted that some elements of its conduct reflected the factors listed under ‘high culpability’ in the sentencing guidelines but argued that it should get credit for the fact that some of the factors listed under ‘low culpability’ were also applicable. The judge was not persuaded and agreed with the prosecution that the culpability...
ALTON TOWERS OWNER FINED £5,000,000 FOLLOWING ‘THE SMILER’ CRASH

was ‘high’ (the second highest category, below ‘very high’ (which effectively means deliberate)).

The next step was to determine which starting point and range applied by reference to the size of the company measured by turnover. The sentencing guidelines classify corporate defendants as “micro” (turnover up to £2 million); “small” (£2 million – £10 million); “medium” (£10 million – £50 million); and “large” (more than £50 million). There is a final category of “very large” companies, namely those whose turnover “very greatly exceeds [£50 million]”. If a company is very large, the court has the discretion to move outside the set ranges of fines in the guidelines in order to ensure a fine is sufficiently large to properly reflect the offence and provide a suitable deterrent. There has been much debate as to the size of turnover that would justify classification in this category. This is an important issue for larger companies. Although the Sentencing Guidelines may have led to an increase in the level of fines imposed they are, at least for smaller companies, more predictable than was once the case since they are set by reference to specified ranges. The difficulty for very large companies is that the guidelines do not make clear when the courts will depart from the top point of the set ranges of fines (i.e. £10 million for health and safety offences; £20 million for corporate manslaughter) and by how much.

Merlin’s turnover in the years prior to the incident ranged from £367 million to £412 million. The judge said that it “was certainly arguable” that Merlin was a very large company but ultimately he found that it was not necessary to move outside the sentencing range for a large company.

For a large company guilty of a ‘category 1’ offence with high culpability, the starting point is a fine of £2.4 million with a range of £1.5 million to £6 million. However, taking into account the aggravating factors described above, the judge moved into the higher range (£2.6 million to £10 million, usually applicable to category 1 offences with very high culpability). He concluded that the appropriate fine was £7.5 million, reduced by one third to £5 million to take account of Merlin’s early guilty plea.

COMMENT

The judgment illustrates a number of the developments we have seen since the sentencing guidelines came into force in February.

It is interesting that, in order to achieve what he viewed as a proportionate fine, the judge chose to apply the sentencing range for a more serious category of offence rather than by classifying Merlin as a very large company. It is also interesting that the judge appears to have accepted Merlin’s argument that a defendant could, in principle, be found to have a level of culpability on the ‘borderline’ between two of the bands set by the Sentencing Guidelines (albeit, on the facts, he did not find that culpability was borderline in this case).

ADDITIONAL REFERENCES

Health and Safety at Work etc. Act 1974
In *Suh v Mace*, the Court of Appeal held that discussions between a Defendant’s solicitor and a Claimant litigant in person were or ought to have been seen by both parties as “negotiations genuinely aimed at settlement” and therefore protected by the without prejudice rule. In doing so, the Court overturned the High Court’s decision, which it said took too narrow a view of the kinds of discussions that may be protected by the rule.

**BACKGROUND**

The underlying claim was brought by two tenants, a recently estranged husband and wife, against the Defendant landlord. The claim alleged wrongful forfeiture of their lease of business premises.

The wife asked to meet the Defendant’s solicitor, a Ms Jackson. At the outset of the meeting, when asked about the purpose of the meeting, the wife explained that she wanted to know what was happening with the case and how it was progressing. Ms Jackson proceeded to ask the wife a series of questions, which (on Ms Jackson’s account of the meeting) elicited an admission that there were outstanding arrears of rent at the time of the forfeiture.

In the course of the meeting, the wife indicated that she wanted to get out of the litigation. Ms Jackson said the Defendant might be prepared to negotiate to let the wife withdraw from the proceedings without paying all the costs if she made a statement confirming her admission regarding outstanding arrears.

Ms Jackson served a statement summarising the discussions and exhibiting her attendance notes. The wife served a statement in response. The Claimants subsequently argued that the discussions were protected by without prejudice privilege and therefore neither Ms Jackson’s statement nor the wife’s response were admissible in evidence.

The High Court held that the discussions were not without prejudice, as they were not for the purpose of a genuine attempt to compromise a dispute between the parties. The Claimants appealed.

**DECISION**

The Court of Appeal (Vos LJ, with whom Beatson LJ agreed) overturned the High Court’s decision and found that the discussions were protected. The true question was whether the discussions were or ought to have been seen by both parties as negotiations genuinely aimed at settlement. The judge took a narrow view of the kind of discussions that might be regarded as such. In the Court of Appeal’s judgment, a broader view was required.

Lord Justice Vos commented that, where litigants in person are concerned, it may sometimes be more difficult to determine objectively whether discussions amounted to negotiations genuinely aimed at settlement. Here, however, he said it would have been obvious to any outsider that the wife had asked for the meeting because she wanted to see how she could get out of the proceedings. She was not there to answer Ms Jackson’s questions, nor to obtain legal advice (which Ms Jackson repeatedly pointed out she could not provide). The only sensible purpose for such a meeting must have been to seek some kind of resolution to the litigation.

Further, there was no justification for “salami slicing” the meeting into parts that were open and parts that were without prejudice. Such an approach would contravene the broad view required by the authorities. Therefore, the entirety of the discussions and the subsequent correspondence were without prejudice and therefore, prima facie, inadmissible in evidence.

The Defendant further submitted that the wife could not benefit from the without prejudice protection because: (i) she had used the cloak of without prejudice discussions for what the High Court judge had found to be lies contained in her witness statement, or alternatively (ii) the Claimants had waived without prejudice protection, including by putting forward the wife’s witness statement supporting their case that the admissions had not been made, but not arguing that the discussions were subject to without prejudice privilege. The Court of Appeal rejected these submissions.

In relation to (i), the Court of Appeal noted that there is an established exception to the without prejudice rule where a party has abused the privileged occasion by using it as a cloak for perjury, blackmail or other “unambiguous impropriety”. That exception did not apply here. On the Defendant’s case, the wife had told the truth in the without prejudice meeting. The fact that the wife later denied admissions she had allegedly made in the without prejudice discussions, even if the judge was justified in saying the denial was a lie, did not amount to an attempt to use the rule as a cloak for perjury, blackmail or other unambiguous impropriety.
In relation to (ii), the Defendant had obviously waived its right to rely on the privilege by filing Ms Jackson’s statement in the proceedings and making it plain the Defendant intended to rely on the content of the discussions. Whether the Claimants had waived the privilege required an objective evaluation to determine whether it would be unjust, in the light of their conduct, for them to argue that the admissions were privileged from production at trial. On the facts, that was not the case. The wife’s statement and the various other matters relied on to support the submission of waiver were all reactions to the Defendant’s solicitor’s attempt to ignore the privilege which attached to the discussions. It would be unjust and contrary to the requirement for the privilege to be protected to hold that the Claimants’ unguarded response to that conduct amounted to a waiver of the privilege itself.

COMMENT

The decision illustrates that discussions may be protected by without prejudice privilege where it should be obvious that their purpose is to try to resolve the dispute, even if that is not openly acknowledged and the question of settlement does not come up until some way into the discussions. The case suggests that a broad view is likely to be taken, particularly where one party does not have legal representation and so the purpose and status of the discussions might not be made as clear as would be expected if lawyers were involved on both sides.

The judgment also suggests that a court will be slow to find that a party has waived without prejudice privilege simply because it has responded to an opponent’s attempts to introduce evidence of the discussions without raising the issue – particularly, though perhaps not exclusively, where the party in question is unrepresented. Still, the safe course where an opponent seeks to introduce evidence of without prejudice discussions must be to object to their admissibility without delay.
In two cases this year, the courts have rejected attempts to introduce evidence of without prejudice (WP) communications. The decisions emphasise the important public policy role of the WP rule in encouraging settlement by ensuring parties can negotiate freely, without fear of concessions made during settlement negotiations being used against them in the course of litigation.

In *Wildbur*, the Court found that even the fact of a failure to reply to an offer of mediation (if there was such a failure) was protected by the WP rule.

In *Ravenscroft*, the Court confirmed that there was no general exception to the protection of the WP rule where WP communications were referred to only for the purposes of an interlocutory hearing.

**BACKGROUND**

It is well-established that the protection of the WP rule is not absolute. It cannot for example be used as a cloak for impropriety and there are various other circumstances where evidence of WP communications can be admitted, such as where the issue is whether a concluded settlement has been reached, or where the fact of negotiations taking place is needed to explain a party’s delay. However, these two decisions illustrate a general tendency on the part of the courts to give the WP rule broad application and resist making further in-roads into the protection it offers.

**DECISION**

**Wildbur**

The Claimant sought judicial review of the MoD’s decision on a “service complaint” he had lodged after he was made redundant by the army. In granting permission for judicial review, the judge encouraged the parties to endeavour to settle the matter, including by the use of mediation.

The Claimant proposed mediation. The MoD then wrote proposing a WP meeting. A consent order was made staying directions for a specified period to enable the parties “to undertake alternative dispute resolution”.

A WP meeting took place but was ultimately unsuccessful and the case proceeded. The MoD objected to two passages of the Claimant’s reply to the MoD’s detailed grounds of resistance. These passages stated that the MoD had “refused mediation”, attending only an “informal meeting”.

Cranston J ordered the passages to be struck out on the basis that they had disclosed the content of WP communications. Applying *Cutts v Head*, the WP rule applied to a failure to reply (if there was a failure) as much as to an actual reply. This principle was not limited to specific offers of settlement; it applied equally to the fact of an offer of settlement negotiations.

In many cases, a party who proposes mediation will wish to be able to point to that fact, and any refusal or failure to respond on the part of its opponent, once the court comes to consider the question of costs, after the substantive issues have been determined. Where that is the case, it is advisable to mark the correspondence “without prejudice save as to costs” so that it can be considered by the court at that stage.

**Ravenscroft**

The Claimant brought an action against the Canal & River Trust (CRT) after the CRT seized his boat due to licencing issues. He applied for the appointment of a “McKenzie Friend” to assist him at the hearing, on the basis that he was impecunious, had no relevant experience in litigation and was largely illiterate. The CRT took exception to the Claimant’s choice of McKenzie Friend, Mr Nigel Moore, who they said was part of a broader campaign against the CRT.

As part of their objection to his appointment, the CRT sought to rely on a short extract of WP communications made in the course of settlement negotiations between the parties. The CRT submitted that the Court could have access to such communications for the purpose of deciding interlocutory
hearings, and that this did not infringe the public policy requirement that admissions made in WP communications may not be used for the purposes of the trial. Chief Master Marsh disagreed, finding that the extract could not be relied on.

The Court distinguished Family Housing Association v Michael Hyde, where a party was permitted to rely on WP communications to resist a strike-out application for want of prosecution. That decision established an exception to the WP rule where a party seeks to explain the passage of time by reference to WP negotiations. There is not, however, a general exception which applies whenever WP communications are referred to only for the purposes of an interlocutory hearing.

The Court described what the CRT was seeking to do as an attempt to ‘cherry pick’ from the WP communications to benefit their own interests. The Court emphasised that any exceptions to the rule “should be kept closely confined to prevent an undesirable watering down to the protection provided”.

**ADDITIIONAL REFERENCES**

Cutts v Head [1984] Ch 290
Family Housing Association (Manchester) Ltd v Michael Hyde & Partners [1993] 1 WLR 354
COURT OF APPEAL FINDS SETTLEMENT OFFER NOT SUBJECT TO “WITHOUT PREJUDICE” PROTECTION AS IT AMOUNTED TO AN UNAMBIGUOUSLY IMPROPER THREAT

The Court of Appeal has considered the rarely invoked “unambiguous impropriety” exception to without prejudice (“WP”) privilege. Upholding the decision of Rose J at first instance, the Court of Appeal found that a settlement offer made on behalf of the Claimants following an unsuccessful mediation constituted an unambiguously improper threat in the nature of blackmail and, as such, was not protected by WP privilege.

The decision serves as a reminder that WP privilege cannot be used as a cloak for impropriety. It also underlines the fact that there is a distinction to be drawn between the use of proper leverage in the context of settlement discussions and the making of improper threats. The courts will take a dim view of the latter.

BACKGROUND

The purpose of WP privilege is to encourage parties to communicate openly with one another without fear that things said in the context of settlement will later be relied upon in court. However, as noted by Walker LJ in Unilever v Procter & Gamble, “the veil imposed by public policy may have to be pulled aside...in cases where the protection afforded by the rule has been unequivocally abused”. Such will be the case where there has been “perjury, blackmail or other ‘unambiguous impropriety’.”

Historically, most of the authorities have dealt with perjury-type cases. In view of the public interest in encouraging honest admissions to facilitate the resolution of disputes, the courts have been slow to make findings unambiguous impropriety in such cases. More recently, however, there have been a number of cases involving improper threats or blackmail, including in the well-publicised case of Boreh v Djibouti, and now also Ferster. In those sorts of cases, the courts have shown greater willingness to make findings of unambiguous impropriety, thereby exposing the conduct in question.

In Ferster, the question of unambiguous impropriety arose in the context of acrimonious and fiercely fought litigation between three brothers (Jonathan, Warren and Stuart) regarding their respective interests in an online gaming business. Acting through the company, Warren and Stuart brought a variety of claims against Jonathan, which they commenced by way of search and freezing orders. Jonathan, in turn, issued an unfair prejudice petition alleging that Warren and Stuart had procured the company to bring the claims against him for the improper purpose of forcing him to pay an inflated price for their shares.

A mediation took place during which Warren and Stuart offered to sell their shares to Jonathan but no price could be agreed. Over the next few months the parties, through their legal advisers, remained in contact with the mediator and further offers were exchanged.

In April 2015, DAC Beachcroft on behalf of Warren and Stuart sent, via the mediator, an email (the “DACB Email”) in which they claimed they had discovered that Jonathan had failed to disclose the existence of certain overseas bank accounts pursuant to the freezing order. They went on to say that, unless Jonathan agreed, within 48 hours, to pay an increased sum (being more than £2m in excess of what they had previously sought by way of settlement) for Warren and Stuart’s shares, they would bring committal and other criminal proceedings against Jonathan, ruin his reputation and make it impossible for him to operate a business in the online industry in the future. Those threats were exacerbated by further threats made against Jonathan’s life partner, who was not a party to the proceedings, that he too may be investigated and/or charged.

Jonathan denied having any undisclosed bank accounts and pressed Warren and Stuart to set out the basis for their belief that any such accounts existed. Warren and Stuart declined to do so,
comment

Ferster is of interest as it confirms the position taken in a number of recent cases that the courts are ready to take a robust approach to lifting WP privilege in cases involving improper threats. This is in contradistinction to the softer approach which has historically been taken in the so-called “perjury” cases.

Ferster follows on from the recent decision in Boreh (referred to above), where threats against Mr Boreh made during recorded without prejudice discussions were accepted as being unambiguously improper. There, Flaux J observed that:

“...the threats made to Mr Boreh go way beyond what is permissible even in the hardest fought commercial litigation. What was being said was that, if he settled the litigation (in fact for more than it was worth) he could avoid the risks of extradition to Djibouti, being in prison there for the rest of his life, money laundering and similar criminal-related actions in the US and elsewhere...”

The public policy considerations behind these judgments are readily understandable. It is in the public interest to encourage parties to make candid admissions which may facilitate an early, cost-effective resolution of a dispute. It is not in the public interest to encourage parties to make improper threats and indeed doing so is likely to be counterproductive when it comes to settlement.

decision

The Court of Appeal agreed with Rose J’s view that the DACB Email amounted to improper threats and thus fell within the unambiguous impropriety exception to WP privilege. That meant Jonathan was able to rely upon it as evidence of Warren and Stuart’s improper motive in the petition proceedings.

The Court of Appeal offered some useful guidance as to what amounts to unambiguous impropriety and identified the types of factors the Court will take into account when assessing whether a privileged occasion has been abused. Relevant factors included:

1. The threats went far beyond what was reasonable in pursuit of civil proceedings, by making the threat of criminal action.
2. The threats extended to Jonathan’s family.
3. It was unnecessary to determine whether Warren and Stuart had a genuine belief in the substance of the allegations made because the impropriety arose from the nature of the threats made.
4. The purpose of the threats was to obtain for Warren and Stuart personally a financial advantage which ought to have accrued to the benefit of the company.
5. The “settlement offer” made no attempt to connect the wrongdoing alleged to have been committed by Jonathan to the increased demand. In particular, the increased demand was tied to threats affecting Jonathan’s liberty, family and reputation, not to the value of the claim.

The Court rejected the suggestions that it should be inferred that the email was proper because it had been composed by a reputable firm of solicitors or passed on by the mediator. The Court also distinguished the situation in Ferster from one where the threat could only be discerned by picking through many hours of negotiation, often between laymen using colourful or exaggerated language. In Ferster, the email was a single, carefully drafted communication.

It is also worth noting that Rose J, at first instance, similarly rejected an argument that privilege in unambiguously improper conduct was protected by a separate and distinct species of “mediation privilege” or the contractual terms of the mediation agreement itself. Such an extreme consequence would require an agreement in clear and unmistakable terms and, even if such an agreement could be established (which it had not) there would be significant issues as to whether, as a matter of public policy, it could ever be effective.

additional references

Boreh v Djibouti (2015) EWHC 769 (Comm)
Unilever plc v Procter & Gamble Co (2000) 1 WLR 2436
UK: CIVIL COURTS STRUCTURE REVIEW RECOMMENDS EXPANDED ROLE FOR ADR

The final report of Lord Justice Briggs in his Civil Courts Structure Review published on 27 July 2016 includes some interesting conclusions as to the role currently played by ADR in the civil justice system in England and Wales and a number of recommendations aimed at expanding that role.

Key recommendations are for:

• the proposed new Online Court to include an expanded range of conciliation options (beyond the short telephone mediation originally recommended); and
• the re-establishment of a court-based out of hours private mediation service in County Court hearing centres.

The review was commissioned by the Lord Chief Justice and the Master of the Rolls in July 2015 and is intimately linked with the wider ongoing reform programme being conducted by HMCTS (Her Majesty’s Courts and Tribunals Service). Briggs LJ’s interim report was published in January 2016, following which he consulted further on his provisional recommendations. The final report was published on 27 July 2016. While the role of ADR was not the primary focus of the review, Briggs LJ’s observations and recommendations in this regard, summarised below, are important given the breadth of the consultation exercise involved and the stature of the review.

BOUNDARIES BETWEEN ADR AND THE CIVIL COURTS

The review’s consideration of ADR focuses primarily on the potential for pre-action ADR to resolve claims before they enter the court system. In this regard, Briggs LJ concludes that he had confined his review too closely in his interim report, in limiting it to considering whether some adaptation of the MIAM (the Mediation Information and Advice Meetings used in the Family Court) should be introduced more widely.

Following further research and consultation, the final report concludes that the extent to which mediation has reached a satisfactory steady state, as an alternative to determination of disputes in the civil courts, is “at best, patchy”. The position is probably only satisfactory in cases of the highest value, with distinct shortcomings in the availability and use of pre-issue ADR for cases of low and modest value (up to say £250,000). Further, there is a particular shortfall for personal injury and clinical negligence claims – not necessarily simply attributable to the nature of those disputes.

In particular:

• The Small Claims Mediation Service is constrained by the number of mediators and logistical limitations on when a mediation must occur, resulting in only approximately 35-40% of parties who wish to use it being able to do so. By contrast, a form of small claims conciliation being provided by District Judges in certain County Court hearing centres has had a much higher success rate and is more expeditious.

• Briggs LJ regards as ‘less than satisfactory’ the abandonment of the previous County Court-sponsored scheme involving out of hours short mediations at hearing centres, replaced by the National Mediation Helpline which was itself then abandoned (apparently for reasons of budgeting rather than performance).

Briggs LJ recommends the re-establishment of a court-based out of hours private mediation service in County Court hearing centres.

ADR WITHIN THE ONLINE COURT

It is proposed that cases in the new Online Court (proposed for claims up to £25,000) would progress through three main stages:
(1) a largely automated, inter-active online triage process to enable users to articulate their case and to identify documentary
UK: CIVIL COURTS STRUCTURE REVIEW RECOMMENDS EXPANDED ROLE FOR ADR

evidence; (ii) conciliation and case management by case officers; (iii) resolution by judges – either on the documents or by hearing (face-to-face or by video or telephone).

The interim report envisaged that the conciliation in the second stage would be limited to short (1 hour) telephone mediations by the case officers, following the Small Claims model. However, in light of Briggs LJ’s final conclusions as to the gaps in the provision of ADR, the final report concludes that this is too narrow and recommends that case officers (who it is proposed should be legally qualified and experienced) should identify and recommend to parties the conciliation method best suited to the case. This may include telephone mediation by the case officer (provided they have received mediation training) but may also involve face to face mediation (likely to involve referral to specialist private mediators), use of Online Dispute Resolution and judicial early neutral evaluation. Case officers would not be expected to provide face to face mediation or early neutral evaluation.

Briggs LJ rejected suggestions that inclusion of the conciliation stage might deter would-be users of the Online Court from pursuing pre-action ADR (as anecdotal evidence suggests is occurring with the Small Claims Mediation system, given that the mediation service is free). In Briggs LJ’s view, the courts’ sponsoring of ‘culturally normal’ conciliation (as an umbrella term) is an essential element of a new court designed for navigation by litigants without lawyers, given that many litigants know little about conciliation options unless lawyers provide that information. Further, the final report introduces additional stages into the Online Court process, which will include informing parties about possibilities for pre-action resolution.
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If you are interested in seminars or workshops on any areas of insurance and reinsurance then please contact any members of the insurance and reinsurance disputes group.

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