HFW

INSURANCE BULLETIN
SEPTEMBER 2024

In this Insurance Bulletin:

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"The report warns firms that the FCA will intervene as necessary to address issues and risks arising from non-compliance with the PROD 4 rules."

REGULATORY

FCA publishes product oversight and governance thematic review for general insurance and pure protection products

The FCA has recently published its thematic review looking at whether firms in the general insurance and pure protection sectors are meeting their product governance obligations under the rules in the FCA's Product Governance Sourcebook (PROD 4).

The rules in PROD 4 were revised in 2021, and introduced the requirement for firms to ensure that an insurance product which is within the scope of PROD 4 provides fair value to the customers within that product's target market.

Summary of Findings

As part of its review, the FCA analysed information from 28 manufacturers and 39 distributors.

The headline is that the FCA found that firms are not doing enough to comply with the PROD 4 rules. For manufacturers, the FCA appears frustrated by what it describes as shortcomings and inconsistencies in how firms approach their product oversight and governance arrangements. Similarly, for distributors, the FCA noted that some firms have made limited progress in relation to their understanding of their responsibilities under PROD 4.

Examples in the review of firms failing to comply with the PROD 4 rules included:

1. ineffective product governance frameworks;
2. shortcomings in the quality of fair value assessments;
3. a lack of granularity in target market statements; and
4. insufficient consideration of distribution arrangements.

However, the FCA did recognise that some firms had developed, and implemented, effective frameworks and procedures that were consistent with the PROD 4 rules.

Next Steps

In the review, the FCA indicates that it is disappointed to see firms failing to meet their regulatory obligations under PROD 4, and reminds them that the rules are designed to deliver fair value to customers. The key concern for the FCA is that shortcomings in compliance with PROD 4 create a risk of harm to customers.

The findings in the review echo the FCA's recent work on the implementation of the Consumer Duty, which found some firms failing to evidence fair value properly, not paying enough attention to distribution strategies and being unable to justify remuneration.

The report warns firms that the FCA will intervene as necessary to address issues and risks arising from non-compliance with the PROD 4 rules.

We have already seen the FCA intervene at a product level to address fair value concerns, including its recent intervention in respect of Guaranteed Asset Protection (GAP) insurance products. Looking ahead, at a market level, we are likely to see the FCA putting pressure on the general insurance and pure protection sectors to improve, possibly by introducing more detailed requirements around product governance and fair value. We might also expect to see a more targeted approach, with the FCA's frustrations translating into more severe interventions for firms that it considers risk customer harm due to non-compliance with the PROD 4 rules.

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FCA publishes review of the oversight of appointed representatives

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Following the FCA's introduction of enhanced rules on the oversight of appointed representatives (ARs) on 8 December 2022, the FCA has recently published the findings of its review on how principals are adhering to these increased expectations. The review of 270 firms found that compliance with the AR regime requires improvement.

Despite 96% of principals expressing confidence in their effective implementation of the rules, the FCA identified significant gaps in oversight. Some principals were adopting a tick-box approach to compliance and relying on superficial measures such as website checks or self-declarations from their ARs, rather than ensuring thorough and effective supervision. Most principals had also not changed their onboarding or termination provisions, despite the need to consider these processes in the light of new rules, and to be able to evidence that they are robust and sufficient.

Further information on the FCA's findings is as follows:

Self-Assessments

The FCA found that only slightly over half of the self-assessments which it reviewed were of a good quality, while just under one-fifth of principals had not conducted the self-assessment at all. The FCA set out examples of good practice, which include self-assessments that evaluate the firm's oversight of ARs, the adequacy of its controls, and resources. Findings should be compiled into a single document with an action plan to address compliance gaps. These assessments must be conducted annually and should avoid a tick-box approach, ensuring all concerns are addressed.

Annual Reviews

The FCA found that less than half of the reviewed annual reviews were of a good quality, while 18% of principals had not conducted the annual review at all. Principals are expected to undertake an annual review of their ARs' business models and activities, including any unregulated business. Similar to self-assessments, the included examples of good practice and areas for improvement make clear that annual reviews should avoid a tick-box approach and ensure comprehensive evidence-gathering to meet all regulatory requirements. Consumer Duty compliance should be embedded into the review, such as considering fair value assessments and staff training on the Duty.

Monitoring, Oversight, and Acting Out of Scope

The FCA found that only half of principals held regular meetings with their ARs, and fewer than a third reviewed consumer-facing materials or management information to ensure that they were operating within scope. Good practice includes monitoring proactively ARs' monthly activities, conducting in-person visits, and comparing activity reports submitted by ARs with the principal's own data. This includes filing calls with ARs and observing interactions between ARs and consumers. Areas of improvement include not understanding the AR's business model, and the AR agreement failing to state clearly the regulated activities that the AR is permitted to carry out.

Onboarding

The FCA found that only one-tenth of principals have revised their AR onboarding procedures to align with the new rules and now conduct more detailed checks. The FCA sets out that good behaviour includes documented procedures for onboarding to be kept up to date, with ongoing training provided. Principals should not solely rely on automated checks for background searches and should consider the impact of the AR's appointment on their financial and non-financial resources.

Termination, Offboarding, and Orderly Wind-Down

The FCA found that only one-tenth of principals have revised their AR terminations procedures to align with the new rules, with some

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taking additional steps to ensure orderly wind-down. As set out in the examples of good practice, principals are expected to implement policies for the termination of AR agreements when the relationship is no longer beneficial. This helps avoid the "halo effect" of being listed on the Financial Services Register purely to promote risky unregulated activities. The AR's website should be reviewed following termination to ensure it no longer states that the AR can undertake regulated activities on behalf of the firm.

Next steps

The FCA's conclusions were similar to those of its recent review of monitoring under the Consumer Duty[1]: some principals have made efforts to embed the new rules, but the FCA requires improved compliance with the AR regime. Jane Savidge, the Interim Head of Department for ARs, observes that some principals are failing to *"get the basics right"* by adopting a *"bare minimum"* approach.

It is therefore crucial that principals ensure they have assessed their existing processes in response to the new rules and have sufficiently documented any revisions. The FCA has followed up directly with firms in the review and will take swift action where it sees principals not meeting its standards in the future.

We discuss more about whether and when a principal can limit third party liability for its ARs in our article by Simon Williams below.

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1 https://www.hfw.com/insights/insurance-bulletin-july-2024

What? How? Can a Principal limit third party liability for its Appointed Representatives?

The Court of Appeal clarified in *KVB Consultants v Jacob Hopkins McKenzie* that a principal of an appointed representative (AR) can limit its third party liability for what activity the AR carries out, but not how it carries out an activity.

In our briefing here, we discuss some examples to illustrate what this might mean, where there might be grey areas, and action points for parties when structuring new relationships or reviewing existing ones.

Insurance Brokers' Regulation 2024 in the UAE

On 25 July 2024 the Central Bank of the UAE issued a new Insurance Brokers' Regulation.

Whilst there is some degree of continuity, the Regulation introduces some new elements, some of which will likely have significant impact on the way in which insurance broking business in the UAE is carried out. In our briefing note here we discuss the changes in more detail.

Court of Appeal decision on "at the premises" wording

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"It remains to be seen if this is the final word on the causation issues arising from these policies"

The Court of Appeal has handed down its judgment on whether non-damage business interruption cover responds to the COVID-19 pandemic where the insuring clause requires there to be disease "at the premises"[1]. Although applying a different approach to the first instance judge, the Court of Appeal reached the same conclusion, holding that these clauses do in principle respond to the interruption caused by COVID-19 restrictions.

Background

The judgment concerns preliminary issues in a number of matters heard together. In each case the relevant business interruption policy wording was triggered by interruption or interference resulting from either an occurrence of a notifiable disease at the premises (ie a disease clause), or by order or advice of any local or governmental authority as a result of an outbreak or occurrence at the premises of notifiable disease (ie a hybrid clause)[2]

It was assumed for the purposes of the preliminary issues being considered that the insured would be able to prove a case of COVID-19 at the premises.

At first instance, it was held that the logic and rationale of the Supreme Court's decision on causation in relation to radius clauses in *FCA v Arch*[3] applied to at the premises wordings. The Supreme Court held that each case of COVID-19 within the radius was a concurrent cause of the government restrictions.

Appeal

Insurers criticised this approach. They said that, rather than simply applying the FCA Test Case approach, the court should have construed the clauses on their own terms. Insurers made two arguments: either that "but for" causation applied (i.e. it must be shown that the restrictions would not have been imposed "but for" a case at the insured premises), or that there was cover only where the occurrence of disease at the premises was a "distinct effective" cause of the closure. On either case, it would be necessary that a case at the premises had some direct causal effect on the action of the Government, as opposed to being one of many concurrent causes.

Insurers drew a distinction with radius clauses. They argued that radius clauses, some of which had radii of 25 miles, contemplated a wide-area effect by their nature. By contrast, a clause insuring the consequences of disease at the premises is focussed exclusively on the specific insured location. In one of the cases insurers argued that the authorities must have known about the disease on the insured's premises for it to have made a contribution to the decision to impose the restrictions and therefore be causative.

Appeal judgment

The Court of Appeal agreed with insurers that the correct approach was to interpret the policies with regard to their language and context, and not to ask whether they differed materially from the radius clauses in *FCA v Arch*. With this in mind, the nature of the insured peril would inform the required test of causation between the peril and the loss that the parties had agreed to.

Nevertheless, the Court found in favour of the policyholders. The insured peril required the occurrence of a notifiable disease which was, by definition, capable of spreading widely and rapidly affecting a large area. Therefore, if they had turned their minds to it, the parties would have contemplated that restrictions would be likely to be imposed in response to an outbreak of notifiable

1 The cases are *LIEC v Allianz, Hairlab v Ageas, Mayfair v AXA, Kaizen Cuisine v HDI* and *Why Not Bar v West Bay* [2024] EWCA Civ 1026

2 The precise wording of each clause being considered varied

3 [2021] UKSC 1

disease as a whole, and for the clause to have meaning the parties must have intended cover in such circumstances. Therefore, it could not have been intended "but for" causation should apply. Instead, the parties must have intended that the causation requirement would be satisfied if the occurrence of disease at the premises was one of a number of causes of the closures.

It was not necessary for the authorities to know of the occurrence at the insured premises in making the restrictions, albeit that there must have been such a case as a matter of fact. The response of the authorities was to all cases of COVID-19 whether known or unknown. Therefore, in ordering the national lockdown the government was responding to disease at the premises in combination with all other cases of COVID-19.

The Court also found the following in the context of the specific wordings:

- "Public Authority" is not limited to local authorities and includes measures by the government or any public body; and 'Medical Officer of Health' includes the Chief Medical Officer, Deputy Chief Medical Officer and other medical officers advising such public bodies.
- It was not enough to trigger cover that someone was at the premises with COVID-19 at a time before it became a notifiable disease. The insured peril required an occurrence of a notifiable disease at the premises – and an occurrence is well-known to be something that happens at a particular time at a particular place in a particular way. That requirement is simply not fulfilled if a person does not have a notifiable disease when they are present. The insured's appeal on this point was rejected.
- The word "suffered" in the phrase "suffered by any visitor or employee" meant occurred or sustained, and did not mean the same as manifested, in the sense of it being apparent.

Conclusion

It remains to be seen if this is the final word on the causation issues arising from these policies, or if there will be an appeal to the Supreme Court. However, an important issue remains as to how policyholders establish a case of Covid-19 at their premises and, in particular, whether they can do so by reference to statistical modelling.

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"Although a professional indemnity policy requires a claim to be notified, in order for an insured to be indemnified, the insured must first suffer a loss."

To trust or not to trust, what happens to insurance proceeds held by an insolvent insured?

The claim in *Wood v Desai*[1] concerned an attempt by third party claimants to obtain the monies paid under a professional indemnity insurance policy to the insured professional, against which the claimants alleged a professional negligence claim.

Although the insured's liability in respect of the professional negligence claim had not been established, insurers had paid out the policy limit in settlement of their liability under the policy, as they were contractually entitled to do. Subsequent to the insurance payment, the insured went into liquidation. The claimants argued that they had a proprietary interest over the insurance monies which the insured had received by way of a constructive trust or, in the alternative, unjust enrichment.

Background

Boscolo Limited (the "Company"), provided interior design and project management services. The claimants issued a professional negligence claim against the Company following an alleged breach of contract for interior design services provided in relation to an apartment in Hampstead, London. The contract between the parties incorporated the British Institute of Interior Design Conditions which required that the Company obtain and maintain professional indemnity insurance. The Company already had such cover with a limit of indemnity of £250,000 for any one claim, in excess of £500.

After the claimants' claim had been notified, insurers initially took control of the defence, and the parties corresponded to explore settlement. However, the Company was in financial difficulty at that stage. As permitted under the claims conditions of the policy, insurers paid the Company the limit of indemnity *"in connection with"* the claim and relinquished control of the defence. The Company instructed their own

1 [2024] EWHC 1893 (Ch)

solicitors to handle the claim, who were subsequently paid part of the indemnity on account of costs.

The claimants issued proceedings against the Company for the sum of £700,000 in contract and negligence, arguing there was a constructive trust over the balance of the insurance monies and, in the alternative, claimed unjust enrichment or damages for breach of contract. The claimants also issued proceedings against insurers for intentionally procuring a breach of contract and/or knowingly assisting in a breach of trust.

The Company subsequently entered voluntary liquidation. The Company's only remaining asset was its bank balance of £246,000 which included the balance of the insurance monies paid under the policy. It had a number of creditors, the biggest of which was one of the directors of the Company itself. Liquidators sought directions from the Court under section 112 of the Insolvency Act in relation to the monies.

The parties' positions

The claimants argued that they had a proprietary interest in the insurance monies as follows:

1. On a true construction of the contract for services, the claimants were beneficiaries of the policy in equity. As such, any insurance monies received by the Company were held by them as agent or trustee and such a term should be implied as it was so obvious that it would go without saying this was the intention and would be necessary to give the contract business efficacy in the circumstances.[2]
2. In the alternative, the claimants argued the insurance monies were subject to a constructive trust and it would be unconscionable for the Company to assert any beneficial title over them as the monies had been provided to protect the Company's clients against potential insolvency. If the Company retained the insurance monies or paid them to their creditors, those monies would have "come to the wrong hands" in the eyes of equity.[3]
3. A constructive trust would also prevent unjust enrichment of the Company where the insurance monies had been paid at the expense of the claimants' clear contractual protection pursuant to the conditions for insurance under the contract.

In response to the constructive trust argument, liquidators relied upon case law which established that no special rights applied to insurance monies in circumstances of insolvency and accordingly, the insurance monies should remain part of the Company's general assets.[4] Liquidators also disagreed that it was an implied term in the contract that an effective policy had to be in place.

They did not agree that the insurance monies had been paid in acknowledgment of the Company's liability, particularly where the Company's liability had not been established at that point in time, as proceedings remained ongoing. Further, it was not unconscionable for the Company to treat the payment as part of its general assets in the absence of express terms confirming that any property obtained by the Company would be held on trust for its clients.

Liquidators challenged the claim for unjust enrichment on the basis that the legal conditions required under case law did not arise, particularly in circumstances where the claimants had not been deprived of any benefit that they would have otherwise been entitled to by way of the policy. The policy was granted to the Company for the Company's benefit.

Judgment

Justice Paul Matthews held the insurance monies belonged to the Company and, under the usual insolvency process, the liquidators were entitled to deal with them as necessary. He found as follows:

1. Although a professional indemnity policy requires a claim to be notified, in order for an insured to be indemnified, the insured must first suffer a loss i.e. civil liability must be established (following the well-known authority *Post Office v Norwich Union*[5]). In this case, no such liability had been established to the claimants because negligence proceedings were ongoing. The Judge acknowledged that it would not be impossible for a professional indemnity policy to be held in some form of trust by the insured for the benefit of its clients, but in the absence of a form of specific agreement or declaration of trust that would not be the case. The policy in this case was not expressed to be for one project or for any particular clients, but was for all work on an ongoing basis.

   Turning to the wording of the Code of Conduct which had been incorporated into the contract between the parties (which the claimants pointed to in order to distinguish this matter from prior case law), the responsibilities to obtain insurance were expressly owed to the "institute and the interior design profession" and not necessarily for the benefit of any clients. This necessarily also applied to insurance proceeds, and therefore the Company did not hold the insurance proceeds for the benefit of the claimants.
2. The Judge did not agree that a term should be implied to the effect that the clients should have a proprietary interest in the insurance proceeds, as it was not so obvious that it was required to give business efficacy to the contract. The absence of case law successfully supporting the claimants' argument was a clear indicator that such an implication was incorrect. The insurance made business sense without the need to imply such a term in that it was obviously beneficial to the Company to have professional indemnity insurance.
3. As to the constructive trust: first, a payment made by an insurer

2 The claimants referred to the Privy Counsel's application of the Supreme Court's decision in *Marks & Spencer's plc v BNP Paribas Securities Services Trust Co (Jersey) Ltd* [2016] AC 742 on the rules for implication of terms in *Ali v Petroleum Company of Trinidad and Tobago* [2017] ICR 532

3 Pursuant to Lord Sumption's judgment in *Angove's Pty Ltd v Bailey* [2016] 1 WLR 3179 SC

4 Re *Harrington Motor Co Ltd, ex p Chaplin* [1928] Ch 105, *Hood's Trustees v Southern Union General Insurance Co of Australasia* [1928] Ch 793. Notably, this case law led to the enactment of The Third Party (Rights Against Insurers) Act 1930 which outlines that such monies would be earmarked in certain circumstances.

5 [1967] All ER 577

under a contractual policy right, before liability is established, to discharge the insurer's possible future obligations to indemnify under the policy, is not necessarily the traceable exchange product of the contractual right to indemnity. There is no contractual right to an indemnity until liability to the third party is established. Further, the Judge disagreed with the claimants' application of *Angove's Pty*. In the circumstances and in light of the mechanics of an indemnity policy, the insurance monies had been paid to the "right" (as opposed to the "wrong") hands.

4. Although he was not required to do so given that the claimants' position on a constructive trust was incorrect, the Judge considered the claimants' unjust enrichment claim. There was no unjust enrichment as no additional or "over" value was gained by the Company: the potential rights under the policy had been exchanged for the payment. Further, no loss has been suffered by the claimants because of the payment by the insurers,

The Judge therefore directed that the insurance payment belonged to the Company beneficially.

Discussion

Justice Paul Matthews' decision highlights the common law position where the Third Parties (Rights against Insurers) Act 2010 does not apply[6]. The timing of (i) the receipt of the insurance monies and (ii) the insured's insolvency (i.e. after the payment) were key factors in the decision. If the sequence of events had been different, the Third Parties Act may have allowed the claimants to bring both the liability claim and a claim against insurers under the policy, and potentially obtain a different outcome

It is understood that an application for permission to appeal has been made.

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6 Or the Third Parties (Rights Against Insurers) Act 1930 if still relevant under the transitional provisions