Insurance Litigation

Contributing editors
Mary Beth Forshaw and Elisa Alcabes

2018

GETTING THE DEAL THROUGH

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Insurance Litigation 2018

Contributing editors

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Simpson Thacher & Bartlett LLP

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Preface

Insurance Litigation 2018

Fifth edition

Getting the Deal Through is delighted to publish the fifth edition of *Insurance Litigation*, which is available in print, as an e-book and online at www.gettingthedealthrough.com.

Getting the Deal Through provides international expert analysis in key areas of law, practice and regulation for corporate counsel, cross-border legal practitioners, and company directors and officers.

Throughout this edition, and following the unique **Getting the Deal Through** format, the same key questions are answered by leading practitioners in each of the jurisdictions featured.

Getting the Deal Through titles are published annually in print. Please ensure you are referring to the latest edition or to the online version at www.gettingthedealthrough.com.

Every effort has been made to cover all matters of concern to readers. However, specific legal advice should always be sought from experienced local advisers.

Getting the Deal Through gratefully acknowledges the efforts of all the contributors to this volume, who were chosen for their recognised expertise. We also extend special thanks to the contributing editors, Mary Beth Forshaw and Elisa Alcabes of Simpson Thacher & Bartlett LLP, for their continued assistance with this volume.

GETTING THE DEAL THROUGH

London
February 2018

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United Kingdom

Hermes Marangos, Tom Rotherham and Lucy Alexander

Signature Litigation LLP

Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

In England and Wales, insurance disputes are litigated in the following fora of the civil courts:

- county courts;
- High Courts;
- the Court of Appeal; and
- the UK Supreme Court (although only on appeal from either the High Court or the Court of Appeal).

Claims with a value of more than £100,000 can generally be issued in the High Court in the first instance, otherwise appeals may be heard here from the relevant county court. If the dispute in question involves particularly complex insurance or reinsurance issues, then it may be heard in the Commercial Court (a specialist part of the Queen's Bench Division). Judges in the Commercial Court have extensive experience specific to the disputes over which they preside. Disputes that require financial market expertise will likely be heard in the Financial List of the Commercial Court.

It is commonplace for a reinsurance contract to contain an arbitration clause. If correctly drafted (and therefore enforceable), the parties will have to resolve their dispute via arbitration, which may be conducted under ad hoc rules or those of a particular arbitral institution.

It is important to note that a reinsurance contract may also require the parties to submit their dispute to another dispute resolution mechanism before litigation or arbitration, for example submission to a reinsurance mediator. The English court will also encourage parties to attempt alternative dispute resolution (most often mediation) before litigating; failure to do so may result in costs penalties.

2 When do insurance-related causes of action accrue?

The general rule is that a claim for breach of contract must be brought within six years of the accrual of the cause of action. This will in most cases be six years from the breach, but this is obviously harder to ascertain with insurance policies.

With regard to liability policies, the right to indemnity is triggered when the liability is ascertained, which may be in the form of an agreement, an award or a judgment. With property, marine or life policies, the cause of action will be deemed to be when the event occurs.

3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The following should be considered at the outset of an insurance dispute:

- limitation: you should ensure that, if acting for the claimant, that the claim is within the limitation period (see question 2);
- the dispute resolution clause and choice of law: it is very important to consult the policy wording, to see what method of dispute resolution is provided for, and under which law. It is common for insurance disputes to be arbitrated, and for this to be reflected in the policy;
- pre-action steps such as protocol compliance and mediation: insurance disputes rarely call for onerous pre-action steps, but it is worth checking to avoid being penalised. The court will certainly want to see evidence that the parties have first attempted mediation;
- time and cost: the English court system requires a certain level of front loading of court costs, which should be considered at the outset of a dispute. There will likely be at least a year between commencing a claim and the trial. The winning party may be able to redeem most of their costs from the other side after judgment;
- disclosure: disclosure is quite an onerous obligation in the English legal system, as parties must disclose documents that both help, and are adverse to, their case. As a result, this can be quite a timely and expensive process;
- appeals: the right to appeal a decision is not automatic in every venue in the English court, and can be at the judge's discretion. In addition to this, an appeal can take up to a year to execute, which usually has serious cost implications for both parties. Arbitration typically carries little scope of appeal;
- confidentiality: it's important to bear in mind that, unlike arbitration, litigation in the English courts is public (unless there is very good reason for it not to be);
- mitigation: the party seeking to prove they have suffered a loss is under a duty to mitigate said loss. If this is not done, then any compensation awarded may be reduced as a result; and
- commercial relationships: it's important to consider at the outset of a dispute whether litigation is the best course of action. It can irrevocably damage any continuing business relationship between parties, and so negotiation or mediation may sometimes be a better way forward.

4 What remedies or damages may apply?

For the insured

The insured will most likely want a fully and timely indemnity as allowed for by the policy. In a departure from historical treatment of late payment, the Enterprise Act 2016 introduced an implied term in insurance contracts whereby insurers must pay sums 'within a reasonable time' (although this can be contracted out of in non-consumer contracts). A breach of this implied term will give rise to a claim for damages. The insured must bring a claim for late payment within one year of payment by the insurer.

For the insurer

The insurer will most likely want a declaration of non-liability for the claim in question. Before the Insurance Act 2015 (the 'Act') came into effect, the main remedy for an insured's breach was avoidance of the claim (if the breach was of a warranty or a condition precedent, or in the case of material non-disclosure). Since August 2016, however (when the Act came into force), the remedies available to the insurer have been altered. The Act applies to consumer contracts (save for Part A). It will also apply to non-consumer contracts, to the extent that its provisions (all but the section prohibiting basis clauses, which will apply regardless) are not contracted out of by the parties. The new remedies are as follows:

- a breach of warranty will now suspend the policy, rather than avoiding it, and so the insurer will continue to be liable if the breach is remedied before the loss occurs. This is because, under the Act, all warranties have become 'suspensive conditions'. It is also worth noting that all basis of contract clauses (where pre-contractual

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representations are converted into warranties) are now prohibited, and parties are not able to contract out of this position;
- the duty of disclosure now falls within a wider duty on the insured to provide insurers with a fair representation of the risk. If a breach is not deliberate or reckless, then the aim will be to put the insurer in the position that it would have been in had there been fair disclosure as follows:
  - where the insurer would have declined the risk, the policy can be avoided;
  - where the insurer would have accepted the risk but with additional contractual terms, the contract will be treated as if such terms were included; and
  - where the insurer would have charged a greater premium, the claim will be scaled down proportionately.

5 Under what circumstances can extracontractual or punitive damages be awarded?

The general rule is that extracontractual or punitive damages will almost certainly not be awarded for breach of contract under English law. The court may award simple interest as provided for by the Supreme Court Act 1981.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

Insurance policies are interpreted in accordance with the general principles of contractual construction. This means that the court will take an objective and commercial approach in trying to decipher the intentions of the parties at the time of agreeing the policy in question. This will be achieved by reference to what a reasonable person, having all the background knowledge that would have been available to the parties, would have understood them to be using the language in the contract.

The Consumer Rights Act 2015 serves to protect the insured against terms in policies that are deemed unfair. If a term is not deemed transparent or prominent within the policy, then it can be assessed for unfairness and can in turn be challenged.

7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision will be deemed ambiguous if there is more than one credible interpretation. This ambiguity will be resolved by applying the following principles, to fulfil the objective set out in question 6:
- natural meaning of words: the starting point will be the natural meaning of the words used, although in an insurance context it's important to note that words in a policy, specifically loss-causing events, can have multiple natural meanings;
- precedent: the court will consider previous decisions to help decide an ambiguous provision, but they will not be bound by these;
- contra proferentem: any ambiguity will be decided against the person who drafted the policy, which will usually be the insurer, but may sometimes be the broker (as agent to the insured);
- extrinsic evidence: the court takes an objective approach to ambiguous provisions, and so extrinsic evidence will not be considered;
- business common sense: if a provision is ambiguous and there is more than one possible construction, the court will choose the one that makes the most commercial sense, but they will not reject the meaning simply because one party made a bad bargain;
- implied terms: the court is reluctant to move away from express wording, but they may be willing to imply certain terms if they still cannot ascertain the meaning; and
- Consumer Rights Act 2015: if a term in a consumer contract, or a consumer notice, could have different meanings, the meaning that is most favourable to the consumer will prevail.

Notice to insurance companies

8 What are the mechanics of providing notice?

Typically, the insurance policy will specify how and when a notification should be made (in addition to what needs to be notified). Any notice requirements should be strictly complied with, so that cover cannot be denied. The insured must give the insurer the details of the loss, including time and place, to enable the insurer to obtain sufficient evidence to meet the claim. There is likely to be a time limit to give notice of a claim, after which cover may be refused (see question 11). As of 4 May 2017, indemnity insurers are also under a time limit, whereby they have a legal obligation to pay valid insurance claims within a reasonable time. This duty applies to all insurance and reinsurance policies taken out, varied or renewed from 4 May 2017.

It is important to remember that blanket notifications, covering unknown losses or events, may well be rejected by the insurer. It is therefore prudent for the insured to be as specific as possible about the facts giving rise to the claim.

9 What are a policyholder's notice obligations for a claims-made policy?

Under a claims-made policy, the policyholder must notify a claim during the period agreed under the policy, but the liability on the insured may have occurred prior to the policy.

The policyholder is also under a duty of fair representation, which means that they will have to disclose every material circumstance that he or she knows or ought to know, or sufficient information to put a prudent insurer on notice that it needs to make further enquiries into the identified material circumstances.

10 When is notice untimely?

Notice of a loss or a claim must be given within the time specified by the policy itself, or upon the occurrence of the event giving rise to the loss or claim.

Giving notice of circumstances, which may give rise to a loss or claim, must be done as soon as reasonably practical or possible. It is best to be prudent to avoid denial of coverage, although it can be difficult to predict whether a claim will emerge. See question 8 regarding the dangers of blanket notifications.

11 What are the consequences of late notice?

The consequences of late notice will vary depending on the wording of the policy, and whether the notice provision is a condition precedent to indemnity or a condition. If notice is considered to be just a bare condition of the contract, then the insurer will have to prove harm in order to avoid the policy.

Before the Act came into force, conditions precedent had to be fully complied with on a very strict basis. If the insured breached one of these then the insurer could refuse cover, regardless of whether they had suffered any material harm or prejudice as a result. Now breach of conditions precedent do not allow the insurer to deny cover, provided that the insured can prove that non-compliance could not have increased the risk of the loss which occurred. This protection is only available in consumer contracts, and, more importantly, only if the term does not 'define the risk as a whole'.

If a notice provision is deemed to be caught by this protection, in practice the insurer will likely deal with a breach by claiming that they have been prejudiced by the late notice. They will argue that, as a result, they have been unable to properly investigate and deal with the claim, and so will reduce compensation available to the insured (potentially by up to 100 per cent depending on the harm caused by the breach).

The Court of Appeal has recently stressed that conditions precedents will only be deemed as such if they are set out in very clear terms, and any ambiguity will be decided in favour of the insured. In addition, a recent High Court case considered that claims cooperation conditions and conditions requiring the provision of information were more than capable of being conditions precedent, as the 'commercial purpose of [these] conditions is obvious', and in this case they related to a liability that had already arisen (*Denso Manufacturing v Great Lakes Reinsurance* [2017] EWHC 391 (Comm)).

Insurer's duty to defend

12 What is the scope of an insurer's duty to defend?

As a general rule, under English law, an insurer is not under any duty to defend a claim made against an insured. The policy may, however, provide that the insurer will do so (usually subject to the insurer's view on whether a defence has a reasonable chance of success). Insurers may agree to this obligation in a bid to make their policies more attractive. In this situation, a contractual duty to defend will materialise, and any

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breach of this will give rise to a claim for damages and other remedies for breach of contract.

The more common practice is to have subrogation and assignment clauses contained in the policies. A subrogation clause gives the insurer the right, once it has paid the insured under the policy, to 'step into their shoes' and recoup some if not all of their losses from a third party. This secondary claim would be in the name of the insured, from whom the insured would then claim any sums received by way of compensation. An insurer may also be subrogated to any benefits that a court may award, for example interest and costs. An assignment of the rights under the policy required agreement of the parties, and will enable the insured to pursue the claim in their own name.

13 What are the consequences of an insurer's failure to defend?

As discussed in question 12, the insurer may agree to a contractual duty to defend a claim, but this will usually have a caveat of only arising where there is a reasonable chance of a defence succeeding. A dispute may arise between the parties as to what constitutes a 'reasonable chance', in which case the parties would follow the dispute resolution mechanism outlined in the policy itself.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

'Commercial General Liability' is now used in the insurance market to describe some insurance policies in England and Wales. These policies are more widely described as being public and product liability policies, which provide cover in respect of an insured's liability to third parties in respect of personal injury or property damage caused by the insured. It is normal for 'personal injury' to be defined by the policy and such definitions usually cover injury, sickness, disease and death resulting from such an injury.

15 What constitutes property damage under a standard CGL policy?

Property damage in a public and product liability policy is typically defined as being loss or physical damage to the property of a third party.

16 What constitutes an occurrence under a standard CGL policy?

Public liability policies are 'occurrence' based, where the policy is triggered on the occurrence of the insured event – usually bodily injury or property damage specified in the policy. In contrast, product liability policies can be occurrence or 'claims-made' policies. Under a claims-made policy, indemnity is triggered by notification of a claim or circumstance to the insurer.

17 How is the number of covered occurrences determined?

Typically, a policy will specify a certain level of cover per claim, and that the total cover provided will be subject to an aggregation of claims, whereby all claims arising out of the same occurrence are treated by the insurer as a single claim. Whether or not different claims 'aggregate' for the purpose of cover has been the subject of a great deal of litigation and its outcome is usually sensitive to the relevant facts and policy wording. Nevertheless, analysis of what is an occurrence is considered by reference to a number of factors including time and location.

In March 2017 the Supreme Court handed down one of the most important judgments related to aggregation provisions in recent years, in *AIG Europe Limited v Woodman and others* [2017] UKSC 18. The decision provided useful guidance on the meaning of the phrase 'a series of related matters or transactions' when used in an aggregation clause, namely that this requires some 'real connection' between the transactions. The judgment also serves as a reminder that the application of any aggregation clause is a fact-sensitive exercise.

18 What event or events trigger insurance coverage?

As set out in the answer to question 16, there are crucial differences between occurrence-based and claims-made policies. Policies written on a loss-occurring basis are triggered by the occurrence of bodily injury or relevant damage (as specified by the policy). Claims-made policies are triggered by notification of a claim or circumstance to the insurer. For this reason, compliance with notification provisions is essential to ensuring cover is provided under a claims-made policy.

Update and trends

In *Ted Baker v AXA* [2017] EWCA Civ 4097 the Court of Appeal considered the issue of an insurer's duty to speak during the claims process, to avoid being estopped from arguing certain procedural defences later down the line. Although an insurer is 'generally speaking, under no duty to warn an insured as to the need to comply with policy conditions', the Court of Appeal found that a duty to speak, in this case to make its position plain, may arise 'if, in the light of the circumstances known to the parties, a reasonable person in the position of the person seeking to set up the estoppel would expect the other party acting honestly and reasonably to take steps to make his position plain'. The decision makes it clear that this principle would be of general application.

In terms of emerging trends, 2018 will likely see an increased focus on cyber security and the different types of cover sought by insureds. An increasing number of cyber attacks will in turn increase claims under D&O policies for breach of duties.

19 How is insurance coverage allocated across multiple insurance policies?

One insurer may pay the claim and then seek recovery from the other insurers, however insurers will often include wording to exclude cover where there is more than one policy.

First-party property insurance

20 What is the general scope of first-party property coverage?

First-party property insurance provides cover for loss or damage to an insured's goods or buildings, or both, following the occurrence of an insured event. Policies can either specify an event that is insured against or operate as an 'all risks' policy.

The goods covered by such insurance are usually listed in the policy and are only covered if they are stored in a specified location (eg, artwork kept in a secure gallery or a car kept in a garage). Typically, first-party property policies will include a number of exclusion clauses covering normal wear and tear that occurs during normal use of the specified goods, arson and fraud.

Policies also usually include an 'excess' (or 'deductible'), which is the amount of loss the insured is responsible for before it is entitled to be indemnified by insurers.

21 How is property valued under first-party insurance policies?

Under an 'unvalued' policy, the insured property is valued as at the date of the reported loss with the principal that an insured is barred from recovering more than this amount (ie, the actual loss suffered).

As the name would suggest, a 'valued' policy allows the insured to fix the value of an insured item as at the date of the policy. The insured can therefore recover the full value insured if a total loss of the property is sustained. Typically, valued policies are purchased for high-value single items such as jewellery or artwork.

22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

Insurance against losses arising from natural disasters is widely available in England and Wales. Policies will usually specify the location of the insured risk, with most polices having extra territorial effect given that natural disasters such as hurricanes, wild fires and earthquakes do not occur in England. Insureds should always carefully consider governing law and jurisdiction clauses in policies that operate with extraterritorial effect, as well as stating the currency in which claims will be paid.

Natural disaster policies are 'occurrence'-based policies and therefore issues of aggregating numerous 'occurrences' into a single claim (establishing the cause of occurrence of a particular loss can be particularly challenging in the wake of a natural disaster) can lead to litigation between insurer and insured.

Directors' and officers' insurance

23 What is the scope of D&O coverage?

D&O policies are 'claims-made' polices that protect the insured from loss suffered as a result of a third-party claim following an alleged wrongful act by the insured. Policies normally define 'wrongful act' as

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actual or alleged breach of director's duties, the making of misleading statements, misrepresentations or other errors or omissions that give rise to a claim. As is the case with other claims-made policies, a claim notified in 2018 that is still ongoing in 2020 is covered under the 2018/19 policy and will be excluded from the 2020/21 policy.

Coverage under D&O policies is usually broken down into three 'sides' of the policy wording:

- side A cover – covers losses suffered as a result of a claim against a director or office that cannot be indemnified by the company;
- side B cover – covers indemnifications made by the company to a director or officer in respect of a claim made by a third party; and
- side C cover – covers claims brought against the company by its shareholders.

In addition to the cover above, the policy will also specify if there is a deductible to be retained by the insured, as well as any exclusions or exceptions to cover. Typical exclusions are fraud and for 'insured v insured' claims where a director who is also a shareholder makes a claim under the policy, or the company brings a claim against one of its directors.

24 What issues are commonly litigated in the context of D&O policies?

Common issues that arise between insurer and insured in respect of D&O policies include disagreements over the definition of 'director' and 'wrongful act' in the policy, whether a claim was notified in time and in accordance with the notification provisions set out in the policy and whether any pre-existing exposure to claims were properly disclosed to the insurer prior to the inception of the policy.

Cyber insurance

25 What type of risks may be covered in cyber insurance policies?

The main heads of cover under a standard cyber policy are typically:

- network security and privacy liability;
- privacy breach response costs and security event costs;
- regulatory defence costs;
- cyber BI cover;
- data and software restoration; and
- cyber extortion.

In some cases, reputational risk cover can also be added, although this is difficult to quantify and capacity in this area is limited.

The definition of security breach will generally include denial of service attacks, transmission or receipt of malware and viruses and unauthorised access or use.

26 What cyber insurance issues have been litigated?

While cyber policies are too recent to have produced any substantive case law, there have been multiple disputes between insurer and insured in respect of cyber policies. In the United States a number of insureds have made claims under cyber policies where funds have been voluntarily sent to a fraudster as a result of an email scam. Insurers usually deny coverage under a cyber policy in these instances because funds were sent voluntarily rather than hacked or stolen. Conversely, insurers have tended to cover the payment of Ransomware attacks, but disputes have arisen in respect of quantifying the resulting business interruption loss to the business while IT services are suspended.

The best practice is for all insureds to remain aware of the fundamental aspects of coverage when looking to a cyber policy. Ensuring quick and proper notification of a claim or circumstance (particularly in the case of a ransomware attack, which is often an indicator of further attacks), making a full disclosure of all risks and exposures to insurers or brokers prior to inception of the policy, and being sure to note the different limits and sublimits of coverage for first and third-party claims are all advised.

A major issue of concern is the interplay between cyber attacks and failure by companies to take protective action either by disgruntled employees and ex-employees or outsiders misusing information or hacking into companies' systems. It is presently considered that most companies do not have proper systems in place, which will likely lead to clams against D&Os that are cyber-related.

Terrorism insurance

27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Historically, losses caused by terrorist attacks have been excluded in most types of commercial insurance policies in England and Wales. In response, the UK government established Pool Re, a reinsurance scheme ultimately backed by the UK government that provides reinsurance cover to insurers who are member of the Pool Re scheme for property of business interruption losses caused by terrorism. All insurers who are members of the Pool Re scheme must offer terrorism cover to insureds that request commercial property cover; some insurers will include terrorism cover as standard, while some will charge an additional premium.

The scope of terrorism cover available from insurers therefore depends to a large extent on the reinsurance cover available to insurers from Pool Re. As such, terrorism cover in the UK tends to be limited to commercial property and business interruption policies where terrorism is the proximate causes of any losses. For example, if an act of terrorism caused a dam to burst, any third-party commercial property damage would be covered. As a general rule, policies do not cover personal injury caused by terrorism.

The scope of cover is limited to terrorist acts that take place within the United Kingdom, but excluding Northern Ireland, the Channel Islands or nuclear sites. The act that triggers cover must constitute an act of terrorism as defined by the Reinsurance (Acts of Terrorism) Act 1993, although insurers are at liberty to provide their own definition of terrorism in policy wordings, with many opting to use the definition in the Terrorism Act 2000.

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From April 2018, Pool Re will extend its cover to include material damage and business interruption caused by acts of cyber terrorism (remote digital interference). The scope of the cover available is designed primarily to protect commercial property and will be offered as standard to policyholders buying terrorism insurance from a Pool Re member. Business interruption cover is designed to apply only to events occurring at a policyholder's premises. It is likely that more and more areas of business interruption will be covered to deal with the new form of measures and countermeasures against terrorism, which lead to business losses.

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