HFW

INSURANCE BULLETIN
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In this week's Insurance Bulletin:

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1. COURT CASES AND ARBITRATION

England and Wales: Business interruption – proving the value of the claim

The case of *Contact (Print and Packaging) Limited v Travelers Insurance Company Limited*[1] concerned the failure of a printing press belonging to the claimant, which gave rise to a significant property damage and business interruption insurance claim. The court grappled with three principal issues: (1) was the loss caused by a covered peril, (2) was the claimant entitled to claim for the replacement (rather than repair) of the printing press, and (3) what was the true value of the BI claim?

As to issue (1), the mode of failure was cracking of teeth in some of the gears in the press. Insurers argued the cracks resulted from fatigue caused by gradual deterioration of the gears. The claimants argued that there had been a sudden displacement of the plinth on which the press was mounted, resulting in catastrophic cracking. The policy excluded claims arising from gradual deterioration, change in water table level, subsidence and settlement of new structures, but wrote back in claims arising from subsidence which was not caused by the normal settlement of new structures or the movement of "made-up" ground".

Whilst there was extensive expert evidence on this issue, the judge was hampered by a lack of contemporaneous investigation, and neither party was able to positively prove the cause of the failure. Nevertheless, the judge held that (a) there was no direct or compelling evidence that natural ground movement was not the cause of the failure and (b) it was the only cause which had not been ruled out as realistically implausible. Accordingly, he held that that the claim was covered under the subsidence write-back.

On the investigation point, the judge criticised the insurers for failing to warn the claimant that further investigations into the cause of the failure may be required to prove the cause of the loss, but noted that the law did not require an insurer to speak up and warn of the consequences of failing to investigate. This is not easy to reconcile with the decision in *Ted Baker v Axa Insurance* [2017] EWCA Civ 4097[2].

As to issue (2), the judge found that, in the circumstances of this case it was reasonable for the claimant to purchase a replacement press, rather than have the damaged one repaired.

In relation to issue (3), the policy indemnified the insured for reduction in turnover and additional increase in cost of working. The former was to be calculated by applying the rate of gross profit to the amount by which the turnover in the indemnity period fell short of the turnover for the immediately prior 12 month period. In ascertaining the rate of gross profit, adjustments were to be made to reflect business trends and changes in circumstances.

The claimant's primary position was that there were no adjustments to be made, and that it was simply a question of comparing the 12 months pre- and post-loss periods. The insurers argued that if proper adjustments were made, there was no loss. As usual in these types of cases, the parties produced expert reports from forensic accountants relying on wildly different assumptions and producing completely different results. The judge criticised the claimant for the paucity of evidence produced in relation to the state of the company at the time of the loss, in relation to which, documents had been neither retained nor disclosed. He found that the business had been in decline at the time of the loss, and that the claimant had failed to establish any claim for reduction in turnover. He made a small award in relation to the increased cost of working.

Business interruption claims are notoriously difficult to adjust and this case is a sage reminder of the burden on a policyholder to prove its loss of profit, rather than to rely simply on historical data.

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1. [2018] EWHC 83 (TCC)
2. Covered in our September 2017 Edition 1 Bulletin: http://www.hfw.com/downloads/HFW-Insurance-Bulletin-September-2017-Edition-1.pdf

England and Wales: · Contextualism in the interpretation of insurance contracts

This case[1] involved the proper construction of an exclusion clause contained in a series of Financial Guarantee Indemnity ("FGI") policies issued by the Insurer to the Insured, as part of a wider litigation funding scheme for personal injury solicitors. In determining the issue, the Court had to weight competing textualist and contextualist interpretations of the clause.

The funding scheme was structured as follows:

- A lender ("C") provided loans to the solicitors to fund their recoverable and irrecoverable costs;
- The Insurer provided: (i) Legal Expenses Insurance for clients entering into conditional fee arrangements with the solicitors; and (ii) FGI insurance for the solicitors themselves, in respect of their irrecoverable costs.

The Insured was a firm of solicitors which participated in the funding scheme. This involved:

- An umbrella agreement with C, setting out the general terms applying to the loans.
- An Irrecoverable Costs Loan Agreement ("ICLA") with C, in respect of each individual loan.
- An FGI policy written by the Insurer in respect of each funded case.

The Insured encountered financial difficulties. C terminated the umbrella agreement, leaving large sums due from the Insured to C. Under a refinancing agreement, C advanced significant further sums to the Insured, which were used to repay the existing loans.

The Insured claimed under a number of the FGI policies with the Insurer. The claims were disputed, and were ultimately the subject of proceedings. At first instance, the court found in favour of the Insured.

On appeal by the Insurer, the central issue involved the proper construction of an exclusion clause in the FGI polices, providing that the FGI polices would not respond:

"where the terms and conditions of the Loan have not been strictly adhered to, including but not limited to any agreement entered into by [the Insured] and [C] to repay a Loan."

The Court of Appeal had to determine whether or not the refinancing agreement constituted an "agreement entered into by [the Insured] and [C] to repay a Loan." The Insurer argued that it did, such that the exclusion operated. In particular, the Insurer argued that:

- The words were to be taken as meaning what they said, so as to extend the exclusion for breach of the Loan itself to breach of any agreement to repay that Loan; and
- The refinancing agreement was just that: an agreement to repay the loans advanced under all the extant ICLAs.

The Court of Appeal, however, held that the refinancing agreement did not constitute such an agreement. In doing so, the Court held that, in order properly to understand the clause, one had to have regard both to the context of the litigation funding scheme, and, in circumstances in which the meaning of the clause was ambiguous, to business common sense.

The litigation funding scheme was a highly structured arrangement, with detailed provisions. However, nothing in the financing documents, nor in the FGI policies themselves indicated that future global refinancing was in the contemplation of the parties.

For these reasons, in the Court's view the Insurer's construction of the policies did not accord with the context and background of the FGI Policies or with business common sense. Properly construed, the disputed part of the clause instead referred only to any replacement agreement entered into as part of the same litigation funding scheme

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1. *Nesbit Law Group LLP v Acasta European Insurance Company Limited* [2018] EWCA Civ 268

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to repay the individual loan under the ICLA in question. The appeal was accordingly dismissed.

The case is an interesting illustration that, following recent Supreme Court judgments in cases such as A*rnold v Britton* [2015] UKSC 36 and *Wood v Capita Insurance Services Ltd* [2017 UKSC 24, the courts will still give significant weight, in appropriate circumstances, to the underlying commercial arrangements and to business common sense, in construing contractual provisions. Notably, the Court took such an approach in this case, even in circumstances in which it found the Insurer's more textualist (but ultimately unsuccessful) argument *"beguilingly attractive for its simplicity and for the fact that it neatly gives meaning to every aspect of the exclusion clause."*

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England and Wales: · Claims aggregation in medical negligence insurance

In our bulletin of 13 January 2017[1], we reported that insurer RSA had succeeded in establishing that the lower of two policy limits applied to "linked" claims made under the medical PI section of a Combined Liability policy. That first instance judgment has now been upheld on appeal[2].

The insured, a private hospital operator, had paid more than £20m in respect of 700 or so negligence claims made by former patients. Its claims-made annual PI cover had a Schedule which provided a limit of £10m per claim, and of £20m in the annual aggregate. The body of the policy contained a clause (A) which stated that "all claims during any Period of Insurance …attributable to one source or original cause…shall not exceed the Limit of Indemnity stated in the Schedule", regardless of the number of claimants, and a clause (B) which stated that all claims made during the Period of Insurance, irrespective of the number of sources or original clauses or claimants "shall not exceed the Limit of Indemnity stated in the Schedule."

It was not expressly clear whether clause A referred to the £10m per claim or the £20m annual aggregate limit stated in the Schedule, and the clause did not expressly say that all claims attributable to one source or original cause (i.e. "linked claims") were to be treated as one claim (or Claim) for the purpose of applying the Limit. Spire argued for the £20m limit for linked claims, and RSA for the £10m limit. It appears there was no appeal against the Judge's earlier finding, in RSA's favour, that the policy deductible of £25,000 applied per claim (whether linked or not), up to a limit of £750,000.

In dismissing Spire's appeal against the Judge's finding that the £10m limit applied to linked claims, the Court of Appeal applied the following principles:

1. In construing the policy, the starting point was the combined effect of the relevant provisions, without giving greater weight to either the Schedule or the main policy wording; and,
2. the Court assumed the insured was a sophisticated reader of the policy, which had the benefit of professional advice;
3. the policy could have been drafted more clearly, but this was not uncommon and the Court should construe the contract as it is, not as it might have been drafted.
4. aggregation clauses can work either in the insured's or the insurer's favour, depending on the circumstances, and so the Court should not be predisposed to narrowing or broadening their effect.

The Court of Appeal held that the "cause or original cause" clause was clearly an aggregation clause: it identified a unifying factor and linked the claims, and it provided that the limit for linked claims could not be exceeded. Clauses A and B and the Schedule together provided a coherent scheme for limiting recovery in respect of a single claim (£10m), a set of linked claims (£10m), and

1. http://www.hfw.com/downloads/HFW-Insurance-Bulletin-13-January-2017.pdf
2. *Spire Healthcare Ltd v Royal & Sun Alliance Insurance Plc* 2018 WL 01116084

unlinked claims (£20m.) Lord Justice Simon said: "I accept that it would have been much neater and more elegant if linked claims were defined to constitute one single claim by an appropriate definition of "Claim" .... But, in frequently used, modified and revised policies of insurance, neatness and elegance are often lost." Since he found there was no ambiguity in the policy drafting, he saw no role for the doctrine of interpretation contra proferentem (i.e. where there is an ambiguity in the contract, that element will be construed against the author/insurer).

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2. MARKET DEVELOPMENTS

Global: Blockchain – friend or foe?

Insurers have recognised the need to adapt to evolving technological advancements and in particular, the advantages of Blockchain in circumventing possible data privacy issues. Distributed Ledger Technology offers not only added security through data encryption, but also a way to monetise data via the use of smart contracts and cryptocurrencies. This has the potential to challenge the dominance of tech giants, for example, Facebook, Amazon and Google, in relation to the use of data as a means of generating revenue.

We are seeing a greater emphasis on ensuring data privacy with the introduction of stricter rules in the EU such as the upcoming new General Data Protection Regulation this year. Blockchain allows individuals increased control over the use of their data and therefore avoids the problems of companies prying into personal data. In addition, Blockchain significantly diminishes the need for intermediaries. As a result, insurers are eyeing up the benefits of the new technology.

However, it is possible that peer-to-peer insurance models could be generated whereby the insurer is replaced by automated "smart contracts", which set out the parties' obligations and are stored on the blockchain. An example of a smart contract is "Fizzy", developed by Axa. Fizzy provides insurance against two hour plus flight delays using data automatically gathered from air traffic control.

Insurers will need to protect against the ever-expanding tech giants, particularly in view of Amazon's recent entrance into the healthcare market in the US and rumours that Facebook and Google are considering similar entries. However, insurers must balance this on the one hand with the threat of obsolescence posed by developments in technology on the other.

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3. HFW PUBLICATIONS AND EVENTS

Australia: HFW authors Australia chapter of 2018 Chambers & Partners Insurance Practice Guide

We are delighted to announce that HFW Partner Richard Jowett and Senior Associate Phil Kusiak of Melbourne office have authored the Australia chapter of the 2018 Chambers and Partners Insurance Practice Guide. The report, which covers everything from regulation to Insurtech, emerging risks and legal developments, is available to download here: http://www.hfw.com/Insurance-Practice-Guide-Chambers-and-Partners-2018.

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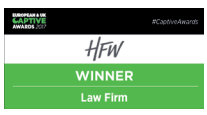

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