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Insurance issues

Key issues for the insurance market

Summer 2016

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Welcome to the Summer 2016 edition of Insurance Issues, our six-monthly look at key issues and developments affecting different areas of business in the insurance market.

Affecting all areas, Brexit looms large on the horizon. The exact impact of the UK's decision to leave the European Union is yet unclear and will remain that way until negotiations between the UK and the other EU states have begun and develop. It is, however, evident that there will be major implications for the insurance market, from access to the single market and passporting rights to reciprocal arrangements for the enforcement of cross-border judgments and rules governing choice of law in insurance policies.

On a domestic level, 2016 has already seen a number of important decisions in the courts with implications for the whole market. Key among these are the Supreme Court's ruling last month in *Versloot Dredging v HDI Gerling* on so-called fraudulent devices used to support insurance claims and the Court of Appeal's decision in April in *AIG Europe Limited v OC320301 LLP*, a decision on aggregation that will impact areas of insurance well beyond the solicitors' PI context in which it was decided.

This month also sees the coming into force of the most important insurance law legislation in over 100 years. The changes introduced by the Insurance Act 2015 have been widely anticipated and will see significant modifications to the remedies available to insurers for non-disclosure and misrepresentation and to the effect of warranties and conditions precedent in policy terms. With rather less fanfare, the delayed Third Parties (Rights against Insurers) Act 2010 finally came into force on 1 August. For liability insurers of insolvent insureds, the Act will make it easier for third party claimants to claim directly from insurers and allows requests for information to be made of insurers and brokers which must be answered within 28 days.

Looking ahead, from May 2017 insurers may be faced with claims for damages for late payment of insurance claims. A new section 13A in the Insurance Act will imply a term into all insurance contracts that an insurer must pay sums due in respect of a claim within a reasonable time. In this edition we have included a section looking at the implications.

We hope you find Insurance Issues useful and informative. We are always keen to hear your views on our publications and if you would like to discuss any of the issues in this edition please get in touch.

Aviation

Key Issues

Employers' right to compensation under the Montreal Convention in the event of delayed flights

The European Court of Justice handed down its judgment on 17 February 2016 in the case of *Air Baltic Corporation AS v Lietuvos Respublikos specialiųjų tyrimų tarnyba* (C-429/14) finding that employers can demand compensation in the event of delayed flights.

The proceedings concerned compensation for damage caused by the delay of flights of Air Baltic Corporation AS carrying two agents of the Special Investigation Service of the Republic of Lithuania. The two investigators arrived at their final destination with a delay of 14 hours. As a result, additional travel costs were incurred and these costs were asserted against the airline by the employer.

The court ruled that the Montreal Convention *(Convention for the Unification of Certain Rules for International Carriage by Air, in particular Articles 19, 22 and 29 thereof)* must be interpreted as meaning that an air carrier which has concluded a contract of international carriage with an employer of persons carried as passengers, such as the employer at issue in the main proceedings, is liable to that employer for damage occasioned by a delay in flights on which its employees were passengers pursuant to that contract, on account of which the employer incurred additional expenditure.

According to the ruling, the airlines are liable for losses incurred by employers because of delays to their employees' flights. However, employers can only demand the maximum amount of damages for delays, which is currently approximately €5,000 according to the Montreal Convention. Claims for losses sustained as a result of delay are not unusual; however, generally conditions of many carriers provide that the contract of carriage is with the passenger rather than a third party. It will be a question for the lex fori as to whether an employer, or some other third party, is a party to the contract of carriage.

The CJEU has confirmed that the compensation awarded to such entities cannot exceed the cumulative limit to compensation that could be awarded to all of the passengers concerned if they were to bring proceedings individually. This decision will no doubt be followed by an increase in claims received from employers and other entities with an interest in the contract of carriage.

Cybersecurity and the airline industry

Cybersecurity has been ranked increasingly high in many businesses for some time now. According to the survey carried out by PwC, 85% of airlines' CEOs view cybersecurity as a significant risk. Should an airline suffer a cyber-attack not only might it loose data, such as customer records, financial details and confidential information of the company, but also an attack could have a severe impact on the airline's core operations, with cyber-attacks having the potential to seriously disrupt and endanger the safety of flights. A specific challenge for the aviation sector is the incredibly diverse nature of their business in terms of geography, business lines (passenger and cargo), complex public and private systems and significant contact with other bodies in the industry. Given the increased connectivity on planes, such as the ability to connect to the Wi-Fi on the plane, anyone with access to the system can now potentially cause damage.

With currently no uniform benchmark or standard in existence, the aviation sector needs to ensure that they develop their own policies which are followed across the company and all their business lines.

The huge and continuing growth of the aviation sector, and the changing and rapidly developing threats from cyber-attacks, mean that the insurance industry needs to be aware of the changing threats and be able to offer protection to them. But there is also considerable potential for innovative underwriters to take advantage of this new emerging/continuing developing risk.

What's on the Horizon?

Unmanned aerial vehicles (UAVs) or drones used to be associated with military raids or unmanned spacecraft. Today, they are increasingly operating in everyday life and the UAV industry is fast increasing. Whilst there haven't been many accidents so far, there have been enough to generate concern amongst underwriters that the likelihood of collisions will only grow. Once regulations are somewhat standardised, the general use of UAVs will increase, which will likely result in more incidents.

Many countries are still developing appropriate regulation of drones in their airspace. The UK has been able to develop some guidance in this area. In July 2015, the CAA published a 'Dronecode' aimed particularly at drones in the 1kg to 20kg weight bracket. The guidance requires the following:

— Flying the drone no higher than 400 feet, and always within the sight of the operator, i.e. approximately 500 meters.

— If the drone is fitted with a camera, it should not be flown closer than 150 meters to a congested area or a large group of people.

— The drone should stay at least 50 meters from a person, vessel, vehicle or structure.

The guidance published by the CAA seems to be a step into the right direction; however identification and enforcement will be real problems. How will an offender be identified unless he returns to the accident scene to retrieve the broken bits of his drone? As such, insurers are likely to be deprived of any realistic prospects of subrogation.

The risk of terrorism is, of course, just one of the risks associated with drones. While government agencies continue to struggle with the regulatory implications of UAVs, insurers are concerned with breach of privacy issues and privacy protection, data collection and enforcement, harassment, spying, cyber-attacks and other potentially criminal activities. Currently, most opt to exclude those exposures. Adjusting, investigating and settling losses nonetheless could be very difficult.

In order to enhance the protection of the public and civil aircraft in the UK from such threats, robust regulation aimed at manufacturers and retailers of drones should be made an imminent priority. Insurance is to be expected to be a key component of the risk management framework that will need to be developed for the systems to operate safely and with due regard to third parties.

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Financial Institutions and D&O

Key Issues

Regulation of financial institutions has been in the spotlight for a number of years. However, a more recent issue for regulators to grapple with is the challenge presented by new technologies and the resulting opportunities and risks created within the financial sector. The last couple of years have seen digital currencies (most famously Bitcoin but including numerous other examples) and 'Fintech' (the application of technical innovation within the financial sector) increasingly in the headlines. In common with other business sectors where technology is driving change, companies pioneering Fintech are often said to be 'disrupting' existing business models and processes. While innovation is to be welcomed and may bring benefits to corporates and individuals alike, any disruption of the status quo naturally raises questions about whether existing rules and regulations remain adequate. That is particularly the case in a highly regulated sector such as financial services. Moves by politicians and regulators to address some of these changes can be seen in a number of recent developments.

In May 2016, the European Parliament passed a resolution recommending that the European Commission set up a taskforce to monitor virtual currencies, such as Bitcoin, to prevent their being used to launder money or finance terrorism. The proposal suggests the taskforce should build expertise in the underlying blockchain technology of virtual currencies. The resolution recommends that the taskforce should be tasked with recommending necessary legislation but warns against an overly heavy-handed approach. It acknowledges that virtual currencies have a positive role to play with the potential to transform the financial sector. At the same time, the resolution notes a number of risks which should be addressed appropriately. Among the risks identified is the legal uncertainty surrounding new applications of distributed ledger technology (DLT) and the high volatility of virtual currencies and the potential for speculative bubbles.

Additionally, the EC is considering proposals to bring virtual currency platforms within the scope of the existing EU Anti-Money Laundering Directive, which is due to be updated. The proposals include a measure that would require platforms to undertake due diligence when customers exchange virtual currencies for real ones aimed at ending the anonymity associated with such platforms.

In the UK, the Treasury Select Committee (TSC) has published the text of letters sent to the Chief Executive of the Financial Conduct Authority and the Deputy Governor of the Bank of England for Prudential Regulation in which the TSC has asked for an explanation of the FCA's policy in relation to crowdfunding and an explanation of the PRA's approach from a prudential standpoint. The issues which the TSC have identified include where responsibility lies for ensuring accurate information is conveyed to investors, whether there are sufficient incentives in place on such platforms to assess the creditworthiness of borrowers and firms seeking investment through such platforms and what impact the growth of crowdfunding has had on competition in the financial services sector. The TSC intends to publish their responses in due course. Comments from the head of the TSC highlight the growth of the peer-to-peer lending market (said to have totalled £4.4 billion in the final quarter of 2015) and emphasise the need to strike a balance between protecting consumers who may have a false sense of security about the risks and rewards of investing in peer-to-peer lending while not stifling the development of competition which could ultimately benefit consumers.

What's on the horizon?

Corporate accountability is an increasingly important issue for corporations, and their directors and officers, across all business sectors. An example is legislation to create a new corporate criminal offence of failure to prevent the criminal facilitation of tax evasion which the government is considering introducing following HMRC's consultations on the proposed legislation and guidance, with the latest consultation having closed in July. The intention behind the new offence is to overcome the current difficulties in attributing criminal liability to corporations for the criminal acts of those acting on their behalf.

It is expected that the proposed offence will require three stages. (1) A criminal tax evasion by a taxpayer under the existing criminal law. (HMRC has given as examples an offence of cheating the public revenue or fraudulently evading liability to pay VAT). (2) The criminal facilitation of this offence by a person 'associated' with the corporation, whether by being knowingly concerned in, or by aiding, abetting, counselling or procuring the tax evasion by the taxpayer. (3) The corporation's failure

to take reasonable steps to prevent associated persons from committing the criminal facilitation of the offence. 'Associated persons' is widely defined, encompassing both employees and independent contractors, while 'corporation' includes a body corporate or partnership. The language essentially mirrors the recently created offence under the Bribery Act 2010 where a corporate fails to prevent bribery on its behalf, and extends the same concept to tax evasion. The new offence can be committed even where no gain accrues to the corporation and applies to all bodies corporate and partnerships operating in the UK, regardless of whether they operate commercially or for other reasons. An unusual feature of the draft legislation is that it extends to the facilitation of overseas tax evasion. A UK based corporation that fails to prevent those who act on its behalf from criminally facilitating a tax loss overseas, where the jurisdiction suffering the tax loss has laws in place equivalent to those in the UK, will be guilty of the new offence.

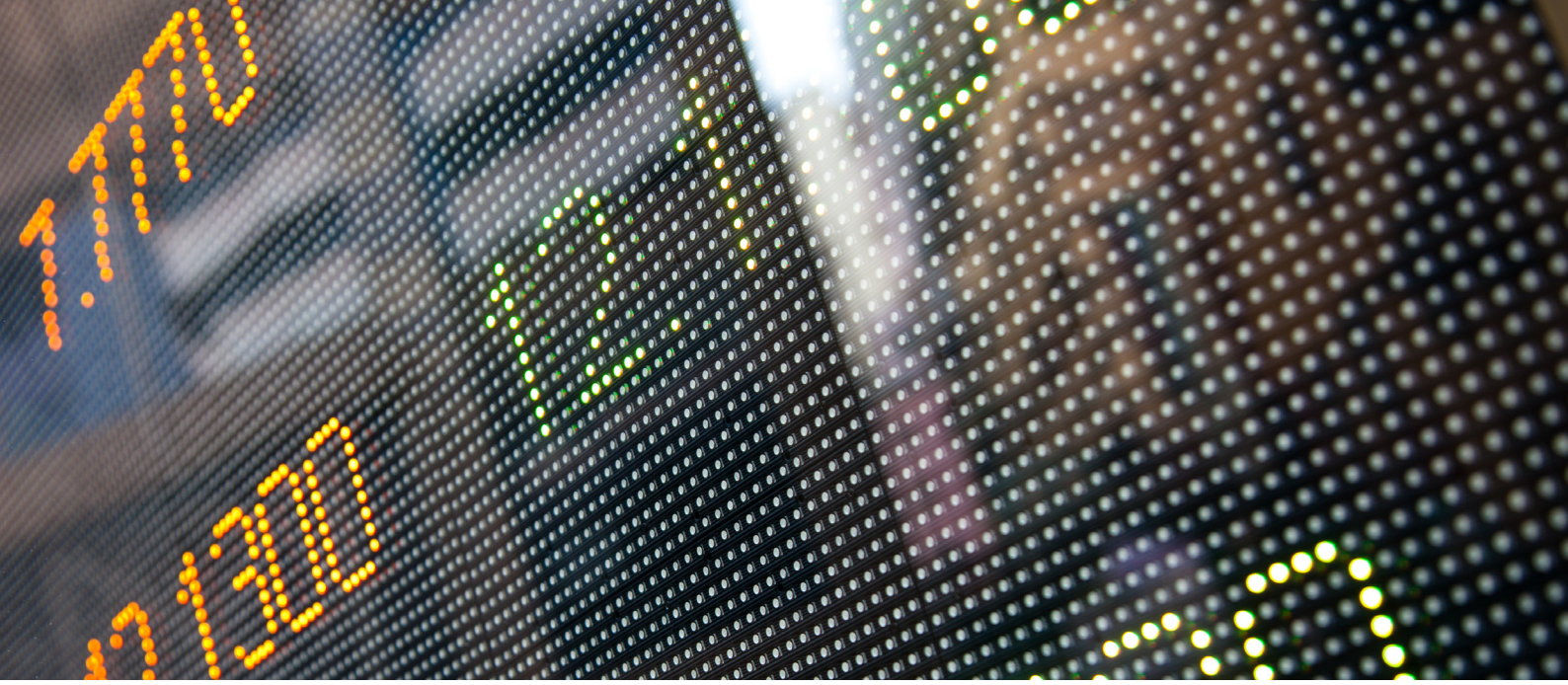
If introduced, it is anticipated that the new legislation would apply to all corporations although clearly it will be of significant interest to financial institutions. The proposed offence has parallels with the Bribery Act 2010, which saw the first conviction of a corporate for overseas bribery earlier this year. The draft guidance on the new offence adopts the same six principles to guide corporate conduct as are contained in the Bribery Act 2010 guidance. Of particular significance is 'Principle 1: proportionality of reasonable procedures'. A corporation that puts in place reasonable procedures to prevent persons associated with it from criminally facilitating tax evasion, which are proportionate to the risk, will not be guilty of the new offence. As with the existing anti-bribery legislation, it will therefore become increasingly important for directors and officers to ensure that adequate procedures are in place to protect the organisations which they manage.

Claims trends

In October 2015, new powers were introduced for administrators (as well as liquidators who already had such powers) to bring claims against directors for wrongful trading and fraudulent trading and, most significantly, a new power to assign such claims to third parties. Part of the rationale behind the change was a perception that relatively few insolvency claims were being pursued against directors, thought in part to be due to lack of funding or reluctance on the part of insolvency office holders to take on litigation risk. As the power applies to insolvencies commenced after the introduction of the legislation there will inevitably be a time lag before its impact is seen. However, with the first anniversary of the legislation approaching, participants in the D&O insurance market will be watching with interest to see whether a 'market' in claims against directors begins to show signs of developing over the next couple of years.

To find out more

We publish weekly Financial Lines bulletins providing up to day summaries of key developments in the sector. To be added to our mailing list email Simon Garrett.



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Financial Services Professionals

Key Issues

Dual proceedings: FOS and court cases

In June the High Court in *Templars Estates Ltd and others v National Westminister Bank Plc* granted claimants a stay of court proceedings so that they could have their case determined at the Financial Ombudsman Service (FOS).

In view of limitation, the claimants had issued proceedings against the defendant banks in a claim for negligent advice regarding interest rate hedging products. The trial was unlikely to be before 2018 and the claimants therefore sought to have the case dealt with at the FOS as a quicker, less formal, tribunal.

The banks submitted that it was a stale claim, that there should not be any further delay, that there should be a speedy resolution, and that granting a stay for potentially up to a year would prejudice them and their employees.

The court decided that the previous delay had not been the claimants' fault. They had been diligently pursuing their complaints against the banks. To refuse the claimants a stay of proceedings would be prejudicial to them, particularly where the banks had more resources than the claimants. The FOS represented a more informal and economical process for resolving customer disputes. There was no evidence that the banks would be prejudiced by the stay, as the matter was unlikely to be heard until 2018 in any case. The banks' witnesses were unlikely to be prejudiced; for example, there were no elderly witnesses involved. The court equated the claimants' application for a stay to an application for mediation to avoid the full costs of litigation – and that was invariably to be encouraged.

If the claimants failed before the FOS they were permitted to come back to court to continue proceedings. That was not a ground for denying a stay and would always be the case if a claimant went to the FOS but was unsuccessful. However, in light of the Court of Appeal case of *Clark v In Focus* (2014), the claimants should not be in a position where they could seek the first £150,000 plus interest of their loss (i.e. the FOS award limit) and then claim for that loss in excess at court afterwards. Accordingly, the claimants undertook that if a stay was granted *and* the FOS granted them an award they would (and could) not return to the High Court to continue proceedings for the 'balance of their loss'. On the basis of that undertaking, a stay was granted.

The case still puts claimants in a potentially better position than they have been previously. Consistent with the FCA Handbook 'Disp Rules', the choice traditionally was *either* pursuing a claim in court, or a complaint at the FOS. With the latter choice, that could mean that time is running against a claimant and, if unsuccessful at the FOS, the claimant could then be too late to issue court proceedings. In light of this case, the FOS may be minded to direct claimants that they should issue court proceedings to stop their claim becoming time-barred but, if it becomes necessary to serve those proceedings, seek an immediate stay to have the FOS hear the case.

FOS's approach to 'execution only' investment business

In a number of recent cases, the FOS has determined that – whilst the IFA stated it was not advising and that is was acting on an execution only basis – the IFA was nonetheless liable for the client's choice of pension investment. In each case, the IFAs recommended that the clients open new self-invested personal pension plans (SIPPs), but did so in the knowledge that the clients would then invest in an unregulated collective investment scheme (UCIS). The investments transpired to be worth less than envisaged. The IFAs were ordered to compensate the clients' SIPPs or pay compensation to them directly if that were not possible.

The FCA Handbook provides that an IFA's duties to a client are much more limited if they are acting on an execution only basis. Notably, neither the duties as to the *suitability* of an investment nor a transaction's *appropriateness* apply. The FCA still expects IFAs to obtain a signed letter from the client that they understand that they are not being advised in any way but have instead selected the investment themselves. In its online guide to how it assesses complaints regarding what is apparently 'execution only business', the FOS says it will not just accept signed letters or notices unless the client is a sophisticated investor. If, however, the client appears not to *have an investment history and no apparent connection to the investment industry*, it will probably decide that the case needs further investigation.

In one recent decision notice, the FOS seemed to go a step further, saying that firms cannot avoid their duty to give suitable advice by limiting the scope of advice they provide. That was particularly so when the IFA knew where the client would be investing and that the

investment in question was high risk. If the IFA was in doubt about the client's capacity for that risk, it should have investigated with the client further. All of this might suggest that the FOS considers there is no such thing as execution only business, notwithstanding what the FCA Handbook says. However, in other decisions on the issue, the FOS seems to accept the categorisation (but said that the business was *not really* execution only and the clients were not sufficiently sophisticated to be advised on this basis).

The decisions suggest that the FOS will continue to expect IFAs to test their clients' understanding and expectations and to document that clearly in writing. That applies even where the IFA is not actually advising. The difficulty for the IFA is that in merely processing an investment, that is executing it, the fee is unlikely to be significant and may well not justify any real investigation of the client's investment decision. On one view, the decisions are also an example of the FOS extending its remit so that it determines matters which, strictly, are not subject to the jurisdiction of the FOS, being an unregulated activity.

IFA working group to implement FAMR

The regulator, the Financial Conduct Authority, and HM Treasury published the Financial Advice Market Review (FAMR) in March 2016. The report criticised a number of IFAs' practices, particularly as to assessing a client's attitude and investment experience. It went on to recommend a package of measures aimed at improving access to advice and guidance.

The FCA has since set up a working group of IFAs/wealth managers to take forward three recommendations:

— Recommendation 12: the working group should work with employer groups to develop a guide to the top ten ways to support employees' financial health, and devise a strategy for rolling this out. It should align the timing of this with the joint factsheet for employers and trustees that is due to be published by the FCA and the Pensions Regulator in early 2017.

— Recommendation 17: the working group should publish a shortlist of potential new terms to describe 'guidance' and 'advice' by Q3/Q4 2016.

— Recommendation 18: the working group should lead a task force formed of interested stakeholders to design a set of rules of thumb and nudges with the aim of increasing consumer engagement.

The working group will report to the FCA Board and the Economic Secretary on the progress of its work after 12 months. It will set out in the report any further work that it considers is necessary to complete the recommendations it has taken forward. It will be interesting to see if those in the industry can come up with a better formulation of the terms 'guidance' and 'advice' and whether lesser duties apply to the former. That is all the more relevant now pension providers and administrators are called upon to provide guidance to those accessing their pensions.

What's on the horizon?

Tax mitigation schemes

In April the Supreme Court refused investors in the *Eclipse 35 LLP* case permission to appeal against an earlier decision of the Court of Appeal (*Eclipse Film Partners No. 35 LLP v The Commissioners For HMRC* (2015)) which concluded that Eclipse was *'not commercially trading with a view to make any profit'* so could not benefit from tax relief.

Eclipse formed part of a distribution scheme set up in 2007 to exploit rights over the films 'Enchanted' and 'Underdog'. Some 289 investors invested £840 million into Eclipse, funded by way of a loan from a Barclays group company for £790 million and £50 million from their own resources. Investors received a total of £293 million which they used to prepay £293 million in interest on the loans.

On the proper meaning of 'trade', the Court of Appeal affirmed the First Tier Tribunal's finding that the transactions, although commercially real, and not a 'sham' as alleged by HMRC, lacked the speculative nature and element of risk indicative of a trade.

In determining whether Eclipse was carrying on a trade, the Court of Appeal stripped the transactions back to their basic elements, focusing on the activity and enterprise that was carried out as a whole.

Although the film rights had a real value, the court agreed with the FTT that the prospect of receiving any contingent receipts was so remote as to be insufficient to confer trading status.

The Supreme Court's refusal to hear the appeal means that the earlier robust decision of the Court of Appeal will set the tone for similar schemes being challenged by

HMRC, particularly where the fact-finding tribunal has held that the activity was not trading. It remains to be seen whether HMRC will use this as an opportunity to issue follower notices to other taxpayers who participated in like film schemes. That is, those schemes designed after the statutory rules which permitted sale and leaseback schemes had been withdrawn in 2007.

The decision could significantly impact those professionals (and their insurers) that advised investors in such schemes. It does not automatically follow that the failure of an investment or scheme to defer tax means that an adviser has been negligent. Most of the investors in such schemes will have been sophisticated, wealthy, investors who appreciated the risks. But claims are inevitable given the amounts likely to be at stake.

Peer-to-peer lending

Crowdfunding, a method of raising funds through an online portal to finance (or re-finance) a company's activities, has been around for a few years. It was only earlier this year, however, that it was announced that advising on loan based crowdfunding, or peer-to-peer lending (P2P) is an activity regulated by the FCA. The FCA also confirmed in March that an individual investor can bring a complaint before the FOS in respect of advice received in relation to P2P investments. This is of particular significance given that the number of investors seeking advice on P2P is set to increase following the Chancellor's announcement in April 2016 that P2P agreements could be held in an Innovative Finance ISA by investors (and investor returns become tax free). IFAs have reportedly been slow to embrace advising on P2P investments (with concerns raised about their ability to evaluate the merits of the numerous and varied P2P opportunities). Nevertheless, we anticipate that we are going to see the number of recommendations to invest in P2P lending increase significantly, particularly as P2P firms such as RateSetter increasingly look to engage with the advisor community. Consequently, this is likely to be an area where we will see new claims in the future. IFAs will have to ensure that they get up to speed on P2P lending quickly, if they have not done so already, and ensure that they have sufficient knowledge to provide clients with adequate warnings / explanations of the risks involved.

To find out more

Visit our Law-Now website at **www.cms-lawnow.com** and read more on *tax mitigation schemes*. To subscribe to our weekly Financial Lines round up of developments in the sector email Simon Garrett.

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Fraud

Key Issues

Fraud is not a new issue for the insurance market which is striving to deal with the problem of increasing fraudulent claims. In January the Insurance Fraud Taskforce's final report was published. The report highlighted the particular problem of fraud in low value personal injury claims and in May the government accepted the report's recommendations.

Other key developments include the new statutory regime governing insurers' remedies for fraudulent claims and the Supreme Court's ruling on fraudulent devices.

Remedies for fraudulent claims

The Insurance Act 2015 has codified the remedies available to insurers where a fraudulent claims are made. If a fraudulent claim is made, the insurer will not have to pay the claim and can recover anything already paid to the insured in respect of the claim. This reflects the previous legal position.

The Act gives the insurer an additional remedy. The insurer may, by giving notice to the insured, treat the contract as terminated from the date of the *fraudulent act* without returning premium. A 'fraudulent act' is the behaviour that makes the claim fraudulent and may happen after a loss has occurred or a claim been notified. For example, an insured may make a genuine claim and subsequently add a fabricated head of loss. In that situation the insurer may terminate the contract from the date of the later fraudulent act.

If the insurer gives notice that it is treating the contract as terminated, the insurer remains liable under the contract in respect of any *relevant event* occurring before the fraudulent act. 'Relevant event' means the trigger for the insurer's liability under the contract. This will depend on the wording used in the policy and could, for example, be the notification of a claim or the loss occurring.

The Act also sets out the remedies that apply where a fraudulent claim is made in the context of group insurance, protecting the position of non-fraudulent beneficiaries under the policy.

Fraudulent devices or collateral lies

In *Versloot Dredging BV v HDI Gerling Industrie Verischerung AG*, the Supreme Court has decided by a 4:1 majority that the use of fraudulent devices – or collateral lies as the court preferred to call them – in support of genuine claims will no longer result in the claim being forfeited.

This is said to be the first time that the House of Lords or the Supreme Court has had the opportunity to resolve the question whether the fraudulent claims rule applies to justified claims supported by collateral lies.

The key distinction is whether the claim is, on the one hand, entirely falsified or exaggerated, in which case, as now confirmed in statute (section 12 Insurance Act 2015), the claim is forfeit on account of the dishonesty, or, on the other hand, a claim that is wholly genuine but dishonestly supported.

The Supreme Court has decided that in cases where *'the lie is dishonest but the claim is not'*, the sanction of forfeiture of the claim is a wholly disproportionate response. This is based on the fact that, unlike in a fraudulent claim, a collateral lie brings the insured nothing which he was not entitled to have anyway, whilst the insurer loses nothing if he meets a liability that he had anyway. The insured's right to indemnity arises as soon as the loss is suffered. The insurer should not, therefore, be protected by the application of the fraudulent claims rule from the obligation to pay an indemnity for which he has been liable in law ever since the loss was suffered. According to Lord Sumption, giving the lead judgment, there is no other context in which the civil law avoids a transaction on account of a fraud which has no impact on its intended target.

Insurance is recognised as a special case, because of the typical information disparity between the insured and the insurer, but the judge stated that, ultimately, even the law of insurance is concerned more with controlling the impact of a breach of good faith on the risk than with the punishment of misconduct.

Whilst confirming that the 'moral character' of the insured's lie is not mitigated because the lie turned out to be unnecessary, and referring to the danger of encouraging an insured to believe he has a 'one-way bet' if he lies in support of a genuine claim, the court considered that *'there are principled limits to the role*

which a claimant's immorality can play in defeating his legitimate civil claims'.

Lord Clarke put the position simply: the question whether collateral lies told by the insured should entitle underwriters to refuse to discharge their liability under a contract is essentially a policy question. In his view, public policy does not require that the insurer should be able to avoid payment in these cases.

Lord Hughes stressed that a perception that a fraudulent claimant now has nothing to lose through his embellishment would not be accurate. The fraud will still constitute a criminal offence (although the risk of prosecution is low), the claimant's credibility will suffer, costs sanctions may be imposed and future insurance premiums may be substantially increased.
Ultimately, though, the judges considered that they needed to be guided by their own sense of what is just and appropriate. As Lord Clarke said, the extension of forfeiture to a purely collateral lie is not justified – it is simply too large a sledgehammer for the nut involved.

There is no change to the position that where a fraudulent insured fabricates or fraudulently exaggerates a claim and uses a fraudulent device in support, the claim is forfeit. But where a genuine claim is supported by a lie that has no actual impact on the claim payment, this does not give insurers a right to forfeit the claim. This deferment is a real concern for the insurance industry which has for many years battled against fraudulent claimants.

Insurers may wish to include express clauses in all policies specifying that cover will be denied in the event that a fraudulent device is used to support an otherwise genuine claim (although such clauses may now be subject to challenge as being unreasonable). Policy documentation should also include warnings about the consequences of lying in support of a claim, whether genuine or not.

To find out more

Our Insurance Act Zone provides an easy to use, one-stop resource covering all of the changes introduced by the Act. You can also visit our Law-Now website at **www.cms-lawnow.com** and read more on the Supreme Court's decision in *Versloot Dredging v HDI Gerling*.

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Healthcare

Key Issues

Claims management companies

In recent years, there has been a concerted move by the government to limit the powers of claims management companies (CMCs). Both representatives from the insurance sector and the House of Commons have highlighted the 'claims culture' surrounding personal injury claims as a particular issue for the UK healthcare insurance market. Whiplash personal injury claims remain higher in the UK than any other European country and CMC turnover in 2014/15 reached £310 million, increasing by £72 million on the previous year.

These profits have, in large part, been shouldered by the insurance industry, with BIBA members now expressing concern over the risk of additional costs arising from personal injury claims. The resulting higher premiums have created serious issues for brokers attempting to create the best policy for healthcare providers and companies wishing to provide employees with health insurance.

In 2013 an attempt was made to control CMC activity by limiting how much claimants could recover from defendants. Unfortunately, since then, claims numbers have returned to pre-2013 levels. As a result, the government has decided to adopt a different approach to the regulation of CMCs. The 'Brady Report', published just before the 2016 March budget, suggested that efficient CMC regulation could be achieved through the regulation of CMC managers and directors.
In essence, the reforms called for wider and more thorough supervision of CMCs in an aim to reduce the number of fraudulent or unmeritorious claims aimed at the healthcare sector in particular. The suggested reforms were largely adopted by George Osborne and announced in his 2016 March budget. Of particular note is that existing CMCs are now required to re-authorise themselves in an attempt to prevent CMCs from disappearing and then 'phoenixing' under a different name.

The then Chancellor also announced that the Financial Conduct Authority (FCA) would take the lead on managing the proposed reforms. Whilst a separate body, the Claims Management Regulator (CMR), has been in charge of CMC regulation since 2007, it was highlighted that the FCA have consistently used their powers to greater effect. Integrating the FCA's resources and powers with the expertise of the CMR is likely to ensure more efficient control of dishonest or nuisance CMCs. The reforms do however require primary legislation, which is likely to occur in 2018. The impact of such a move on the healthcare insurance sector can therefore not be accurately assessed for some time, but the measures have been widely praised by the insurance sector as an important protection against higher insurance premiums.

Insurance Premium Tax

The March budget also announced a further 0.5% increase in Insurance Premium Tax (IPT). This increase, coupled with the one announced in July 2015, has resulted in a 10% tax upon Personal Medical Insurance (PMI). AXA PPP has stated that such increased costs would inevitably be passed on to the insured, making employer sponsored health insurance more costly and therefore less attractive to large employers. There are methods of avoiding these additional costs. An increasing number of insurance companies are now offering to assist large employers in establishing healthcare trusts that enable them to avoid IPT. Instead of paying premiums to an insurer in exchange for medical insurance, a company is able to pay cash to a trust which counts employees as its beneficiaries. This money is then used to pay for medical treatment. Whilst many insurers are predicting a reduction in the numbers of companies buying medical insurance, this could be mitigated by an increase in the number of healthcare trusts. With future increases in IPT predicted by many commentators, it is highly likely that healthcare trusts will become an increasingly attractive alternative for employers.

What's on the horizon?

2016 could mark a revolutionary period for the healthcare insurance sector. With the increasingly important role played by technology, the insurance industry in the US is moving into Silicon Valley. With customers beginning to demand personalised insurance policies, tech companies such as Neurosky are moving into the P4 medical space (Predictive, Preventative, Personalised and Participatory). The sensors generated by Neurosky can detect ECGs, stress levels and brain waves. This enables more accurate risk prediction and can ensure that a customer's insurance policy is tailored to their health risks.

Whether customers are willing to enter into such an arrangement is still to be determined. A recent poll commissioned by Deloitte indicated that only 46% of customers aged between 25 and 44 were willing to share their health data with insurers. This number dropped to 40% in the over 55s. David Rush, head of insurance at Deloitte, suggested that as more 'tech-savvy millennials' bought private health insurance, this number was likely to increase. Whilst some insurers remain optimistic about such policies, others remain unconvinced that sharing intimate information with insurers will be accepted by customers.

Claims trends

2014-2015 saw a reduction in life expectancy that it is believed to have resulted from dementia and flu related deaths, both of which are associated with older patients. A larger elderly population is more likely to succumb to bacterial infections associated with conditions such as the flu. As a result, a great deal of attention has become focussed on predicting the impact of anti-biotic resistant bacterial strains upon life expectancy.

Warnings from both the UK Government and bodies such as the World Health Organisation have suggested that antibiotic resistant strains could have a major impact upon life expectancy. Such strains currently result in 50,000 deaths per year in Europe and the US. It is expected that this number will rise in the coming years, with older patients less able to fight a bacterial infection without the assistance of antibiotics.

It may be that 2014-2015 was an exception, and life expectancy will continue to increase. It is clear though that infections that affect older patients are likely to play a greater role in life insurance risk predictions.

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Insurance Act 2015

Key Issues

Readers will be well aware of the majority of the changes to insurance law introduced by the Insurance Act 2015. These include important changes to the duty of fair presentation owed by commercial insureds and the remedies for breach of the duty, as well as changes to the law governing warranties in insurance contracts which will apply to both commercial and consumer policies.

Less attention has been given to an amendment to the Act that will allow insureds to claim damages for late payment of insurance claims. A new section 13A will imply a term into all insurance contracts that an insurer must pay sums due in respect of a claim within a reasonable time.

New duty

Section 13A will mean that if an insurer is in breach of the duty to pay claims within a reasonable time, the insured will be able to bring a claim for damages (or any remedy available to it for breach of contract). The claim will be in addition to the right to be indemnified under the policy and interest. Applying the usual rules of contract, where an award of damages places the injured party in the position they would have been in had the contract been performed, the damages awarded could be substantial (for example where a delay in payment has caused loss to an insured business).

What is a reasonable time for payment of a claim is not defined. Section 13A simply provides that it will depend on the 'relevant circumstances', giving some examples of matters that may be taken into account:

— the type of insurance;

— the size and complexity of the claim;

— compliance with any relevant statutory or regulatory rules or guidance; and

— factors outside the insurer's control.

Inevitably, the question of what is a reasonable time will be an area of dispute. While the (non-exhaustive) list of factors to be taken into account gives some guidance, we can expect the courts to expand on these factors and that what is reasonable may vary markedly depending on the type, size and complexity of cover in any particular case.

Importantly, the legislation recognises that insurers need to be able to investigate claims properly and section 13A expressly provides that reasonable time includes a reasonable time to investigate and assess the claim. Insurers will have a defence to a claim under section 13A if they can show that they had reasonable grounds for disputing a claim. Demonstrating that the insurer had reasonable grounds to delay payment may not, however, be straightforward, particularly where advice received by the insurer on the merits of a claim is subject to privilege. In deciding whether the insurer breached the implied term, its conduct will also be taken into account. So, for example, an insurer might act reasonably in delaying payment while investigating a claim but be in breach if it was slow to take into account further information confirming the validity of the claim.

Contracting out

For non-consumer insurance, insurers will be able to contract out of the late payment provisions either entirely or by imposing a limit on liability provided (1) the insurer satisfies the transparency requirements contained in section 17 of the Insurance Act 2015 and (2) it has not acted deliberately or recklessly.

To satisfy the transparency requirements an insurer must show that the contracting out provision is clear and unambiguous as to its effect and that it took sufficient steps to draw the term to the insured's attention (or the attention of its broker) before the contract was entered into.

A breach will be considered deliberate or reckless if the insurer either knew it was in breach or did not care whether or not it was in breach.

Limitation

A one-year time limit for bringing a claim against the insurer under the new section 13A will apply. The one-year period for bringing a claim will run from the date when the insurance claim is settled and will operate in addition to the usual limitation period of six years from the date of breach of contract, so that a claim for late payment will be time-barred by whichever period ends soonest. The intention behind the time-limit is that it will assist insurers in reserving for claims where there is a risk of a claim for late payment.

Time to prepare

The new duty will apply from 4 May 2017, allowing insurers and brokers to prepare for the changes. There are important implications for market participants to consider, including:

— The question of what is a reasonable time to investigate a claim and how insurers can demonstrate that they have not unreasonably delayed payment is likely to be a contentious area; insurers should review their claims procedures and have systems in place to show that they acted reasonably if required.

— Where risks are written on a subscription basis, issues where non-claims agreement insurers have limited control over claims payments.

— Whether an award of damages would be recoverable under reinsurance arrangements.

— Claims reserves may need revising to reflect any potential increased exposure.

— For non-consumer insurance contracts insurers may wish to consider policy terms limiting or excluding their exposure.

To find out more

Our **Insurance Act Zone** provides an easy to use, one-stop resource covering all of the changes introduced by the Act.

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Insurance Brokers

Key Issues

Broker's duties when making claims

A broker will not always owe a duty to the client to assist and advise on the presentation of claims, but where a broker does act in the making of a claim he must exercise reasonable skill and care and the courts have said that the duty goes beyond merely acting as a post box between the insured and insurers. As noted in Alexander Forbes Europe Ltd v SBJ Ltd (2002), it was the broker's duty to *'get a grip on the proposed notification, to appraise it and to ensure that the information was relayed to the right place in the right form'.*

The Commercial Court recently considered the duties owed by placing and producing brokers in the context of making block notifications. In *Ocean Finance & Mortgages Ltd v Oval Insurance Broking Ltd* liability was apportioned 70% to the producing broker and 30% to the placing broker for the insured's losses arising out of a failure to advise the insured finance broker to make a block notification of circumstances relating to the sale of PPI. The insured's PI insurance was due for renewal in October 2009. In 2008 and 2009 the FSA was indicating its intention to target the sale of PPI and by March 2009 the insured had ceased the sale of single premium PPI. During the course of 2009 the insured received numerous adjudications from the FOS which were adverse to it. Various discussions took place in 2009, and particularly in the run up to the 2009 renewal, between the insured and the producing and placing brokers in relation to the claims position and the systematic failures in the insured's historical practices.

A block notification of circumstances was made in the following 2009/2010 policy year and one insurer declined cover on the basis that notification should have been given in the previous policy year as, under the terms of the policy, notification had to be made 'as soon as practicable'. The insured claimed against the producing broker who joined the placing broker as a Part 20 defendant.

The judge found both brokers partly responsible for the loss. The producing broker had had much greater knowledge of the systematic failures in the insured's sales practices, but the placing broker should have advised the producing broker regarding the insurer's renewal terms. In addition, the placing broker had provided the insurers with a limited notification but should have made a more widespread notification. Whilst there was always the argument that such a broad notification would have been rejected by insurers, Mr Justice Cooke found that the dangers of not making such a notification outweighed any risks involved with notification, subject to the insured obtaining legal advice.

The decision underlines that, in similar circumstances, brokers should advise their clients to seek legal advice on whether or not to make a block notification. There is always going to be the danger of a block notification being rejected by insurers, however the devastating consequences of not notifying were such that *'no competent broker would have failed to consider it and recommend to the insured that they should, subject to legal advice, take such action'.*

Third parties' requests for information

The Third Parties (Rights against Insurers) Act 2010 finally came into force on 1 August 2016. The intention of the 2010 Act (which, except in limited circumstances, repeals the regime under the Third Parties (Rights against Insurers) Act 1930) is to make it easier for third parties to bring claims directly against the liability insurers of insolvent insureds.

One of the changes introduced by the 2010 Act is to make it easier for third party claimants to obtain information about the insurance cover potentially available to meet a claim. A third party will be able to ask for the information by notice in writing to the insured or to any person who is able to provide it, including the broker. Information that can be requested under the Act includes: whether there is a policy that might cover the supposed liability; who the insurer is; the policy terms; whether the insurer has denied liability; whether proceedings have been issued (and if they have, relevant details); and, if there is an aggregate limit of indemnity, to what extent it has been eroded..

Requests must be answered within 28 days, either providing the information asked for or explaining why the broker is not able to provide it. Broking firms will want to have procedures in place to ensure their employees are aware of what categories of information can be requested under the Act and the obligation to respond within 28 days.

What's on the horizon?

The full implications of Brexit for the insurance market will become clearer once notice under Article 50 has been given and the negotiations to achieve the UK's withdrawal from the EU have begun. One area that brokers involved in drafting and negotiating policy wordings should be alive to is that the current rules determining which law will apply if there is a dispute under a policy, and which court will have jurisdiction to hear the dispute, may no longer apply once the UK leaves the EU.

The rules for determining the law applicable to contractual obligations are currently governed by the Rome I Regulation and the FSMA (Law Applicable to Contracts of Insurance) Regulations 2009 and the rules governing which EU member state's courts will have jurisdiction by the Recast Brussels Regulation. Unless otherwise agreed, EU Regulations will cease to apply when the UK leaves the EU and, although equivalent rules may later be put in place, this may not be achieved within the two year period for negotiations, leaving a gap period. This is an area that brokers and other market participants should keep under review.

To find out more

Visit our Law-Now website at **www.cms-lawnow.com** and read more on the decision in *Ocean Finance v Oval Insurance Broking*, the *Third Parties (Rights against Insurers) Act 2010* and what Brexit may mean for *cross-border disputes*. To stay up to date with all issues relating to the UK's decision to withdraw from the EU, visit *Brexit Next: Legal Implications*.

We are the authors of *Insurance Broking Practice and the Law* published by Informa.

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Product Liability

Key issues

Nanotechnology was first hailed as a scientific breakthrough nearly a decade ago but the risks it poses are complex and not fully understood. This revolutionary technology utilises particles and structures as small as one ten-thousandth the diameter of a human hair in the construction of materials. It is currently used in a wide range of sectors including health, environment, electronics and scientific study. The Consumer Products Inventory run by the Project on Emerging Nanotechnologies now lists over 1,600 products that have been identified by their manufacturers as containing nanoparticles.

Nanotechnology has appeared particularly problematic to insurers because the extent of any potential claims is proving difficult or even impossible to assess correctly. This is caused not only by nanotechnology's recent and rapid growth, but also by the medical and scientific uncertainty surrounding it. This uncertainty stems from the unique characteristics of nanoparticles (including their size, reactivity and conductivity) that make this technology revolutionary.

A recent study by the University of Limerick has revealed that awareness of this modern technology is now on the rise among insurers; 64% of the surveyed insurers were vaguely familiar with nanotechnology and 25% had a moderate working knowledge. Insurers' knowledge was found to be at a basic level and not sufficient to differentiate between distinct nanomaterial risks. The survey also found that potential nanoparticle-containing product liability issues were thought to be more of a risk by insurers than by nanotechnology experts.

The survey highlights the need for a better understanding of the risks posed, possibly by collaboration between the insurers, potential insureds, scientists and regulators. A better understanding could even lead to the offering of new insurance products, subject to improvement in the market's ability to quantify potential losses.

What's on the horizon?

In its report, 'SMEs and Risk 2020', Zurich predicted that one of the biggest potential growth areas in technologies used by small businesses would be additive manufacturing, more popularly known as 3D printing. 3D printers are currently in commercial use largely in fields requiring cutting edge design technology, such as oil rigs and Formula One racing.

However, given how easily 3D printing lends itself to customisation and convenience, its use can be imagined in virtually every industry sector. With the growing availability of 3D printers, and some of the lower end models being available for as little as £300, it is only a matter of time before 3D printers are put to more extensive use. The qualities of 3D printing are likely to make it more attractive to SMEs once it is more affordable on a commercial scale.

There is potential for the growth of this technology to create an impact in the insurance sector. Using 3D printers may drastically alter the risk exposure of a business. It is vital that a business seeking or extending product liability cover understands the added risks that could arise from the use of 3D printing. Conversely, it is essential for a broker to examine how the business uses the technology, so the appropriate product liability cover can be offered.

However it appears there are many issues relevant to insurers writing product liability cover which will need clarifying in the near future. The very roles of manufacturer, designer and retailer are yet to be defined for the purposes of additive manufacturing. Liability for a faulty product could lie with the manufacturer of the printer, the designer of the printing software, or even the operator of the printer. The manufacturer of the 'raw materials' used to print the object might also feature in an action involving a faulty product. For instance, the quality and durability of the ink used to print the products might have a role to play in a defect.

The onus is thus on insurers to understand the role of each party, and who could potentially be liable for what. Where the policyholder is an SME, extra care is to be taken both by insurers and the insured. SMEs may be likely to fully understand the risks of the products they place into circulation owing to both lack of experience and a lack of research resources. SMEs that use 3D printing to offer new products may also be unfamiliar with the impact this could have on their insurance cover.

3D printing also challenges the current notion of a traditional supply chain. This will undoubtedly have an impact on product recall procedures. Product recall insurance might need to be taken out by SMEs to prepare for an event where a self-printed product has to be recalled, possibly through an unorthodox supply chain. However, SMEs may not be familiar with this type of cover.

Whilst 3D printing is therefore an area of potential growth for the insurance sector, the extent of the risks posed remains to be seen.

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Reinsurance

Key Issues

Canadian wildfires

Complex issues are likely to emerge for the reinsurance market from the recent Canadian wildfires. Reports suggest the fires may give rise to the costliest insured losses in Canadian history, far exceeding the C$1.7 billion Alberta floods in 2013 with the bulk of the insured losses expected to hit the global reinsurance markets. Although the fires raging around Fort McMurray attracted the most attention, wildfires affected large areas of Alberta, with the fires still only 71 per cent contained.

Cause

The Canadian Police announced that the largest Fort McMurray wildfire was most likely caused by human activity (said to be the cause of approximately half of Canada's wildfires), having ruled out lightning as a probable cause. This is an important issue; the cause of a loss sets the framework against which cover is triggered, and aggregation assessed. A fire started by an accidentally dropped cigarette or out-of-control camp fire will be by its nature an isolated incident, lacking any causal connection with other nearby fires. This presents a significantly different backdrop for coverage analysis than fires in different locations started by arson or by numerous lightning strikes during one storm.

The legal cause of a loss may differ from the cause of the fire, especially in the context of business interruption or contingent business interruption (CBI) claims, where the unavailability of staff, materials, transport or customers may impact commercial operations. The precise issues will be determined by the relevant policy wording in question. In this context, the market will be tested on the lessons it has learned from the 2010 case of *Orient-Express Hotels Ltd v Assicurazioni Generali SpA*. Reinsurers will be on the lookout for properly adjusted underlying claims, and the scope of cover offered by their own treaties.

Aggregation/disruption to home and business

The market initially started referring to the fires as an 'event', but it may well be that losses elsewhere in Alberta are treated as separate events. Issues may arise as to whether CBI losses caused by the fires generally, rather than by a single event, can be aggregated as part of any particular event.

An increasingly common feature of many classes of insurance is the ability to claim for disruption to home or business without the need to suffer physical damage to property. In a typical Canadian homeowner's policy, cover is available for Additional Living Expenses (ALE) if the property is evacuated, but policies are likely to vary on whether this cover responds without any physical damage. In light of the evacuation order for Fort McMurray, many homeowners and business have suffered losses. In the wider Athabasca Sands region, oil operations faced shutdown due to inaccessible roads and the evacuation of staff. Even though there was no physical damage to the oil installations, considerable losses were suffered arising from the interruption of the oil production. Of particular interest will be whether these losses will be aggregable with non-marine homeowners and SME losses from the Fort McMurray region.

The business interruption and CBI fall-out will not become clear for some time. Following Superstorm Sandy in 2012, there was considerable discussion about the take-up of contingent products to protect against affected supply chains and customer numbers. The scope and sub-limits of such cover can vary, and may (or may not) include cover (1) for the impact of civil authority orders preventing or restricting access, such as the mandatory evacuation orders in place for several Canadian communities, and (2) loss of attraction/ reduction in number of customers. Reinsurers will need to examine their own wordings to assess the recoverability of these losses up the chain. Many reinsurances simply exclude the recoverability of CBI losses as they are notoriously difficult to rate.

Triggers/blocked funds

A difficulty for the market may be the identification of a single event as the cause of ALE, CBI and Loss of Production/Increased Costs of Working (LOPI) losses. Consequently, reinsurers on working layers may be exposed to separate losses from the non-marine and energy markets. Whether these can be aggregated together for the purposes of Industry Loss Warranty (ILW)/Original Loss Warranty (OLW) protections and global retrocessional placements will require close scrutiny of wordings, in particularly trigger provisions. Disputes have arisen in the past as to what insured or uninsured losses are to count towards the ILW and how the quantum of the underlying loss is to be calculated (if a suitable index has not been identified in the

wording) and whether subrogated recoveries should be factored in to the calculation.

These issues give rise to a particular difficulty when reserving on collateralised reinsurances, written in the non-traditional markets and thus capital providers may need to determine whether to reserve blocked funds to cover potential losses.

The impact of the Canadian wildfires on the reinsurance market therefore remains unpredictable.

To find out more

CMS' reinsurance team produces regular reinsurance bulletins covering issues of concern to the market. To be added to our email list contact Alex Denslow.

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Solicitors' PI

Key Issues

In April the Court of Appeal gave its long awaited judgment in *AIG Europe Limited v OC320301 LLP and Others*. The Court of Appeal was asked to consider the true construction of the aggregation wording in clause 2.5 (a)(iv) of the Minimum Terms and Conditions (MTC) which governs the aggregation of claims in all solicitors' professional indemnity policies.

Background

Between 2006 and 2009 a UK property development company attracted investment to its two new property developments in Turkey and Morocco. In a bid to protect the investors in the event that the developments failed, the solicitors instructed devised a mechanism whereby: (1) an escrow account was established with the investors being party to the escrow agreement and the solicitors acting as escrow agents; and (2) two trusts were established in respect of which the investors were beneficiaries under the Deeds of Trust. The solicitors were only to release the funds from the escrow account to the local developer when the value of the security held in the trusts was at least the same as the total amount of the investments to be protected – this was known as the 'Cover Test'.

By the end of 2009 the UK developer had gone into liquidation and it was found that all of the invested monies in the escrow accounts had been paid away. The monies paid away are said to be in excess of £10 million. The investors each brought claims against the solicitors alleging, amongst other things, that the solicitors had failed properly to apply the Cover Test when choosing to release the monies in the escrow account.

First instance judgment

In 2015, AIG sought a declaration that the 214 claims brought by the investors could be considered as 'One Claim' for the purposes of assessing the limits of liability under the solicitors' professional indemnity policy. In order to decide whether the investors' claims could be treated as 'One Claim' for policy purposes, Mr Justice Teare had to consider whether the claims arose from *'similar acts or omissions in a series of related matters or transactions'* (per Clause 2.5 (a)(iv) of the MTC). Prior to the proceedings, the aggregation wording in the MTC had not been considered by the courts.

At first instance the judge concluded that the claims should not be treated as 'One Claim' because, whilst the claims did arise out of *'similar acts or omissions'*, those acts or omissions were not *'in a series of related matters or transactions'* because the terms of the transactions were not conditional or dependent on each other. The judge's interpretation of the aggregation wording meant that each claim by each investor would be treated as a separate claim for the purposes of the policy limit. AIG appealed.

Issue before the Court of Appeal

At the centre of the debate before the Court of Appeal was the meaning of the phrase *'a series of related matters or transactions'* in the aggregation clause of the MTC. Submissions were heard on behalf of:

— AIG – that the judge was wrong to read into the phrase a requirement that the matters or transactions be dependent upon one another;

— the trustees/solicitors – that the judge was correct in his conclusion; and

— the Solicitors' Regulatory Authority (who were permitted to intervene) – that there had to be *'at least some intrinsic connection between the relevant matters or transactions, not merely a connection with some external common factor such as the transactions were conducted by the same solicitor'*.

Decision

The Court of Appeal held that the judge was right to hold that the aggregation clause had to be approached neutrally and without any assumptions in favour of an insured or insurers but wrong to say that the matters or transactions had to be dependent on each other. Lord Justice Longmore concluded that the express language of the clause (*'a related…transaction'*) was both imprecise and deliberately avoided the wider forms of aggregation language. He explained that there must be a restriction on the concept of relatedness and that was achieved by implying a unifying factor from the general context. It was for that reason that the Court of Appeal concluded that the 'matters or transactions' in question must have an intrinsic relationship with each other, and not an extrinsic relationship with a third factor (for example, the same solicitor or a geographical area).

In the judgment, Lord Justice Longmore usefully reviewed relevant leading cases on aggregation wording generally and cited an article from the Law Society Gazette on 27 January 2005 which explained the history of the origin of the current wording of clause 2.5 of the MTC, following its amendment after the House of Lords' decision in *Lloyds TSB General Insurance Holdings Limited and other v Lloyds Bank Group Insurance Co Ltd* (2003) (the clause in debate in that case had similar wording to clause 2.5 of the MTC). Lord Justice Longmore referred to the article as part of the 'matrix' against which clause 2.5 had to be construed and noted that the article had not been put before the judge at first instance.

No findings of fact were made because, as Lord Justice Longmore noted, the Court of Appeal did not want to 'inhibit the trier of the facts in any way'. The case was remitted back to the Commercial Court to determine the facts in accordance with the guidance provided in the appeal judgment.

Comment

The decision of the Court of Appeal is not surprising and should give insurers some relief from the restrictive interpretation implied into the language of clause 2.5 by Mr Justice Teare. It is disappointing that the Court of Appeal did not elect to provide further commentary or clarification on the scope of clause 2.5 of the MTC more generally, given that this was the first reported consideration of the clause by the courts.

The Court of Appeal indicated that there should be *'a fresh start'* and that the trier of fact should not be compelled to hold that the relevant acts or omissions of the solicitors were *'similar acts or omissions'*, as decided by the first instance judge.

To find out more

Visit our Law-Now website at **www.cms-lawnow.com** to read more on the decision in *AIG Europe Limited v OC320301 LLP*.

We are the authors of Solicitors' Claims: A Practical Guide published by Sweet & Maxwell.

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Surveyors' PI

Key Issues

Causation and 'but for' test

The Court of Appeal has recently considered the application of the 'but for' test where a lender advanced a loan facility on the strength of a first valuation of a property and later provided additional funds having obtained a second valuation.

In *Tiuta International Ltd (in liquidation) v De Villiers Surveyors* (2016), the lender advanced approximately £2.5 million to a developer on the basis of a valuation in February 2011 of a partly completed residential development. The property was valued at £3.25 million in its present state and £4.9 million on completion. In December 2011 the property was revalued (at £3.5 million in its present state and £4.9 million on completion) and the lender advanced additional funds to the developer. Rather than simply extending the original facility, this was done by refinancing the loan facility with the original loan being repaid from funds lent on the second loan.

When the term of the second facility expired £2.84 million remained outstanding. On a sale, the property realised only £2.14 million and the lender brought a claim against the valuer alleging that the December 2011 (but not February 2011) valuation had been negligent. At first instance the valuer successfully applied for summary judgment on the basis that, as £2.5 million had already been advanced at the time of the December 2011 valuation, that valuation (even if negligent) had not been causative of the claimed losses. Applying the 'but for' test of causation the first instance judge agreed with the valuer.

The Court of Appeal found that the judge had mis-applied the 'but for' test. Rejecting the argument that in a case of this kind the court should look at the substance of the transaction rather than its form, the Court of Appeal said that in order to determine whether loss had been caused by the negligent over-valuation it had to identify correctly the nature of the transaction entered into and the part the valuer played in it. When a lender is considering making a fresh loan, the purpose to which the new loan will be put (including in this case repayment of the earlier loan) is irrelevant to the valuer and (if negligent) the valuer will be liable for losses flowing from the lender entering into the transaction. On the facts, the second loan stood apart from the first and the basic comparison for ascertaining the lender's loss was between the amount of the second loan and the value of the security. If the valuer had wanted to limit its exposure, they should have done so in the terms of its retainer.

Reliance and the correction of inaccurate valuations

The decision in *Mortgage Express v Countrywide Surveyors Limited* (2016) emphasises the importance of surveyors explicitly notifying the client of any inaccuracies in their valuations as soon as they come to light. The court considered the extent to which subsequent email correspondence without full disclosure of the inaccuracies contained in original valuations withdrew the lenders' ability to rely on those valuations. During the period December 2004 to June 2005 Countrywide Surveyors Limited (CWS) provided valuation reports to Mortgage Express Limited (MEX) for 64 new-build flats in a new marina development at Sovereign Harbour, Eastbourne. In reliance on those valuations MEX lent monies to borrowers. On 19 July 2005 CWS notified MEX that it considered the valuations to be overstated and asked for an opportunity to review its advice before any further lending was done by MEX. MEX then requested revaluations of 21 properties, which were provided by CWS on 25 August 2005. These turned out to be on average only 50% of the original valuations. MEX claimed that as a result of relying on 41 of the 64 original valuations it lost more than £3.3 million.

The court referred to the concept of a continuing representation, where it was reinforced that if there is an appreciable interval between the making of the representation and the other party's reliance on it, the representation is deemed to be repeated at every successive moment in the interval until it is withdrawn or modified.

The crucial question was therefore: whether the email correspondence in July and August 2005 was sufficiently clear so as to withdraw and/or modify the valuations, so that they did not count as a representation as at the date of completion?

The burden of establishing a withdrawal or modification lies with the person making the correction. This is an objective test, but does take into account the factual matrix of the transaction. Applying the test to the facts

the email from CWS dated 25 August 2005 it was found not to expressly withdraw the valuations, not say they should not be relied on, and not specify the extent of the problem. Rather it merely requested an opportunity to review the advice. Further, the court also commented on the time it took to provide revised valuations, it concluded that, in the context of the matter, 3 or 4 days (as opposed to the 17 days it took) would have been reasonable, as in the absence of further communication within that time period it would be unreasonable to expect MEX to put a complete halt to its lending.

This decision raises important learning points for surveyors in terms of reliance on their valuations by the client. If there is to be a correction of a previous valuation, whether by way of withdrawal or modification, this needs to be made expressly and in no uncertain terms. The correction should make full disclosure of the extent of inaccuracies. The valuations to which the correction applies should be specified clearly and individually, even if this is obvious. If modifications are being provided, this needs to be done within a reasonable period of time.

Recovery of costs when claim form issued but not served

The decision in *Webb Resolutions Limited v Countrywide Surveyors Limited* (2016) highlights the costs liability that a claimant faces where a claim form has been issued, but not served on a defendant.

In May 2011, Webb issued a Letter of Claim against Countrywide in accordance with the Professional Negligence Pre-Action Protocol. The sum claimed was £31,148. In July 2013, Webb's solicitors wrote to Countrywide's solicitors putting them on notice that, as primary limitation was expiring in a few days' time, they expected instructions from their client to issue proceedings.

A claim form was then issued in August 2013 but was never served on Countrywide. There was further correspondence between the solicitors and in April 2014, Countrywide's solicitors wrote to Webb's solicitors asking if a claim form had been issued. Owing to the lack of reply, Countrywide's solicitors obtained a copy of the claim form from the court. Countrywide then wrote to Webb's solicitors seeking costs owing to the failure to serve the claim form. Webb disputed this entitlement.

Webb argued that the decision to not serve the claim form on Countrywide was a commercial one, owing to the low value of the claim. It was submitted that Webb should not to be penalised for this rationale. The court took a sceptical view about this; it concluded that Webb had issued to encourage Countrywide to settle, as Webb continued to pursue Countrywide for its costs and made a Part 36 offer.

Webb argued that the pre-action costs incurred could not be considered 'incidental to the claim' as when the claim did become the subject of litigation it might not have included all the issues covered pre-action. The court rejected this argument on the basis it could not find any issue which would have not formed part of an issued claim.

In its finding the court took into consideration the decision in *Clydesdale Bank v Kinleigh Folkard & Hayward* (2014). In that instance, the court found that the trigger for the purposes of the recovery of costs was the issue of the claim form and not its service.

Accordingly, the court had no hesitation in ordering that Webb be held liable for Countrywide's costs. The court felt that, in exercising its discretion, it would be wrong for it to ignore the considerable expense incurred by Countrywide, as well as Webb's awareness of the disproportionate expense (given the low value of the claim) of the course it was pursuing.

This decision is a welcome one for defendants in reinforcing the position that a claimant cannot, without consequence, simply gamble on using the issue of a claim as a weapon with which to force a defendant to settle. Once a claimant issues it places itself with a potential costs liability, including for those pre-action costs already incurred. Indeed, this reflects our recent experience in a number of successful costs recoveries in similar circumstances when acting for defendant surveyors. Accordingly, whether a claimant issues will be a tactical consideration for defendants when faced with the proposition of a standstill agreement or a claimant who fails to properly set out its case during the Pre-Action Protocol process.

Claims trends

While the impact of the Brexit referendum vote remains to be seen, as the economy previously picked up we have seen claims of different origins to those brought against valuers at the height of the financial downturn, which primarily concerned overvaluations. Examples of these new prevailing claims are those against surveying practices arising out of the management of portfolios (such as a failure to recognise and react to the rise in the market by securing higher rents) or those against monitoring surveyors on the new developments which the boosted economy is facilitating. It is now very much a watch this space as to whether the impact of Brexit on the property market sees a return to the situation experienced during the financial downturn.

To find out more

Visit our Law-Now website at **www.cms-lawnow.com** and read more on the decisions in Mortgage Express v Countrywide Surveyors Limited and Webb Resolutions Limited v Countrywide Surveyors Limited.

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Title Insurance

Key Issues

The market for title insurance

Title insurance policies play an increasingly important role in real estate transactions, protecting borrowers and their lenders against defects in title, and in particular attempts by parties claiming rights over the property in issue to seek restitution.

Title insurance is a long-established product in the UK, but claims are relatively few and far between. The system of Land Registration in the UK is well-established and rival claimants to real estate rarely come forward (although given the value of UK real estate even relatively minor disputes over boundaries and rights of way can spiral into costly litigation).

With the collapse of communism, title insurers expanded into CEE, with UK-based companies such as First Title and Secure Legal Title dominating the market. Policies are almost invariably written applying English law and jurisdiction, offering some protection for insurers against 'rogue' court decisions.

In CEE jurisdictions, the history or property ownership up to and including the communist era may be disputed. Restitution actions are more frequent. These types of actions have the potential to destroy the value of real estate assets on which lending is secured.

Owners v lenders

Title insurance policies may either be Owner Policies or Lender Policies. Owner Policies are taken out in the name of owner of the mortgaged property but the lender will require that the policy contain a loss payee clause. A loss payee clause is a clause which provides that in the event of payment being made under the policy in relation to the insured risk, payment will be made to a lender rather than to the insured owner. By contrast, a Lender Policy is taken out in the name of the lender so payments made under the policy in relation to the insured risk will be made to the lender without the need for a loss payee clause.

The disadvantage of an Owner Policy is that the loss payee clause offers no protection from any failure to comply with the policy's conditions by the insured and the loss payee has no rights under the policy itself to pursue a claim. In addition, where a loss payee clause is sought, careful thought needs to be given as to how it will work in practice and with other terms of the policy. The historic formulation of the lender's interest simply being 'noted' ought to be unattractive for a lender. The lender's rights and obligations ought to be more clearly delineated.

A lender may opt for a Lender Policy because it minimises the prospect of any act or omission of the insured impacting the lender's interests. A Lender Policy effectively means that the lender has a separate policy and the lender's cover should not be impacted by the insured's conduct. The lender will, however, have to comply the terms and conditions of the policy, including the duty of utmost good faith (see below).

Lender policies tend to be more expensive. The insurer has to rely on the lender's due diligence, which may be a stage removed from the owner's knowledge of the property, and price the risk accordingly. There may be difficulties assigning the benefit of policies without insurers seeking an additional premium.

Making a claim

Lenders should be aware that a policy will not usually respond automatically and that there is a claims process to be completed. Whether the policy is in the name of the lender only or the owner and lender (with the lender as additional insured), or the lender is named as loss payee only, will determine the rights and obligations of the lender.

The desirability of these alternative options may depend on the likelihood that the borrower will be willing and able to pursue the claim and can be trusted to comply with policy conditions in the event of a future claim (because title policies are often open-ended, at least in theory (but protected by the Limitation laws in each jurisdiction) a claim may arise many years later after the policy is put in place.

Typically, notice of a claim is to be given in writing within 28 days of becoming aware of *'anything that may result in a claim'*. This is a very low threshold and we suggest that in practical terms the insured should notify any potential issues as they arise rather than waiting to see if they develop into formal claims. Any delay may impact on recoverability, especially if the notice provision is a condition precedent to liability, a risk for the lender who may be equally unaware of an issue the borrower chooses not to mention.

Thereafter, the claims conditions of the policy should be regarded as a process to be complied with rather than get-out clauses for insurers. Lenders should be aware of their own obligations, but also ensure that the borrower takes all steps necessary to comply with claims conditions.

Title insurance can therefore be a valuable protection for lenders, providing cover for real estate assets securing against events of default, but lenders should be mindful to ensure that policy terms are complied with, to realise the value of the insurance asset in the event of a claim.

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