A BIBA BROKERS' GUIDE TO

A LEGAL ROUND-UP

2019 – Issue 4

BIBA

In association with

DAC BEACHCROFT

Allianz

WELCOME

This guide looks at the law and at some recent cases and decisions that are worthy of note.

BIBA's supplements are brought to you through a partnership of BIBA, Allianz and DAC Beachcroft. We hope that you find DAC Beachcroft's legal expertise, Allianz's industry knowledge and BIBA's desire to share these with you helpful. We welcome ideas for future subjects.

The law is fundamental to insurance and judgments, decisions and regulatory or legislative changes can affect the operation and outcomes of policies.

In this round up we look at some technical legal decisions that have affected policy outcomes, from identifying fraud, determining how and when payments should be made for long term liabilities and the use of motor vehicles.

It also takes us through the first case brought under the Insurance Act 2015 in relation to fair presentation.

All of these could touch the lives of brokers and their customers and make valuable reading.

Mike Hallam, ACII, Chartered Insurance Practitioner, Head of Technical Services, BIBA

NOTIFICATION OF CIRCUMSTANCES

Decisions on the scope of notifications of circumstances can have serious consequences for both insurers and the insured. The date of notification may decide which policy responds, which insurer picks up the claim, and the applicable policy limit and excess. Although a decision on its facts, the Court of Appeal has recently provided some clarification of the law in Euro Pools Plc v Royal & Sun Alliance Insurance Plc (2019).

AUTHOR:
JENNY EACOTT,
DAC BEACHCROFT LLP

Euro Pools, which specialised in installing swimming pools with moveable walls and floors, was required under its Professional Indemnity Insurance policy to notify its insurer of circumstances which "might reasonably be expected to produce a Claim". During the 2006/7 policy year, Euro Pools advised insurers of a problem with the moveable booms which was thought to be due to leaks from the air tanks in the air-drive system and which could be fixed by the use of inflatable bags. However, in the following policy year, insurers were advised that the inflatable bags had failed and were being replaced by a hydraulic system. Euro Pools sought an indemnity for the costs of the mitigation works in respect of the hydraulic system under the 2007/8 policy. The insurers contended that all the mitigation costs attached to the 2006/7 policy and were subject to a single limit of indemnity. This limit had almost been reached.

At first instance, the judge held that the scope of the 2007 notification was limited to a problem affecting the tanks and the claim for mitigation costs therefore attached to the second policy. However, the Court of Appeal held that the claim for mitigation costs attached to the first policy year as a result of the original notification. The Court held that there was a low materiality threshold for a notification to be effective. The test was a relatively undemanding one, comparable to the test to be applied if the clause refers to circumstances that "may" give rise to claims.

The circumstances notified in the first policy year were that the booms were not rising and falling properly. It made no difference that Euro Pools didn't then know the fundamental cause of the problem. Euro Pools was aware that there was a serious problem with the booms and that it might face claims from third parties. It was not appropriate "to over-analyse the problem by dissecting every potential cause of the problem as a different notifiable circumstance". There was an unbroken causal chain running through the sequence of design changes. The claim for the cost of mitigation works thus arose from the circumstances notified in the first policy year.

Adopting a less restrictive approach to notifications, the case confirms that an insured can notify general circumstances which may give rise to a claim without having full knowledge of the cause of the problem or the potential consequences. Once circumstances which may give rise to a claim are notified, any claim with a causal link to those circumstances will be deemed to fall within the earlier period of insurance.

Although it will normally be an insured that is arguing for a broad interpretation of a notification of circumstances, this will not always be the case. Here, Euro Pools sought to constrain the ambit of an earlier notification to access a second policy and renewed limits of indemnity. Like aggregation, which is another recurring source of disputes with insureds, the issues need to be addressed as objectively as possible, without regard for the interests of a particular party.

Drafting an appropriate notification of circumstances, and responding to the notification, will remain challenging for insurers and insureds alike.

ABUSE OF PROCESS AT INTERLOCUTORY HEARING

DAC Beachcroft's Casualty Fraud Team secured an interlocutory strike out of a claimant's claim as an abuse of process on the grounds that it was fundamentally dishonest pursuant to the clear endorsement of the interlocutory jurisdiction by the Supreme Court in Summers v Fairclough Homes Limited [2012] 1 WLR 2012. This case provides the current highest level judgment and uses as the marker for 'abuse of process' the test for fundamental dishonesty as per Howlett v Davies [2017] EWCA Civ 1696. It is also the first judgment on the issue following the line of case authorities interpreting s.57 and CPR r. 44.16.

Following a minor incident at work in November 2011, Matthews alleged that he was still in "agony" six years later; that he was unable to work and would require permanent and significant care. He also alleged that he was grossly disabled by his accident-related injuries and presented as such to various treating experts, medico-legal experts and the The Department for Work and Pensions (DWP). The claimant's claim began to unravel when further investigations commenced and surveillance evidence significantly undermined the claimant's case that his life had changed considerably post-accident, particularly when compared to footage taken with the consent of the claimant during one of his medico-legal appointments on the same day that compelling surveillance footage was obtained. The claim was pleaded at £150,000 but there is little doubt that in the absence of appropriate and tactical fraud strategy, including effective deployment of covert surveillance, the claimant may have sought to amend his pleadings and claim significant future loss claims exceeding £1million.

AUTHOR:
HELEN LAIGHT,
DAC BEACHCROFT LLP

THE VERDICT

At the application hearing, HHJ Simpkiss commented on Matthews' "extreme" dishonesty and was of the view that "a very significant part of [the claim] has been dishonestly exaggerated". He went on to strike out the whole claim as an abuse of process on the ground that it was fundamentally dishonest.

The costs savings achieved from this successful interlocutory application were estimated at £175,000 and the application avoided a trial estimated to require a 10 day listing.

DISHONEST JUDGEMENT

Angela Rainey, representing the defendant at a two-day hearing, commented that this case was "one of the most blatant examples of a dishonestly exaggerated injury that she had seen in her practice".

The claimant was ordered to pay the defendant £50,000 on account of costs.

EXAGGERATED CLAIMS

AUTHOR:
JAMES BURGE,
FRAUD MANAGER,
ALLIANZ

According to fraud prevention service Cifas, the highest increase in fraud has been observed in household and motor claims, with an increase of 52% and 45% respectively between 2017 and 2018.[1] However, the success of counter fraud techniques in the personal lines market has seen a trend of fraudsters concentrating on commercial lines.

Instances of fraud continue to emerge in personal injury (PI) claims. A recent example seen by Allianz involved a PI claim from a customer of a takeaway store who reported finding metal shards in a spring roll purchased from the premises. A combination of "inconsistent, confusing and contradictory" information, including lack of medical evidence, led to a judge dismissing the case on the grounds of fundamental dishonesty.

Another case saw Allianz receive a liability claim from its insured, a motor repair shop. Four claimants alleged to have sustained injuries following a faulty brake repair to the vehicle. Following investigation, many inconsistencies were found in the claimants' stories and the claim was dismissed by a court which again ruled 'fundamental dishonesty'.

Historically, recession and economic instability have been cited as contributory factors to a rise in fraud generally. In January 2019, KPMG stated that "new systems and new landscapes... have in the past opened new and lucrative loop holes ripe for the picking from unscrupulous criminal gangs and businesses looking improperly to cut their costs".[2] It remains unconfirmed how and if the current political uncertainty in the UK could impact upon insurance fraud trends. However, insurers will be mindful that an economic downturn could potentially lead to a spike in such activity.

Insurance companies continually develop new and increasingly sophisticated methods to detect fraud. These include statistical analysis, sharing information with other insurers and working with industry bodies such as the Insurance Fraud Bureau (IFB), the Insurance Fraud Enforcement Department (IFED), and the police.

Brokers play an important part in tackling fraud, since they generally have more interaction with the client than the insurer and can develop a sense of whether a claim is genuine or not. They can also advise clients on how to reduce the likelihood of becoming a victim of fraud, such as reviewing personal information they share online and checking their credit history.

It's important for insurers and brokers to work together to combat fraud, keeping costs down for genuine policyholders and claimants.

Recent figures from the Association of British Insurers (ABI) show that detected dishonest claims totalled £1.2bn in the UK in 2018.[3] Insurance fraud, including fictitious or exaggerated claims, continues to be a source of frustration for insurers, who are committed to identifying and preventing such activity at the earliest opportunity.

[1] https://www.cifas.org.uk/newsroom/household-motor-insurance
[2] https://home.kpmg/uk/en/home/media/press-releases/2019/01/insurance-scammers-and-rogue-tradesmen-help-to-drive-p1-2-billio.html
[3] https://www.insuranceage.co.uk/insurer/4167426/abi-figures-show-1300-insurance-scams-a-day-detected-in-2018

PERIODICAL PAYMENT ORDERS (PPOS)

AUTHOR:
WILLIAM POTTS,
DAC BEACHCROFT LLP

Mesothelioma is an incurable cancer invariably caused by exposure to asbestos for which there is no known cure. Clinical trials are ongoing to investigate whether immunotherapy treatments (which enable the body's own immune system to fight the tumour) can offer a benefit.

Such treatments are not available on the NHS but defendants and their insurers are being asked to pay for the treatment in compensation claims. These claims are often a headache for insureds and brokers because they are expensive and complicated to settle (usually in excess of £200k including legal costs). Exposure has usually occurred decades earlier quite often involving difficulty in tracing historic EL insurers leaving insureds potentially having to fund these claims.

Master Thornett, one of a number of specialist judges who deal with asbestos cases in the Royal Courts of Justice in London, was asked to consider the issue of funding for immunotherapy treatment in Howard v Imperial Hotels and whether a Periodical Payment Order (PPO) was appropriate. PPOs are structured settlements allowing for an immediate award of damages together with regular additional payments in the future. PPOs are designed to deal with cases where the cost is relatively fixed, finite or determinable. PPOs can only be varied once.

The defendant, by its insurers, had agreed to fund the treatment by way of an "indemnity agreement " whereby the defendant, and its insurers, agreed to indemnify the claimant in respect of any reasonable treatment costs incurred after the settlement of the substantive claim.

Master Thornett concluded that a PPO was not appropriate to deal with the issue of treatment costs given that: (a) the future treatment and; (b) the future costs were unknown at the date of the hearing. It was acknowledged that whilst a PPO can incorporate a provision to vary, there is no obligation to do so.
The order sought by the claimant, at late notice, did not address these concerns. Master Thornett found that drawing upon interim payments was a far more flexible and appropriate tool than a PPO, especially when short notice hearings can be obtained in the Asbestos List (the specialist list in the High Court reserved for asbestos matters).

Further, Master Thornett was not persuaded that a PPO through a trust was proportionate for anyone with a limited life expectancy and felt that interim payments were preferable to PPOs by a "wide margin". In cases where the claimant has better evidence on future treatment, has pleaded and sought a PPO throughout and served witness evidence regarding suffering anxiety as a result of this claim, this wide margin could be narrowed.

RESPIRATORY DISEASES

AUTHOR:
MARK PEARCE,
LOSS CONTROL TECHNICAL
LEAD, CASUALTY, ALLIANZ

As many as 12,000 lung disease deaths each year can be attributed to past exposures at work.[1] Such occupational diseases include asbestosis, mesothelioma, silicosis and chronic obstructive pulmonary disease (COPD).

Certain industries show a higher correlation with incidences of these diseases, such as construction and demolition and welding. This is due to prolonged exposure to harmful substances such welding fumes, dusts and respirable crystalline silica (RCS), the latter of which can be found in bricks and concrete and as filler in some plastics.

Symptoms may not present for years or even decades following exposure to such substances, so claims may be brought against an employer even after considerable time has elapsed. Asbestos-related diseases, for example, have an average time of 20-30 years from exposure to cancer development.[2]

TIMEFRAME

A current or ex-employee with an occupational disease generally has three years to bring a claim for compensation from the 'date of knowledge' - commonly the date of diagnosis by a medical professional. Valid claims require legal liability to attach, meaning it must be proven the disease has occurred as a direct result of employer negligence, where they have failed to protect the health and safety of employees "so far as is reasonably practicable."

LIABILITY

Such claims will usually be covered under an organisation's Employers' Liability (EL) policy. Complications may arise where an occupational disease is diagnosed years after repeated substance exposure and where a number of insurers are involved. The Employers' Liability Tracing Office (ELTO) can assist in identifying relevant insurers for the period the claimant was exposed to the hazard which caused the illness. Normally it falls to the main insurer which was on risk during the most prolonged period of exposure to pay the claim; however this may be divided proportionately amongst a number of insurers. Where a liable employer or insurer cannot be traced, the Mesothelioma Act 2014 stipulates that victims' compensation costs will be met by the EL insurance market, where the eligibility criteria is satisfied.

HEALTH AND SAFETY

The Health & Safety Executive (HSE) has set out priorities around occupational health and has recently issued a safety alert identifying cancer risks associated with exposure to welding fume. This has resulted in a strengthening of its enforcement expectations in relation to the control of welding fume, including that from mild steel welding.

The Control of Substances Hazardous to Health (COSHH) regulations require employers to take appropriate measures to control employees' exposure to hazardous substances; this may include providing appropriate control equipment such as local exhaust ventilation (LEV), implementing procedures to impact control (e.g. looking at changing methods of working and arrangements for supervising and training). Personal protective equipment (PPE) in the form of respiratory protective equipment (RPE) for example, is also relevant but with a need that it should be seen as the final option where adequate control of exposure cannot be achieved by other means.

Brokers looking to assist their clients in the assessment of their responsibilities and insurance requirements may wish to refer to the HSE website as well as the risk management information available on and on www.allianz.co.uk/riskmanagement

[1] Health & Safety Executive: Occupational Lung Disease in Great Britain, 2018. www.hse.gov.uk/statistics/causdis/respiratory-diseases.pdf
[2] Asbestos.com. https://www.asbestos.com/asbestosis/causes/ December 2018

AUTHOR:
HELEN LAIGHT,
DAC BEACHCROFT LLP

EMPLOYERS' LIABILITY FRAUDSTER

The pursuit of a personal injury claim falsely valued in excess of £250,000 led to a 16 month custodial sentence and a costs order of £2,500 for a fraudster who knowingly brought the fraudulent claim against his employer.

Amar Masud alleged that he had hurt his back in January 2013 when his employer required him to lift a table-top weighing 80-90kg. He went on to claim that the accident had led to a 10-year acceleration of a previously asymptomatic disc prolapse, which left him unable to work post-accident.

THE CLAIMS

General damages for personal injuries were reserved at £20,000 and his Schedule of Special Damage amounted to £248,000 including a significant claim for benefits to include mortgage interest payments made by the Department of Work and Pensions (DWP).

Breach of duty was admitted but there were serious concerns regarding Masud's credibility, particularly in respect of his allegations that he had been unable to work, and was incapable of work, post-accident. Surveillance was undertaken and he was seen working in a local chip shop, as well as walking unaided on many occasions despite claiming that he was effectively housebound.

LEGALITIES

Masud's claim was struck out when his solicitors made a successful application to be removed from the court record such that the claimant continued as a litigant in person and subsequently failed to comply with directions. Permission was then given to commence proceedings for contempt of court. Masud took no part in the subsequent proceedings and did not attend the committal hearing.

SENTENCING

HHJ Blair found Mr Masud to be in contempt of Court and sentenced him to 16 months' imprisonment. When delivering his Judgment, HHJ Blair used strong language to describe Masud's fraud and was extremely critical of his failure to co-operate throughout the entire process. DAC Beachcroft and AXA Insurance were commended for their commitment to tackling fraud.

Masud subsequently issued an appeal against the length of his sentence - one of the longest handed down for contempt proceedings. He alleged that his failure to engage in the contempt proceedings was due to depression caused by his inability to work post-accident. He claimed he was anxious and apologised for his conduct. He also blamed his previous solicitors for encouraging his conduct.

HHJ Gore was not impressed and considered Mr Masud's apology to be insincere. He took the view that there was no medical evidence to support Mr Masud's claims that he was unable to deal with the proceedings and the appeal was refused.

HISTORIC LIABILITIES

Also known as Lewis v Tindale, this case is an important decision on the liability of the Motor Insurers Bureau (MIB) to compensate someone injured on private land even though such an event was outside the scope of the current Uninsured Drivers Agreement (UDA).

AUTHOR:
PETER ALLCHORNE
DAC BEACHCROFT LLP

The claimant was injured on private land by an uninsured vehicle, driven by Mr Tindale: it was not disputed that the driver was liable for the accident. The MIB denied that it was liable to compensate the claimant under the UDA on the basis that the accident and injuries were not caused by, or arising out of, the use of the vehicle on a road or other public place, which is the remit of compulsory motor cover as implemented in the UK under section 145 of the Road Traffic Act 1988 (RTA).

The Court of Appeal, upholding the judge's decision at first instance, ruled that as it was an "emanation of the state", the MIB was liable to compensate the claimant as EU Directive 2009/103/EC (2009 Directive), relating to compulsory motor insurance, had direct effect upon it. The MIB was therefore liable to meet compulsory insurance requirements as intended under EU law and as interpreted by the Court of Justice of the European Union (CJEU) in the case of Vnuk. This case confirmed that any use of a vehicle that is consistent with 'the normal function' of that vehicle, even if solely used on private land, came within the scope of those directives.

In the judgment it was stated that any issues arising from the decision could be "addressed by amendment to the RTA and/or the MIB Articles of Association". Until that happens, the decision leaves the MIB liable for claims made in circumstances that it did not contract for and the cost will have to be met by the insurers who are members of the MIB. It seems inevitable that any additional cost will be reflected in policy premiums paid by motorists.

It could be some time before this issue is finally concluded, but for now, the MIB has an exposure for claims on private land for which it was not previously liable. It is understood that as well as seeking leave to appeal this decision to the Supreme Court, the MIB is seeking an indemnity or contribution from the Government, due to its failure to properly implement the Directive.

DUTY OF FAIR REPRESENTATION

AUTHOR:
MICHAEL MCMILLEN,
DAC BEACHCROFT LLP

In Young v Royal & Sun Alliance (RSA) the Scottish Courts delivered what is believed to be the first decision on the insured's duty of fair representation under the Insurance Act 2015. The question before the court was whether RSA, as the insurer, had waived their right to receive disclosure of all material facts by asking limited questions in their proposal form.

DUTY OF FAIR REPRESENTATION

S.3 (1) of the Insurance Act 2015 places an obligation on an insured to make a fair representation to their insurer of the risk. This representation must include either disclosure of every material circumstance which the insured knows or ought to know, or, failing that, sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purposes of revealing those material circumstances. However, the insured is not required to disclose a circumstance if "it is something as to which the insurer waives information".

WAIVER

Waiver in an insurance context can be found to arise in a number of ways and can be either express or implied. An implied waiver commonly occurs where the insured discloses information during the underwriting process which would lead a reasonably careful insurer to make further enquiries of the insured, and the insurer makes no such enquiries. In Young v RSA, the court considered whether RSA had given such a waiver.

FACTS

Mr Young was the director of a company and engaged his broker to obtain a policy covering himself and a company of which he was a director. The broker issued a market presentation to insurers in which the insured asked to select any of the options that were applicable to "...any proposer, director or partner of the Trade or Business or its Subsidiary Companies if they have ever, either personally or in any business capacity". One of the options the insured was able to select was, 'been declared bankrupt or insolvent or been the subject of bankruptcy proceedings or insolvency proceedings'. The insured responded to this 'None'.

RSA offered cover with the subjectivity that the insured had "never been declared bankrupt or insolvent, or had a liquidator appointed", (the Moral Hazard Stipulation). However, Mr Young had in fact been the director of four companies over the preceding five years which had entered insolvent liquidation.

Following a fire at the insured's property, RSA declined a claim brought by Mr Young, and sought to avoid the policy on the basis that he had breached his duty of fair representation by failing to disclose material circumstances that, had they been known, would have stopped RSA from issuing the policy under any terms.

Mr Young argued that an insurer will seek the information that it wishes to know and that by asking for information regarding the bankruptcy or insolvency of the insured, the reasonable assumption was that they were not interested in the bankruptcies or insolvencies of any other party, with the result that they had waived their entitlement to disclosure of such information.

The Court stated that the law on waiver had not been affected by the introduction of the Insurance Act 2015 and that the correct test for whether there has been a waiver is therefore that laid out by the Court of Appeal in Doheny v New India Assurance Company Ltd, i.e. would a reasonable man reading the proposal form be justified in thinking that the insurer had restricted his right to receive all material information, and consented to the omission of the particular information in issue.

Applying the test in Doheny, the Court held that no one reading the Moral Hazard Stipulation would reasonably understand it as waiving that part of the declaration in relation to "any other business capacity". The Court distinguished this case from those concerning the "conventional" proposal form where the insurer has more control over the information it seeks, (and which by implication they find material) where there is likely to be more scope for the doctrine of implied waiver.

DISCUSSION

Following the introduction of the Insurance Act 2015, the burden of identifying what is 'material' to a risk has shifted to the insured. That, coupled with the increasing prevalence of market presentations, in which the insurer has less control over the information presented to them, may greatly reduce the relevance of the doctrine of implied waiver.

However, the law surrounding waiver remains good law and insurers are still under a duty to make further enquiries of the insured when they have been given sufficient notice that such a material circumstance may exist. As such, they should be wary of the form and content of any responses that they make or they will run the risk of being deemed to have waived their right to potentially crucial information.

This case also raises questions about the role of brokers when placing a policy using a market presentation. With the potential consequences for failure to disclose a material circumstance being enormous, brokers will need to ensure that they properly advise their clients on their duty of fair representation and what is likely to constitute a material circumstance. They will also need to inform their clients that the scope of their duty is not necessarily limited to the questions posed by an insurer.

WWW.BIBA.ORG.UK

BIBA GUIDES

Member Helpline:
Tel: **0344 7700266**
enquiries@biba.org.uk
www.biba.org.uk

British Insurance
Brokers' Association
8th Floor, John Stow House
18 Bevis Marks, London EC3A 7JB

Allianz Insurance plc
57 Ladymead, Guildford
Surrey GU1 1DB

DAC Beachcroft LLP
25 Walbrook,
London EC4N 8AF

Produced by **SandisonPay**
01329 835135
www.sandisonpay.co.uk

Here are just some of BIBA's guides, provided in association with DAC Beachcroft LLP and Allianz:

- BIBA Broker Legal Round-Up
- Claims Inflation Trends
- Employers' Liability Insurance
- Business Interruption Insurance
- Security Measures In Today's World
- The Future of Motor Insurance
- Construction Risks and Opportunities