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MENAIR INSURANCE AWARDS 2017 WINNER

UK CAPTIVE 2017 SERVICES AWARDS WINNER LAW FIRM HOLMAN FENWICK WILLAN

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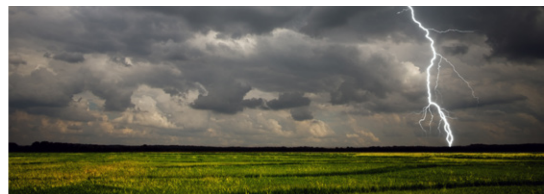

1. Regulation and legislation

UK: Government to change the definition of "financial advice" for regulated firms

In September 2016, the government published a consultation on amending the definition of financial advice. This followed the Financial Advice Market Review's (FAMR) finding that there is a growing trend towards consumers making and executing their own financial decisions, and that for consumers with relatively straightforward needs or small amounts to invest, the cost of regulated advice may outweigh the benefits.

The FAMR suggested that such individuals would benefit from high quality and more specialised and detailed guidance services. As a result of the lack of clarity as to the point at which general consumer support becomes regulated advice, the FAMR found that firms were limiting the amount of guidance being given to consumers for fear of inadvertently giving regulated advice without meeting the relevant regulatory requirements.

The government proposed to amend the definition of regulated advice in Article 53 of the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001 (RAO) to bring it into line with the EU definition set out in the Markets in Financial Instruments Directive (MiFD).

Having considered the responses to the consultation, the government has decided to change the definition of financial advice for regulated firms. Regulated firms will therefore only be giving financial advice where they provide a personal recommendation.

The amendment will affect the insurance market when the Insurance Distribution Directive takes effect in February 2018.

CIARA JACKSON, ASSOCIATE

This new definition will come into effect on 3 January 2018. The effect of this change is that regulated firms will be able to provide more advanced guidance services, which would previously have been caught by the RAO definition of advice as "advising on investments", without having to comply with the higher regulatory requirements associated with regulated advice. Regulated firms will only be deemed to be giving financial advice where they provide a personal recommendation, and will not require authorisation to carry out activities under Article 53 of the RAO unless they are making such a recommendation. Unregulated firms will still be considered to be giving advice without proper authorisation when they "advise on investments" as set out in the RAO.

The amendment will affect the insurance market when the Insurance Distribution Directive takes effect in February 2018.

For more information, please contact Ciara Jackson, Associate, London, on +44 (0)20 7264 8423, or ciara.jackson@hfw.com, or your usual contact at HFW.

2. Court cases and arbitration

New Zealand: *Prattley Enterprises Ltd v Vero Insurance New Zealand Ltd* [2016] NZSC 158

Property insurance: successive losses

In another of the many insurance cases arising out of the Christchurch earthquakes in 2010 and 2011, the Supreme Court of New Zealand (that country's highest court) has recently provided helpful guidance on the measure of indemnity in property insurance cases where there have been successive losses.

The Supreme Court held that, on the facts in *Prattley Enterprises*, what was insured was the indemnity value of the building and it would be a clear breach of the indemnity principle for the insured (Prattley) to recover more than it had lost, that is what the building was worth when the sequence of earthquakes started.

This decision provides comfort to insurers that, in similar circumstances, the indemnity principle should prevent recovery for unrepaired damage overtaken by a subsequent total loss or for amounts which exceed what was lost.

Damage and insurance

Prattley owned a building, close to Cathedral Square, in Christchurch which was used for commercial purposes, namely, the generation of rental income. This building suffered moderate damage in the earthquake of 4 September 2010 and remained in use until it suffered further damage in the Boxing Day earthquake of the same year. From that point, the building was not occupied. Prior to any repairs being carried out, the building was severely damaged in the

earthquake of 22 February 2011 and was demolished in September 2011.

The "total building sum insured" was NZ$1,605,000 and the policy provided that:

"You will be indemnified by payment or, at our option, by repair or by replacement of the lost or damaged property. Subject to the reinstatement of amount of insurance extension our liability will not exceed the total sum insured ...

We will repair or reinstate the building to as reasonably equivalent appearance and capacity using the original design and suitably equivalent materials."

Reinstatement cover in excess of indemnity value was available, but this option was not taken up by Prattley.

Claim

Prattley claimed on the insurance and, after limited negotiations and competing valuations of market value of the building, the parties settled the claim for NZ$1,050,000 plus GST in "full and final settlement" of the insurance claim.

However, Prattley subsequently sought to reopen the settlement, claiming a further NZ$2,338,000. It argued that the settlement had been entered into under a common mistake as to the correct measure of indemnity and should, therefore, be set aside under the *Contractual Mistakes Act 1977*. The basis of its claim was that the policy responded to the cost of repairs or replacement and Prattley was entitled to recover separately and cumulatively up to the policy limits for the damage caused by each of the earthquakes.

Prattley's claim was unsuccessful in both the High Court and Court of Appeal, although the measure of indemnity applied was different in the High Court (market value) from the Court of Appeal (reinstatement, best assessed by the depreciated replacement value of the building).

The calculation of what is required by way of indemnity varied depending on the circumstances, but was always calculated against the background that the purpose of an indemnity payment was to make good the insured's actual economic loss.

BRENDAN McCASHIN, SPECIAL COUNSEL

Supreme Court decision

The Supreme Court held that the settlement could not be reopened, there was no common mistake and the settlement was distinctly favourable to Prattley.

The Supreme Court concluded that the wording of the key clauses in the policy was standard and the obligation of the insurer was to "indemnify" Prattley for damage suffered. Prattley's primary entitlement was to indemnity by payment, but the insurer, at its option, was entitled to provide indemnity "by repair or replacement". However, the fact that this option was available to the insurer did not signify that the indemnity was necessarily to be calculated by reference to the cost of repair or replacement.

The calculation of what is required by way of indemnity varied depending on the circumstances, but was always calculated against the background that the purpose of an indemnity payment was to make good the insured's actual economic loss. If the property was destroyed and was not to be reinstated, the most obvious basis for calculating indemnity was its market value, particularly in the case of a property held for investment purposes. This was the basis upon which the settlement sum was calculated.

The Supreme Court accepted the findings of the High Court that Prattley's loss was in fact only in the region of NZ$520,000, being the pre-event value of the land and building and demolition costs less the post-demolition value of the land, so as to leave Prattley with land and money equating to the pre-event value of what it had before the earthquakes. On this basis, it found that, due to reliance on an erroneous valuation, Prattley was paid out more than double its entitlement and had no legitimate grounds for complaint.

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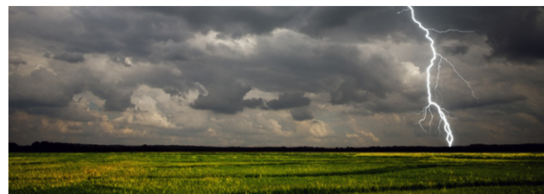

England & Wales: *AIG Europe Limited v Woodman and others* [2017] UKSC 18

In the most important decision to date regarding the aggregation of solicitors' professional indemnity insurance claims, the Supreme Court has overturned the Court of Appeal in *AIG Europe-v-Woodman*.

The policy provision in issue was clause 2.5 (a)(iv) of the Law Society Minimum Terms and Conditions for solicitors' PI insurance, namely: "similar acts or omissions in a series of related matters or transactions..... will be regarded as one Claim", for the purposes of applying the policy limit.

It was accepted (on agreed facts, the claims against the solicitors not having yet been tried) that the 214 underlying claims by disappointed investors against their (insured) firm of solicitors all arose from "similar acts or omissions", the dispute being focused on the rest of the clause, i.e. the meaning of "a series of related matters or transactions...". The investors had suffered loss when their solicitors released their monies to holiday resort developers, from a designated escrow account, without adequate security having been put in place beforehand. There were two resorts, one in Turkey, one in Morocco. The claims totalled more than £10 million, and the policy limit per claim was £3 million. The insurer argued that all claims should be aggregated, with the application of one £3 million policy limit. The investors (through their trustees) argued for no aggregation of claims. However, each mounted an alternative case that claims for one development should be aggregated, whereas claims for one development could not be aggregated with claims from the other.

At first instance (see the article in our Insurance Bulletin of 24 September 2015[1]) the Judge had ruled that for there to be "a series of related matters or transactions" the transactions had, by their terms, to be conditional or dependent on each other, which they were not. On appeal, at the behest of the Law Society as an intervener, the Court thought this too restrictive an interpretation of the relevant aggregation provision, which had been introduced following the narrow interpretation of another provision in Lloyds TSB [2003] 4 All ER 43. The Court of Appeal ruled instead that there must be an "intrinsic" relationship between the transactions, rather than a relationship with some outside connecting factor, even if that factor was common to all transactions (see the article in our Insurance Bulletin of 14 April 2016[2]). In the Supreme Court, the insurers argued that this introduced an unwarranted additional qualification into the policy language, whereas the investors (through their trustees) and the Law Society supported the Court of Appeal's interpretation.

Lord Toulson (with whom Lords Mance, Clarke, Sumption and Reed agreed), said the Court of Appeal's formulation was not "necessary or satisfactory", since "intrinsic" was too elusive a term when used to describe a relationship between two transactions. He said that aggregation provisions can operate in favour of either insured or insurer on given facts, and are not to be approached with any predisposition towards either a broad or narrow construction. However, the Appeal Court had taken too narrow a view of the transactions in describing them as the "payment of money out of an escrow account which should not have been paid out" and he looked to the wider transaction to apply the test.

In the Supreme Court, the insurers argued that this introduced an unwarranted additional qualification into the policy language, whereas the investors (through their trustees) and the Law Society supported the Court of Appeal's interpretation.

ANDREW BANDURKA, PARTNER

He said that determining whether transactions are related is "an acutely fact sensitive exercise" and that, in this case, a "transaction involved an investment in a particular development scheme under a contractual arrangement, of which the trust deed and escrow agreement were part and parcel, being the means designed to provide the investor with security for his investment. The transaction was principally bilateral *[between investor and developer]*, but it had an important trilateral component by reason of the solicitors' role both as escrow agents and as trustees, and the trust deed created a multilateral element by reason of the investors being co-beneficiaries." The transactions regarding the Turkey scheme were connected in significant ways, and likewise those regarding

1 http://www.hfw.com/Insurance-Bulletin-24-September-2015

2 http://www.hfw.com/Insurance-Bulletin-14-April-2016

the Morocco scheme. Applying the aggregation clause objectively, taking the transactions (on agreed facts) in the round, the Supreme Court ruled there were two separate aggregated claims, one for each development – the transactions "fitted together" in sharing the same common underlying objective of the execution of a particular development project, and they fitted together legally through the trusts under which the investors were co-beneficiaries. Although the claims relating to each separate development bore a striking similarity, that was insufficient for them to be aggregated as one claim: they had two sets of underlying transactions, which were not sufficiently related, since they related to different sites, different groups of investors with different deeds of trust over different assets. They should not be aggregated. (There remains a possible issue about a special class of investors who "crossed over" from one development to the other, and a possibility of further argument of fact.)

This important decision recognises the fact-sensitive nature of applying policy tests for claims aggregation, sets out a clear illustration of how the test should be applied to the (agreed) facts of the case, and strikes a balance between the two primary arguments of the insured and the insurer. In doing so, it provides much-needed clarity.

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3. Market developments

UK: London Market Group publishes its recommendations to the UK Government for its Brexit negotiations

The London Market Group (LMG) is creating a taskforce group to work with the Government in its Brexit negotiations for a trade deal for the insurance industry.

The Brexit Roadmap highlights three key objectives it recommends the Government considers in its negotiations:

- A guarantee that the London Insurance Market will have regulatory equivalence with the EU under Solvency II. This would not give market access rights to the EU for UK insurers and reinsurers, but it is important that the UK and EU prudential regulatory regimes remain comparable.
- A new trade deal to allow for continued cross-border activity between UK and EU insurers, reinsurers and brokers.
- At the outset of negotiations it is important to agree an implementation period to move to the new trade agreement. During this time the industry's current market access rights would be maintained. This is crucial to avoid uncertainty on the day the UK leaves the EU, and to allay concerns and uncertainty over whether insurance policies will be enforceable.

At the outset of negotiations it is important to agree an implementation period to move to the new trade agreement.

LAURA STEER, SENIOR ASSOCIATE

More than £6 billion of international business is written in London by carriers with a parent company or principal base located elsewhere in the EU, and more than £8 billion of premium is brought to the London Insurance Market each year, by brokers on behalf of EU customers. It is therefore hoped that companies may choose not to make Brexit contingency plans and open offices outside of the UK, if they are reassured that European business will be maintained for UK insurers.

For more information, please contact Laura Steer, Senior Associate, London, on +44 (0)20 7264 8032, or laura.steer@hfw.com, or your usual contact at HFW.

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