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A critical examination of the disproportionate rights and duties of insurers and insured vis-à-vis good faith, fraud and the settlement of insurance claims

Gerald Swaby

A thesis submitted to the University of Huddersfield in partial fulfillment of the requirements for the degree of Doctor of Philosophy

The University of Huddersfield

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As with any PhD thesis, as the student I am deeply, deeply indebted to a number of precious friends and family, who know who they are. They have helped and supported me through this very long journey over the last six years. I cannot thank them enough for listening and offering their counsel when I have been struggling to make headway: from discussions over the odd barbeque or Chinese meal, they have helped to formulate ideas that have assisted immeasurably. My love, thanks and deepest gratitude to you all!

As someone with a disability, who cannot remember things and whose dyslexia has caused a few humorous moments, I would like to thank those who have supported me over the years and provided the very valuable proofreading necessary for all articles and this thesis: specifically Jackie Lane and Val Williams.

I would also like to thank my Dean, Professor Chris Cowton, for all the help and suggestions that he has contributed to my articles in the draft stage, and also for his counsel on publication. His suggestions are always welcome.
Thank you, Chris!

Finally, I would like to thank Dr Paul Richards, as my supervisor and friend, for all his suggestions in the content of this thesis. Thank you, Paul!

Dedication

I dedicate this thesis to my family with love.

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Summary of Articles and Contribution to Knowledge

<p>First Article</p> <p>'Insurance Law: fit for purpose in the twenty-first century?'</p> <p>(2010) International Journal of Law and Management 52(1) 21, 39</p>	<p><u>Introduction</u></p> <p>This article is to provide the reader with an overview of the current changes that are proposed to the area of consumer insurance. This article will consider those pre-contractual duties of misrepresentation, non-disclosure and utmost good faith. Many consumers face problematic issues in this area, and, in part, this is due to the difference between what has been practiced and the way in which the law has developed. As will be seen, the Financial Ombudsman Service's (FOS's) approach, and that of the law, differ significantly and, in part, this is due to the fact that the law itself stems from the mid-1700s and is therefore somewhat outdated in relation to the 21st century.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none">1. First peer reviewed article to analyse the law in relation to pre-contractual duties critically.2. It criticises the UK insurer-biased approach to pre-contractual duties of the insured when compared with Australian law and practice and that of the FOS.3. First article to suggest that the FOS maximum award limit of £100,000 was too low.
<p>Second Article</p> <p>'Insurance Law Reform: deterring fraud in the twenty-first century'</p> <p>(2011) International Journal of Law and Management 53(6) 413, 434</p>	<p><u>Introduction</u></p> <p>This article provides a critical examination of the current law and the possible changes that are under consideration by the Law Commissions, after public consultation in relation to the continuing duty of good faith and post-contractual duties owed by the insured towards the insurer.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none">1. First article to consider how harshly the law operates on the insured in relation to insurance fraud.2. Provided criticism of the Law Commissions' approach to fraud.

	<p>3. First article to suggest that there needed to be a mechanism to prevent the insurer making unjustifiable allegations of fraud.</p>
<p>Third Article</p> <p>‘The Price of a Lie: discretionary flexibility in insurance fraud’</p> <p>(2013) Journal of Business Law (1) 77, 102</p>	<p><u>Introduction</u></p> <p>This article seeks to advance the view that, on the whole, where <i>de minimis</i> fraud is concerned, the law has now trespassed too far in favour of the insurer and there is a need for the courts to have some equitable discretion in borderline cases.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article to analyse fraud re the quality of the lie to be substantial. 2. First article to analyse the fraud cases proportionately as part of substantiality. 3. First article to analyse the Australian fraud cases’ approach to substantiality. 4. First article to consider how ‘means and devices’ resulted in a disproportionate punishment for the insured in <i>Aviva Insurance Ltd v Brown</i> [2011] EWHC 362 and <i>Sharon’s Bakery (Europe) Ltd v (1) Axa Insurance Plc (2) Aviva Insurance Ltd</i> [2011] EWHC 210 5. First article to suggest that causation should be a part of the materiality test. 6. First article to suggest that some ‘fraud’ could be acceptable as tactical positioning. 7. First peer reviewed article to analyse <i>Aviva Insurance Ltd v Brown</i> [2011] EWHC 362 and <i>Sharon’s Bakery (Europe) Ltd v (1) Axa Insurance Plc (2) Aviva Insurance Ltd</i> [2011] EWHC 210 8. First article to suggest that if <i>Aviva Insurance Ltd v Brown</i> and <i>Sharon’s Bakery (Europe) Ltd v (1) Axa Insurance Plc (2) Aviva Insurance Ltd</i> was heard by FOS,

	<p>then it would have resulted in the insured’s successful recovery of the indemnity.</p> <ol style="list-style-type: none"> 9. First article to consider how the Australian approach would apply to English fraud cases. 10. First article to argue that the FOS approach to fraud should be mirrored in legislation to avoid divergence in the law and good practice followed by FOS. 11. First article to argue that <i>de minimis</i> be reclassified as fraud to place insurers on notice as to the moral hazard. 12. First article to consider that the insured should be allowed to claim rent from the insurer if he uses alternative accommodation that he already owns. 13. First article to identify and correct the international misreporting of <i>Entwells Pty v National and General Insurance Co Ltd</i> [1991] 5 ACSR 424 by the Law Commissions and Kirby <i>et al.</i>
<p>Fourth Article</p> <p>‘Blurring Distinctions: should the innocent insured be tarred with the same brush as their fraudulent agents?’</p> <p>(2013) Insurance Law Journal 24 (60)</p>	<p><u>Introduction</u></p> <p>This article will review the background law on agency to establish how agents are created in the consumer context and will examine the agent’s duty and consequential results of the agent’s fraud upon the innocent insured in pre- and post-contract situations.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article to examine agency law from the insured’s perspective. 2. First, and only, article to find evidence of how fraudulent conduct was being attributed to the insured by their use of agents. 3. First article to review the common law of agency before its application to the insured.

	<ol style="list-style-type: none"> 4. First article to suggest that empirical research is needed to assess the impact of an agent's fraud. 5. First article to identify the discrepancy between the criminal law under the Fraud Act 2006 and civil fraud with respect to the culpability of the insured principal. 6. First article to identify/analyse and establish a hierarchy of remedies for the innocent principal. 7. First article to analyse the international approach in the use of fraudulent agents and their impact on the insured principal's claim. 8. First article to suggest that an insurer should not be allowed to pursue an innocent for costs.
<p>Fifth Article</p> <p>'Cheek by Jowl: fraudulent insurance claims and the counter measures enacted in personal injury cases'</p> <p>(2015) Insurance Law Journal 27 (1)</p>	<p><u>Introduction</u></p> <p>This article critically analyses the anti-fraud provisions in respect of 'fundamental dishonesty' in third party personal injury claims under the Criminal Justice and Courts Act 2015 s 57 and costs orders under Civil Procedure Rule (CPR) 44.16. It analyses comparatively such fraudulent claims with those fraudulent claims made under first party insurance contracts.</p> <p>It examines the scope of the courts' discretion under the concept of 'substantial injustice' under section 57 and 'fair and just' under CPR 44.16. It provides comparative analysis of the Irish approach to fraud and dishonesty in third party personal injury claims under the Civil Liability and Courts Act 2004 ss 14 and 26 to see what lessons the United Kingdom can learn and adopt.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article and first peer reviewed article to analyse the concept of 'Fundamental Dishonesty' under the Criminal Justice and Courts Act 2015 s 57 and CPR 44.16. 2. First article to analyse the distinctions between the Civil Procedure Rules and statutory inconsistencies for

	<p>costs orders under the concept of ‘Fundamental Dishonesty’.</p> <ol style="list-style-type: none"> 3. First article to analyse the differential relationship between ‘substantial injustice’ and ‘fair and just’. 4. First peer-reviewed article to analyse <i>Gosling v (1) Hailo (2) Screwfix Direct Ltd</i> (2014) 29 April, Cambridge Cty Ct (unreported). 5. First article to compare the fraud in first party contract claims and third party negligence claims. 6. First article to establish that it was not possible to consider substantiality in first party claims with substantiality in third party claims, as the latter needed a greater degree of latitude. 7. First article to compare and contrast English law with that in Ireland on the concept of dishonesty. 8. First article to note that there is a marked difference between the English approach to dishonesty and that in Ireland. 9. First peer reviewed article to analyse <i>Hayward v Zurich Insurance Company Plc</i> [2015] EWCA Civ 327. 10. First article to suggest that some exaggeration should be allowed (within reason) for tactical positioning and should not be considered fraud.
<p>Sixth Article</p> <p>‘Insurance Reforms: re-balancing the kilter’</p> <p>(2011) Journal of Business Law (6) 535, 555</p>	<p><u>Introduction</u></p> <p>This article seeks to provide the reader with an overview of the proposed changes that will beneficially affect the rights of businesses and consumers to seek damages for the consequential losses that they may suffer when the insurer delays the payments due when a claim is made under a policy and the effect, if any, on the duty of good faith. In addition, a comparison will be made between the award of damages at common law and the approach adopted by FOS. As will be seen, the latter approach differs significantly from the former and reflects the approach taken in other jurisdictions.</p>

	<p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article to consider that the law was biased towards the insurer and there needed to be a change in the law to allow an insured to recover damages where the insurer had caused the loss to the insured by making a late payment deliberately. 2. First article to compare and contrast the English approach with that in Australia. 3. First article to continue to support the suggestion made in the first article that the FOS maximum award of £100,000 was too small. 4. First article to suggest that the 'hold harmless' doctrine should be abolished. 5. First article to suggest that England should follow the Australian approach. 6. First article to suggest that a consumer should be allowed to recover for distress and disappointment caused by an insurer's conduct.
<p>Seventh Article</p> <p>'Personal injury practice update'</p> <p>(2015) November CILExJ 22, 23</p>	<p><u>Introduction</u></p> <p>This article critically analyses the case of <i>Hayward v Zurich Insurance Company Plc</i> [2015] EWCA Civ 327</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article in a professional practice journal that analyses the CA decision in <i>Hayward v Zurich Insurance Company Plc</i>. 2. First article to consider that this decision could impact on all contracts compromise agreements.
<p>Eighth Article</p>	<p><u>Introduction</u></p>

<p>‘Personal injury law update: proposed reforms’</p> <p>(2016) February CILExJ 23, 25</p>	<p>This article reviews the government’s plans to remove the right to general damages for minor injuries and increase the small claims limit for personal injury claims to £5,000. It considers if there is a compensation culture.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article to compile/publish figures on personal injury claims registered over the last 15 years. 2. First practitioner journal article to consider whether there is a compensation culture in the UK. <p>First article to consider solicitors’ liability in <i>Impact Funding Solutions Ltd v Barrington Support Services Ltd (formerly Lawyers at Work Ltd) and AIG Europe Insurance UK Ltd (formerly known as Chrtis Insurance UK Ltd) (respondent/third party)</i> [2015] EWCA Civ 31, for contributing to the compensation culture.</p>
<p>Ninth Article</p> <p>‘The Insurance Fraud Taskforce reports’</p> <p>(2016) May CILExJ 8, 12</p> <p>(Front cover and lead article)</p>	<p><u>Introduction</u></p> <p>This article reviews the Insurance Fraud Taskforce Report and considers the official figures from the Compensation Recovery Unit to challenge the view that there is a whiplash culture.</p> <p><u>Contribution to Knowledge</u></p> <ol style="list-style-type: none"> 1. First article (and first article in a professional practice journal) to consider the main provisions of the Insurance Fraud Taskforce Report. 2. First article to publish statistics on the so-called ‘whiplash culture’ which demonstrates that there is no compensation culture and that the industry published statistics are misleading and inaccurate.

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Preface

Over the last 250 years, insurance law has become insurer biased to the detriment of consumers and modern business. Codification of judicial precedents and business practices resulted in the Marine Insurance Act 1906. There have been two attempts since the late 1950s to recommend changes, with reviews made by the English Law Reform Committee and the Law Commission in 1980. In the late 1970s, the insurance industry bought itself out of the Unfair Contract Terms Act 1977. In 1981, non-legal changes came gradually with the introduction of the Insurance Ombudsman Bureau, which took account of the law but followed best practice.

With each decade that has passed, changes in practice have deviated away from the strict legal position. The insurer no longer has an agent to arrange policies, collect premiums and complete claims forms. The late 1980s and early to mid- 1990s saw the introduction of distance selling via the telephone. The late 1990s, and early into 2000, saw the massive boom in Internet sales, with search engines focused on finding the best competitively priced quotes from insurers; however, the reforms that were needed still did not occur. The Marine Insurance Act 1906 still applied and formed the basis of insurance law for many common law countries which copied the statute verbatim.¹ As a result, these countries also had similar problems as those suffered by the insured in the UK; however, some have undergone bold reforms, as in the case of Australia,² unlike the UK, which has lagged behind significantly.

¹ There was a need throughout the British Empire to have parity in the law among states and dominions. Australia passed the Marine Insurance Act 1909 and New Zealand passed the Marine Insurance Act 1908. Both Acts replicated the UK Act, but with subtle differences. The Australian Act mirrors the UK Act, but starts six sections later with 'utmost good faith' considered in s 23. Interestingly, however, the New Zealand Act omits any reference to 'utmost good faith'. This does not prevent 'utmost good faith' from being part of the contract, as it falls as part of the common law. The Marine Insurance Act 1909 (Imp) still applies in its entirety to marine insurance. It follows the same common law approach in *Carter v Boehm* (1766) 3 Burr 1905. The pre-contractual duty of disclosure still applies as part of the duty of utmost good faith.

² Australia's insurance law was not limited to the Marine Insurance Act 1909 (Imp), but it was a complex combination of the common law and Imperial, Federal and State legislation. As a result, the Commonwealth Attorney-General, the Hon Robert Ellicott, asked the Australian Law Reform

The Scottish Law Commission and the Law Commission instigated a joint root-and-branch review of insurance law in 2006, as a result of a British Insurance Law Association paper (Insurance Contract Law Reform and Recommendations to the Law Commission (2002)) that highlighted the discrepancies in the law towards the insured. Unfortunately, however, the Commissions chose to focus on certain areas. These focused upon the following:

- (i) They considered warranties in respects of business and consumer contexts and how they operated against the insured.
- (ii) They considered the need for the insured to have insurable interests in what was being insured and whether these provisions should be repealed.
- (iii) They considered whether there should be protection for micro-businesses and whether they should be, in law, treated as consumers.
- (iv) They examined the broker's liability for premiums under Marine Insurance Act 1906 s 53, and whether the law should be brought into line with general contract and agency law.
- (v) They examined the formal requirements for marine policies under the Marine Insurance Act 1906 s 22 and whether there was a need to re-interpret 'policies' as insurance contracts.
- (vi) They examined the Fire Prevention (Metropolis) Act 1774 s 83 and consulted on whether it should be repealed.
- (vii) They also considered (and legislated in Consumer Insurance (Disclosures and Representations) Act 2012 s 9 and Sch II) on the problem of 'for whom does an intermediary act when passing on pre-contractual information onto the insurer?'

This thesis does not cover these aspects. It is concerned, however, with what could broadly be termed 'good faith', the corresponding duties vis-à-vis the insured and the insurer pre- and post-contract where the insured suffers disproportionately due to the way the law has developed pro-insurer biased.

This body of work supporting the award of a PhD examines these corresponding duties where the articles form a basis of a contemporary, critical examination of these duties, and develops suggestions as to how the joint Law Commissions of England and Scotland should have approached changes in relation to the following:

Commission, chaired by Hon Michael Kirby, to undertake a thorough review into insurance law, as there was widespread displeasure with its operation in the then (in the early 1980s) modern-day Australia. For further criticisms see Appendix 1.

1. The background to 'utmost good faith' and reform to consumer and business insurance: pre-incorporation duties.
2. Insurance fraud.
3. Insurers' duties to pay a claim within a reasonable period of time.

This body of work comprises six peer-reviewed articles that form the basis of the above objectives:

1. 'Insurance Law: fit for purpose in the twenty-first century?' (2010) *IJLM* 52(1) 21, 39.
2. 'Insurance Law Reform: deterring fraud in the twenty-first century' (2011) *IJLM* 53(6) 413, 434.
3. 'The Price of a Lie: discretionary flexibility in insurance fraud' (2013) *JBL* 77, 102.
4. 'Blurring Distinctions: should the innocent insured be tarred with the same brush as their fraudulent agents?' (2013) *ILJ* 24 (60).
5. 'Cheek by Jowl: fraudulent insurance claims and the counter measures enacted in personal injury cases' (2015) *ILJ* 27 (1).
6. 'Insurance Reforms: re-balancing the kilter' (2011) *JBL* 535, 555.

There are also some articles that are not peer-reviewed, but were published in the professional practice publication, *CILEx Journal*. These articles, which also directly touch on factual issues in this PhD, are the following:

7. 'Personal injury practice update', Gerald Swaby comments on the dichotomy raised by the decision in *Hayward v Zurich Insurance Company Plc* [2015] *EWCA Civ 327*; (2015) October *CILExJ* 22, 23.
8. 'Personal injury law update: proposed reforms' (2016) February *CILExJ* 23, 25.
9. 'The Insurance Taskforce reports' (2016) May *CILExJ* 8, 12.

1. Background of 'Utmost Good Faith' and Reform of Consumer and Business

Insurance: Pre-contractual duties

The Marine Insurance Act 1906 was a codification Act and part of the problems related to the principles laid down over one century before.³ With judicial precedent, the courts can follow it, distinguish it, or when necessary overturn it. They do not have that option with statutes however; they are limited to interpreting and following them. As a result, the principles of law that applied in 1906 belonged to that bygone era and are unsuitable for a modern 21st century Britain or even the latter half of a consumerised 20th century Britain.

Where there have been many reforms to Acts applicable to business, such as the Sale of Goods Act 1979 (as amended), the Limited Liability Partnership Act 2000 and the Companies Acts, there has been no alteration to the Marine Insurance Act 1906.

Sir Mackenzie Chalmers⁴ was a civil servant and a judge, but he is probably best remembered for his drafting of mercantile bills that became the Bills of Exchange Act 1882, the Sale of Goods Act 1893 and the Marine Insurance Act 1906. The driving force behind these Acts was Victorian businessmen, who were demanding clarity and certainty in the law of trade to reflect the then trade practices. The last of these Acts, the Marine Insurance Act 1906, proved to be the most complicated to pass, taking some 12 years.⁵

³ In *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*, [1995] 1 AC 501, Lord Mustill stated that it was convenient to state non-marine principles by referencing them to the Marine Insurance Act 1906, as it had been accepted and held that the Act codified the common law.

⁴ KCB CIS (1847–1927).

⁵ Lord Herschell LC first introduced the bill into the House of Lords in 1894. The House subjected the bill to a lengthy committee stage. On that committee, there were representatives for loss adjusters, underwriters and ship owners, all of whom supported the bill; however, the bill failed. A new version of the bill was introduced into the Lords in 1895, which contained all the changes by the previous committee, 'but it was so changed as to be hardly recognizable' (Hansard HC vol 122 cols 492–502 (12 May 1903 Deb)). A new version of the bill was introduced into the House and failed in 1896, even though Lord Herschell LC supported it. The bill was reintroduced in 1897 and again failed, then again in 1898 and 1899, and still failed. It was reintroduced back into the House of Lords in 1901 and again in 1902. In 1902, it passed the House of Lords and the House of Commons considered the bill for the first time, but it failed. The bill was introduced into the House of Commons in 1903, but it failed. In

Chalmers first drew his attention to insurance law prior to 1894 when he produced a draft bill on Marine Insurance Law. His bill codified the common law and included the current customs and practices of Lloyds.⁶ Chalmers stated that the 'object of [the Marine Insurance] bill was to reproduce as exactly as possible the existing law without making any attempt to amend it'.⁷ This became the Marine Insurance Act 1906.

One main provision of the Marine Insurance Act 1906 is s 17. This can be traced back to the common law in a case that started in 1759: *Carter v Boehm*.⁸

Some 6,770 miles away from the UK, as the crow flies, lies the island of Sumatra in the (then) East Indies. On this island, there was a fort built by the East India Company: Fort Marlborough. This was not a fort in the military sense as it was, as Lord Mansfield called it, a 'mercantile factory' designed to withstand attacks by the local indigenous population. The Governor of the fort was one George Carter. He feared attack and the loss of the fort from ships of European enemies, (ie, France during the Seven Years' War 1756–1763) as the fort was not built to withstand a bombardment from war ships. He wrote to his brother Roger Carter, in England in September 1759, asking him to act as his agent and get an underwriter to underwrite this risk between the dates of 16 October 1759 and 16 October 1760 for the sum of £10,000; this represented half of the value of Carter's property in the fort, having converted all his money into goods.

Roger Carter approached a policy broker called Cawthorne, who went to Charles Boehm in May 1760. Boehm immediately underwrote the policy based on the

1905, after substantial lobbying by shipping, mercantile and insurance bodies (Lloyds having passed a resolution in favour of the bill), the Prime Minister, Balfour, informed Parliament that there should not be any serious obstacles in the way of the bill passing (Hansard HC vol 14 col 1491 (28 February 1905 Deb)). Eventually, the Marine Insurance Bill was submitted in 1906 into the Edwardian era.

⁶ Charles McArthur Hansard HC vol 122 cols 492–502 (12 May 1903 Deb).

⁷ In 1901, Chalmers published a book on the subject of marine insurance jointly with Douglas Owen, *A digest of the law relating to marine insurance* (Clowes, London) page v.

⁸ (1766) 3 Burr 1905.

October dates.⁹ Unfortunately, unbeknown to all parties back in the UK, on 1 April 1760, during the policy year, two French ships - a 64-gun man-of-war and a 20-gun frigate piloted by the Dutch - attacked and seized Fort Marlborough, taking the contents and prisoners to Batavia, Jakarta. This necessitated Carter's claim under the policy.

Boehm repudiated the claim on the basis that Carter was in the best position to know the risk and had a duty of good faith to disclose this to him. The case came before Lord Mansfield in the Easter Term of 1766. He took the opportunity to introduce into English common law the concept of good faith:

First, insurance is a contract upon speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the insured only. The underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if it did not exist. Keeping back such circumstance is a fraud, and, therefore, the policy is void. Although the suppression should happen through mistake without any fraudulent intention, yet still the underwriter is deceived, and the policy is void, because the risk run is really different from the risk understood and intended to be run at the time of the agreement. The policy would equally be void, against the underwriter if he concealed, as if he insured a ship on her voyage which he privately knew to be arrived, and an action would lie to recover the premium.¹⁰

The governing principle is applicable to all contracts and dealings. Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of that fact and his believing the contrary.¹¹

The principle was clear: a contract was void at the insurer's option where there was a breach of good faith, which included misrepresentations and non-disclosures.

⁹ In 1766, there were only two insurance companies (Royal Exchange and London Insurance) set up by royal charter. All other companies were illegal under the Bubble Act 1720 (6 Geo I, c18). This meant that individual insurers, whose livelihood depended upon the insured's honesty and voluntary disclosure, needed to be guarded to protect them personally from abuse in an industry that had been growing for 40 years: Per M Kirby, 'Insurance contract law reform - 30 years on' (2014) 26 Insurance Law Journal 1.

¹⁰ *Carter v Boehm* [1558-1774] All ER Rep 183 [185].

¹¹ *Ibid* [186].

Whilst this attempt to introduce good faith into the common law ultimately failed, insurance contract law remained a special exception.¹²

Lord Mansfield was quite clear that the duty of good faith was reciprocal, but the focus of this judgment was on the knowledge of the insured and what he should have disclosed. Ultimately the insurer, back in England, was better placed to assess the likelihood of attack, and if he wanted to know the answer to a question he should have asked, which Boehm had failed to do.

Lord Mansfield's judgment was clear that there was a duty of good faith on both sides, but the duty of utmost good faith has been subsequently interpreted as a design to protect the insurer from abuse such as fraud in a fledgling market place. The remedy has always been harsh for the insured. The insurer avoids the policy *ab initio* no matter the severity of the breach.¹³ Mackenzie Chalmers took this principle¹⁴ and codified it as 'utmost good faith'¹⁵ in section 17 of the Marine Insurance Act 1906.

Section 17 states 'Insurance is *uberrimæ fidei*.'

'A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.'¹⁶

¹² Also falling into the exception are company share subscription contracts, family settlements, partnerships and suretyship.

¹³ This was the position for all types of misrepresentation until the Court of Appeal decision in *Economides v Commercial Union Assurance Co Plc* [1998] Lloyd's Rep IR 9.

¹⁴ *A digest of the law relating to marine insurance* (1903), 21 and 22.

¹⁵ Here the word 'utmost' was added later as Lord Mansfield never mentioned it; however, it has become linked synonymously to the easily voidable nature of insurance contracts.

¹⁶ It is important to note that Chalmers' book quotes only Lord Mansfield in *Carter v Boehm* and extracts the principle of utmost good faith from this quote; however, Lord Mansfield never used the term 'utmost'. Instead, this term may have been and has become common parlance to Chalmers through other cases. See *Manifest Shipping Co Ltd v Uni-Polaris Shipping Co Ltd and Others*, ('The Star Sea') [2001] UKHL 1 para 44 per Lord Hobhouse: 'It was probably the need to distinguish those transactions to which Lord Mansfield's principle still applied which led to the coining of the phrases 'utmost' good faith and '*uberrimæ fidei*', phrases not used by Lord Mansfield and which only seem to have become current in the 19th Century. Storey used the expression 'greatest good faith', Wharton 'the most abundant good faith'; a Scottish law dictionary (Traynor) used 'the most full and copious' good faith; some English judges referred to 'perfect' good faith (Willes J), *Britton v Royal Ins Co*, (1866)

The duty of utmost good faith included the duty not to make a material misrepresentation or material non-disclosure. Materiality, in both cases, is tested against a background of what an objective, prudent insurer would want to 'know or ought to know' in assessing whether to enter into the contract at all or in assessing the premium to charge.¹⁷ This tipped the law severely in the insurers' favour. There was no end of possibilities as to what the prudent insurer would want to know or expect to be disclosed.¹⁸ Neither the consumer nor business¹⁹ insured would know what to disclose to an insurer, especially in a modern world. All the insurer needed to do was to sit back and wait for the insured to volunteer information. This has led to businesses 'data dumping' everything for fear that the insurer will avoid a policy for non-disclosure.

The world has moved on however: in the day of Lord Mansfield, the insurers were in a vulnerable position. They did not fully understand the workings of businesses they were asked to insure and there was no consumer market. Today insurers are supported by a plethora of structures. There is highly detailed statistical analysis complemented by rigorous systems and procedures. Data information is stored in

4 F&F 905) and Lord Cockburn CJ to 'full and perfect faith' (*Bates v Hewitt, sup at p 607*). But 'utmost' became the most commonly used epithet and its place was assured by its use in the 1906 Act. The connotation appears to be the most extensive, rather than the greatest, good faith. The Latin phrase was likewise a later introduction. It has been suggested that its use may have been inspired by the use of similar language in Book IV of the Codex of Justinian (4.37.3) in relation to the contract of partnership. The best view seems to be that it had been unknown to Roman law and had no equivalent in Roman law: *Mutual and Federal Ins Co v Oudtshoorn Municipality* 1985 (1) SA 419, per Joubert JA at p 432. The first recorded use of the phrase in the law reports was by Lord Commissioner Rolfe (later Lord Cranworth LC) in *Dalglish v Jarvie* (1850) 2 Mac & G 231 at 243 in connection with the duty of disclosure to the court which arises when an *ex parte* application is made for an injunction; the phrase was however already current by that date as the judgment shows.'

¹⁷ See s 18(2) and s 20(2). A representation or non-disclosure is material if it 'would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk'.

¹⁸ Whilst the courts struggled with many decisions, they were still bound by the inflexibility of the Act. This caused the judiciary to try and mitigate some of the harshness for the insured in the way the Act operated. In *Pan Atlantic v Pine Top*, the House of Lords introduced the requirement that the insurer must be actually induced into the contract in cases of breaches of utmost good faith. So, there was a subjective element for the actual insurer implied into the materiality test. Whilst at the time this was to be applauded, it was very much an issue of too little, too late.

¹⁹ This assumes that it is a small business.

servers with programs analysing and predicting future trends, with actuaries calculating the risk.

The consumer and business insurance markets have grown exponentially over the last 60 years. The types of risk being insured 100 years ago were, by far, narrower than those of today. The way people communicate has changed significantly and this could not have been foreseen in 1906. In the light of the Internet age, there is no longer face-to-face contact with an insurer. No longer does an insurance agent call at the door to sell his policies, collect the premiums or fill in claim forms. The law was fundamentally out of step, and this desperately needed to be updated and made fit for purpose in the 21st century, as highlighted in the first article: 'Insurance Law: fit for purpose in the twenty-first century?'

UK Law Reform Background

The forerunner of the Law Commission was the English Law Reform Committee.²⁰ Lord Simonds, the Lord Chancellor, asked the committee to consider *inter alia*²¹ the effect of non-disclosure on the liability of insurance companies. This was delegated to a sub-committee chaired by Devlin J (as he then was). In 1957, it reported back to Lord Kilmuir, the new Lord Chancellor. The report recommended changes to insurance law on the subject of utmost good faith under the guise of non-disclosure.²² The committee restricted its view to non-marine cases, as there was apparently, at that time, no public interest in including marine issues. In the case of reform, the committee recommended a change in the test of materiality so that it was dependent upon the reasonable insured as opposed to the reasonable insurer. This would have meant that the chances of an insurer avoiding the risk would diminish. The Court of Appeal in *Lambert v Co-operative Insurance Society Ltd*²³ approved the committee's report, but did not implement it.

²⁰ Members included Lord Justice Jenkins, Lord Justice Parker, Mr Justice Devlin, Mr Justice Diplock and others.

²¹ Special condition and exception was also discussed.

²² 'Conditions and Exceptions in Insurance Contracts' (Cmnd 62, 1957) 7.

²³ [1975] 2 Lloyds LR 485.

Despite the committee's recommendations, no action was taken to reform the law. In 1980, the Law Commission undertook a review of insurance law. This was in the light of a proposed EEC Insurance Directive.²⁴ The commission focused on the issue of disclosure and warranties,²⁵ but excluded transport, aviation and marine insurance from the scope of its review. A bill for reform was introduced in Parliament, but this was withdrawn when the Government compromised with the Association of British Insurers (ABI) when it said that the industry would adopt the Law Commission's recommendations voluntarily.²⁶ The industry would implement this by changing the Statement of Insurance Practice.²⁷

The National Consumer Council, in 1997, called for reform in consumer insurance,²⁸ but nothing came of it. Then, in 2002, the British Insurance Law Association (BILA)²⁹ appointed a sub-committee to produce a report on the then current state of insurance law. The sub-committee reported back on 1 September 2002, publishing *Insurance Contract Law Reform and Recommendations to the Law Commission*. The

²⁴ Directive on the Co-ordination of the Legislative, Statutory and Administrative Provisions governing Insurance Contracts. Council Directive 92/49/EEC of 18 June 1992 relating to the coordination of law, regulation and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC.

²⁵ Law Commission, 'Insurance Law, Non-Disclosure and Breach of Warranty' (Law Com No 104 Cmnd 8064, 1980).

²⁶ B Soyer, *Marine Insurance Fraud* (Routledge 2014) Ch 6, fn1.

²⁷ The Statements of Insurance Practice (SIP) formed a voluntarily, binding, self-regulating agreement that was accepted in 1977 by Lloyds and ABI in exchange for insurance being excluded from the Unfair Contract Terms Act 1977 (See 'Warranties in Marine Insurance' p199 para 8.2). The problem with the Statements of Insurance Practice was simply that they could be ignored due to their status being only voluntarily binding. Self-regulation was not legislative reform. (A point made by the Law Commission, 'Insurance Law, Non-Disclosure and Breach of Warranty' (Law Com No 104, 1980) [27–29].

The statements were amended in 1986 and discontinued in 2005, when the sole market regulator, the Financial Services Authority, established by the Financial Services and Marketing Act 2000, introduced the *Insurance Conduct of Business Sourcebook*. Unlike the SIP, the ICOBS rules are binding. NB: The SIP were adopted by the Financial Services Ombudsman's fair and reasonable approach.

²⁸ National Consumer Council, 'Insurance Law Reform: the consumer case for review of insurance law' May 1997.

²⁹ BILA represented brokers, insurers, the judiciary, academics, lawyers and trade associations.

report recommended that the doctrine of utmost good faith should be retained throughout the contract, but subject to some modifications.³⁰

The report supported the Law Commission 1980 report and made recommendations for adopting some of the reforms. The need for reform was paramount. The Statements of Practice and FOS's 'fair and reasonable' approach³¹ was not enough to counter the biased operation of the law in favour of the insurer.³² No matter how honest or how reasonably the insured acted, the insurer was effectively judge and jury on issues of non-disclosure and misrepresentation.

In 2006, the Law Commission and the Scottish Law Commission started a joint review of insurance contract law.³³ This was intended to be a wide-ranging review that would codify the current business practices into a new Act; however, this was not to be the case. In the end, the commissions focused on misrepresentation and non-disclosure; warranties; late payment; and fraudulent claims.³⁴ They should have had the boldness of Australia to adopt radical reform across the whole field. This was a missed opportunity.

The first article, 'Insurance Law: fit for purpose in the twenty-first century?', focuses upon the insured's duty of disclosure and misrepresentation as part of the duty of utmost good faith. It argues that the then (2010) current system did not deliver

³⁰ It should be noted that this duty would vary depending upon what phase of the relationship they are in (see *The Star Sea* case).

³¹ See Ombudsman News, August 2004, Issue 39.

³² The report suggested adopting the 'reasonable insured' test for materiality in cases of non-disclosure and misrepresentation. The report went on to recommend the adoption of a proportional remedy instead of a good faith remedy of avoidance of the contract for a breach of non-disclosure or misrepresentation, but recommended that avoidance be kept available for cases of dishonesty or reckless behaviour.

The BILA report also recommended consideration of the need for the insurer to pay a valid claim within a reasonable time. It concluded that it should be a claim for debt and not damages, and that there should be an implied term that the debt should be paid within a reasonable time.

³³ The Law Commission and the Scottish Law Commission, 'Insurance Contract Law: A Joint Scoping Paper' (2006) <http://www.scotlawcom.gov.uk/files/2512/7981/5440/cp_insurance.pdf> accessed 12 April 2016.

³⁴ The suggested areas based on the Law Commissions' Joint Scoping Paper were: Insurable Interest; Agency; Subrogation; Fraud; Unjustifiable Delay; and Reinsurance.

justice for the insured who has made a non-fraudulent or non-innocent representation at the time of placing their insurance. The article compared the Australian position with that in the UK, and it argued that there was chaos in the UK approach as practice developed by the Insurance Ombudsman Bureau (and latterly FOS) diverged from English law and adopted the approach taken in Australian Insurance Contracts Act 1984.

This article was first presented as a paper at the Association of Law Teachers conference in Amsterdam in 2009 to an audience that included, by chance, some of those involved in the Scottish Law Commission. At the time, the author was asked how long it would take to implement the proposals for consumers. While those involved in the Scottish Law Commission suggested that a bill would not be forthcoming for consumers before 2016, the author disagreed. He suggested that it would be possible to have a bill in place around 2011, which would allow for the UK general election.

As an article, it was awarded the publisher's Highly Commended Award prize for that year by the outgoing editors, Professors Geraint Howells and James Kirkbride.

When the Law Commissions' joint project on consumers' pre-contractual duties ended, there was greater innovation than could have been foreseen prior to consultation.

The proposals were included in the Consumer Insurance (Disclosure and Representations) Act 2012, which became enforceable on 6 April 2013. For the first time, consumers were treated separately from businesses. This Act abolished the volunteering of information by the insured. If the insurer wished to know something, he must ask a question. The insured is under a duty to answer questions with reasonable care (s 2(2)). This is tested against the answers of a reasonable consumer (s 2(3)), abolishing the prudent insurer test. If the consumer insured's answer is careless, then the insurer can no longer avoid the contract *ab initio* unless he would never have entered the contract in the first place (Sch 1, s 5). Instead, he has to pay a percentage of the claim under the reduced proportionality principle in Sch 1, ss 7

and 8. These changes could be seen as a reduction in the scope of good faith to one of honesty and not to make misrepresentations.³⁵

If a consumer failed to answer the question accurately, tested against the reasonable consumer, then if the consumer's answer was inaccurate they would have a proportionate remedy against the insurer based on the formula:

$$X = \frac{\text{Premium Actually Charged}}{\text{Higher Premium}} \times 100$$

As a result of this Act, the insurers now have the same system to follow as that of the FOS, and so at long last the law (which had been ignored in favour of the FOS approach) is now aligned. This has caused some initial teething problems for some insurers. The ABI has had to issue guidance to its members that they could no longer benefit from the duty to disclose. As a result, all consumer-facing documentation from insurers had to be changed otherwise the ABI member may be in breach of Insurance Conduct of Business Sourcebook (ICOBS) and Conduct of Business Sourcebook (COBS).

The Law Commissions' approach, rather than adopting the Australian approach, did go above and beyond what could ever be expected. By introducing this legislation, it placed the UK above the system in Australia for, under the Insurance Contracts Act 1984, disclosures were still required. This left the Australian system playing catch-up with the UK.³⁶

There is one last protection for consumers however: that is the prevention of the insurer contracting out of these provisions as stated in s 15 of the Insurance Act 2015, but the same cannot be said for non-consumers. In fact, there could - and probably will be - a significant problem for the insured under these circumstances in

³⁵ This is like Australia that has kept the duty under s. 21 of the Insurance Contracts Act 1984. Utmost good faith has perhaps been taken back to the original judgment of Lord Mansfield to when an insurer should ask a question if he wanted to know about the risk. The duty to act honestly still remains.

³⁶ This has now been achieved through an amendment to the Insurance Contracts Act 1984. See Appendix 2.

that insurers can contract out of the provisions for 'business' or, more correctly, non-consumers (see below).

Business Insurance and Pre-Contractual Duties

The reform of the pre-contractual duties for non-consumer insurance arrived much later, in the Insurance Act 2015,³⁷ than that of consumers' insurance in the Consumer Insurance (Disclosure and Representations) Act 2012.

The Law Commissions recommended that, in non-consumer insurance, the duty to present the risk should be maintained. The reforms restrict the previously wide protection that the insurer enjoyed under the Marine Insurance Act 1906, where the insured had to disclose 'every material circumstance' which the insured 'knows or ought to know'.

It is difficult to see how an insured under these circumstances can comply when it is impossible to judge what is in the mind of the insurer. The Law Commissions have identified five problems with the way the duty operates in non-consumer cases³⁸ and, post consultation, the Law Commissions recommended a number of reforms.³⁹

³⁷ On 17 July 2014, the Government introduced the Insurance Bill into Parliament. This became the Insurance Act 2015. As at the time of writing, ss 17–20 of the Marine Insurance Act 1906 still apply to business insured. This is due to change when the Insurance Act 2015 comes into force on 1 October 2016, but not radically enough. Section 17 will remain, but it will remove the words '*if the utmost good faith be not observed by either party, the contract may be avoided by the other party.*' This will allow for damages to be awarded for a breach of s 17, which is to be welcomed.

³⁸ Law Commission, (Law Com No 353) [5.6 (i)] The duty is poorly understood; (ii) The duty is too onerous, particularly on medium and large companies; (iii) The requirement to disclose every material fact encourages data dumping; (iv) The 1906 Act gives rise to too many disputes; and (v) The single remedy of avoidance in all cases is too harsh.

³⁹ Law Commission, (Law Com No 353) [6.2] These included: 1. Encourage active engagement of the insurer to ask questions of the insured to assess the risk; 2. Prevent data dumping by the insured; 3. Provide guidance as to how the insured should prepare a fair presentation; 4. Identify whose knowledge in the insured business should be attributed to the insured when the risk is accepted; 5. Explain the exceptions to the duty of disclosure; and 6. Replace the remedy of avoidance with proportionate remedies.

These recommendations were incorporated into the Insurance Act 2015. The Act ensures that the insured has to make a fair presentation of the risk at the time the contract is entered (s 3(1)) and this is defined as a 'duty' under s 3(2). The question 'What is a fair presentation?' is answered in s 3(3) paras (a)–(c), and includes required disclosures in ss (4) and making a disclosure that is reasonably clear and accessible to a prudent insurer, and 'in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith'.

Section 4 deals with the actual knowledge of the insured, and considers what the insured knows, or ought to know, for the purpose of ss 3. This includes the knowledge of an actual individual (s (4)(2)) or the insured's senior management or those responsible for insurance (s 4(3)). Knowledge of the insurer is considered in s 5 and general knowledge is considered in s 6. In addition to actual knowledge, this includes 'matters which the individual suspected' and also Nelsonian blindness for deliberately refraining from or confirming certain knowledge.

A Final Point on Good Faith

The Law Commissions have effectively redesigned the duty of good faith by removing the voidable option from s 17 of the Marine Insurance Act 1906. They were responding to the consultations where there was a clear demand to keep utmost good faith to distinguish insurance from 'normal' contracts. It has been retained as an 'interpretive principle'.⁴⁰ They envisaged that it would still be useful in three roles.

- (1) To interpret the duty of fair presentation.
- (2) To inform the need to imply contractual terms into the policy under the traditional 'business efficacy test'.⁴¹
- (3) To provide judicial flexibility.⁴²

⁴⁰ Law Commission, (Law Com No 353) [30.22].

⁴¹ For example, an implied term allowing the insurer to take over the defence of a claim or ensuring that an insurer acts reasonably (see Law Commission, (Law Com No 353) [30.57].

⁴² Law Commission, (Law Com No 353) [30.23].

What has happened, however, is that good faith in s 17 of the Marine Insurance Act 1906 has been divorced from the duty of fair presentation of the risk.⁴³

Remedies

First, the insurer has a remedy against the insured where there has been a 'qualifying breach' as required by s 8(3) of the Insurance Act 2015. A 'qualifying breach' is defined, in s 8(4)(b) of the Act, as one made (a) deliberately or recklessly, or (b) is neither deliberate nor reckless. This allows for what the Law Commissions termed 'negligent' or 'innocent' breaches.⁴⁴

The remedies are stipulated in Schedule 1 of the Insurance Act 2015. If the insured has acted recklessly or deliberately, then the insurer may avoid the contract, refuse all claims and keep the premium under s 2 of the Schedule. If there is a breach, (that is a non-qualifying breach) and the insurer would not have entered the contract, the insurer can refuse all claims and avoid the contract; however, he must return the premium under s 4 of the Schedule. If the insurer would have entered the contract but on different terms, then the contract is to be treated as though the parties entered it on those different terms, under s 5 of the Schedule. Where the contract would have been entered on those different terms, a proportionate remedy is provided under s 6 of the Schedule. This exactly mirrors that used in consumer cases.

$$X = \frac{\text{Premium Actually Charged}}{P} \times 100$$

P

Contracting-Out Provisions

As previously mentioned, insurers can contract out of the provisions for non-consumers in Part 2 (the duty of fair presentation), Part 3 (warranties and other

⁴³ For an overview of the Australian approach to good faith, see Appendix 2.

⁴⁴ Law Commission, (Law Com No 353) [11.59].

terms) and Part 4 (fraudulent claims) of the Insurance Act 2015. To be able to do so however, they have to satisfy the criteria in s 16 that still offers some level of protection to the non-consumer insured provided that it satisfies the transparency requirement of s 17. This operates in a similar way to the Consumer Rights Act 2015 Part 2 provisions that deal with exclusion clauses. Whilst this does represent a step forward for the industry that had previously bought itself out of the provisions of the Unfair Contract Terms Act 1977, it nevertheless stops short of testing the disadvantageous terms against reasonableness. It effectively does little more than codify the common law in the case of *Parker v South Eastern Railway Company*⁴⁵ and the *contra proferentem* rule.

The first level of the protection for the insured against a disadvantageous term requires the insurer to take sufficient steps to draw the term to the insured's attention before the contract is entered into, or the variation is agreed under s 17(2). This will not apply however, if the insured does have actual knowledge of the term at the time of contracting or variation and the insurer fails in the duty to bring the term to the insured's attention under s 17(5). This will inevitably raise the question as to the definition of 'sufficient'. Given synonyms to this are 'adequate' or 'enough', it does potentially seem that this is a lower threshold than 'reasonableness' under the Unfair Contract Terms Act 1977. The effect, therefore, is that the insured has little protection provided that the insurer gives sufficient notice of the disadvantage term. This mirrors the decisions in *Interfoto Picture Library Ltd v Stiletto Visual Programmes Ltd*⁴⁶ and *J Spurling Ltd v Bradshaw*.⁴⁷

The second level of protection requires the term to be clear and unambiguous under s 17(3). Finally, the last part of the protection requires the first two levels of protection be determined against the characteristics of the insured persons of the kind in question and the circumstances of the transaction. This is probably the most significant change that is beneficial to the insured as it abolishes the requirement to

⁴⁵ [1877] 2 CPD 412.

⁴⁶ [1987] EWCA Civ 6.

⁴⁷ [1956] EWCA Civ 3.

test materiality against the prudent insurer as required by the Marine Insurance Act 1906. As a result, s 21(1) of the Insurance Act 2015 repeals ss 18, 19 and 20 of the Marine Insurance Act 1906 and the common law jurisprudence is abolished under s 21(3) of the Insurance Act 2015.

Given that the first two levels change very little. There is nothing stopping an insurer from contracting out and reverting back to the law as it was under ss 17–20 of the Marine Insurance Act 1906. This would require stating the previous sections as express terms. The insurer may want to charge less if the insured is willing to agree harsher terms. Given that these provisions stop significantly short of testing unfair terms against reasonableness or fairness, generally the law is still firmly biased towards the insurer.

2. Fraud

Statistics

The problem with insurance fraud is that no one can state for certain how big the problem is. By its deceptive nature, it is impossible to say how much undetected fraud is being paid wrongfully by insurers on fraudulent claims. The ABI provides the only statistics that record the value of detected fraud, and unfortunately they do not record fraud in a consistently objective manner. This can be seen from the ABI website, where the figures tend to be focused around grabbing headlines. This is entirely understandable, but makes any reliable objective consideration by academics problematic (see the blank spaces in the table below), although some trends can be seen. The statistics show that over the years the Law Commissions have been investigating this problem from a first party view, the amount of detected fraud has increasingly fluctuated. The number of fraudulent home insurance claims has more than halved over the years, but the number of fraudulent motor claims has increased significantly and their value has more than doubled. There is no distinction made between first and third party claims in this area.

The available statistics are from the insurance industry itself (ie, the ABI's members). As the old saying goes 'there are lies, dammed lies and statistics'. There is, unfortunately, no way of knowing for sure the extent of fraudulent claims. The ABI bases its statistics on detected fraud, and it does suggest that the amount of undetected fraud is around £2bn per year, but this is still guesswork.

Statistics from the Association of British Insurers							
	Number of Fraud Claims Made	Value of Detected Fraud Claims	Number of Motor Fraud Claims Made	Value of detected Motor Fraud Claims	Number of Home Fraud Claims Made	Value of Detected Home Fraud Claims	Percentage of total fraudulent claims
2008 48	107,000	£730m			55,000		4%

⁴⁸ <<https://www.abi.org.uk/News/News-releases/2009/04/Recession-Britain--insurers-detecting-record-amounts-of-fraudulent-claims>> (accessed 12 April 2016).

2009 49	122,000	£840m		£410m	62,000		4%
2010 50	133,000	£919m	40,000	£466m	66,000		
2011 51	138,814	£983m	37,000	£441m	71,000		5.7%
2012							
2013 52	118,500	£1.3bn	59,900	£811m	35,000	£137m	
2014 53	130,000	£1.32bn	67,000	£835m	24,330	£108m	

Fraudulent Claims Rule

The problem with post-contractual fraud can be seen in the second article, ‘Insurance Law Reform; deterring fraud in the twenty-first century?’. This article sets out the law and various approaches to dealing with fraud. It establishes that the law sets out a strong anti-fraud message, which should deter insurance fraudsters,⁵⁴ and to this end the law is biased towards the insurer. However, the reality is that most people are not lawyers and will not know what the law is when they are making a false claim, whatever the state of the law.

The article argues that the insured should not commit fraud dishonestly or recklessly, but if he does it stipulates the requirement that the fraud should also be material and substantial (not *de minimis*). If these requirements are met, then there

⁴⁹ <<https://www.abi.org.uk/News/News-releases/2010/07/Bogus-Britain--insurers-expose-over-2300-fraudulent-claims-every-week>> (accessed 12 April 2016).

⁵⁰ <<http://www.insuranceage.co.uk/insurance-age/news/2097496/abi-figures-reveal-rise-fraud>> (accessed 12 April 2016).

⁵¹

<<https://www.abi.org.uk/~media/Files/Documents/Public/Migrated/Fraud/ABI%20no%20hiding%20place%20-%20insurance%20fraud%20exposed.pdf>> (accessed 12 April 2016).

⁵² <<https://www.abi.org.uk/News/News-releases/2014/05/Insurance-cheats-feel-the-heat-value-of-fraudulent-claims-uncovered-by-insurers-hits-record-level>> (accessed 12 April 2016).

⁵³ <<https://www.abi.org.uk/News/News-releases/2015/07/You-could-not-make-up-Savings-honest-customers-insurers-expose-3-6-million-worth-insurance-frauds>> (accessed 12 April 2016).

⁵⁴ The reality may be different, in that a fraudster is probably not going to read the law reports before making a fraudulent claim.

is the question as to the remedy. Is it the avoidance of the policy as a whole (thus unpicking any previously good claims) or the avoidance of the claim or future claims and termination of the policy? The article argued that there were four different approaches using (i) express terms; (ii) implied terms; (iii) s 17 of the Marine Insurance Act 1906 (before amendment by Insurance Act 2015); and (iv) public policy. The Insurance Act 2015 now firmly establishes the law in the insurers' favour under s 12(1) in that the insurer's remedies are to avoid paying the claim and, if it has made a payment, it may recover it and terminate the policy. If it does terminate the policy, it may keep the policy premium and refuse all liability from the point of the fraudulent claim under s 12(2). There is a question, however, as to whether the fraudulent claims rule extends to 'means and devices' as introduced in *The Aegeon*⁵⁵ by Mance LJ.

Fraudulent 'Means and Devices'

It is arguable that the fraudulent claims rule should not be expanded to this area, where the insured lies in only trying to recover the exact amount of his loss, especially where the insurer is resisting. This was touched upon in the second article, but was specifically considered in the third article, 'The Price of a Lie: discretionary flexibility in insurance fraud', which significantly criticised this area and the two recent decisions in *Aviva Insurance Ltd v Brown*⁵⁶ and *Sharon's Bakery (Europe) Ltd v (1) Axa Insurance UK Plc (2) Aviva Insurance Ltd*.⁵⁷

This article examined the concept of substantiality and need for judicial discretion. This article was the first published to analyse the insurance fraud cases to see, as a percentage, how big the fraud was in each case as a proportion of the total claim. This was quoted in Professor Robert Merkin QC and Dr Aysegul Bugra's article 'Fraud' and 'Fraudulent Claims'.⁵⁸ 'The Price of a Lie' was also given as a conference paper, in London, to over 250 insurers, lawyers, judges and Law Commissioners at

⁵⁵ *Agapitos v Agnew, (The Aegeon)* [2002] 1 Lloyd's Law Reports 573 [30].

⁵⁶ [2011] EWHC 362 (QB).

⁵⁷ *Sharon's Bakery (Europe) Ltd v (1) Axa Insurance UK plc (2) Aviva Insurance Ltd* [2011] EWHC 210 (Comm).

⁵⁸ "Fraud' and 'Fraudulent Claims" (2012) 125 Journal of the British Insurance Law Association, 3.

the joint hosts/organisers Withers/the Law Commissions and BILA on 26 June 2012.⁵⁹ It was also presented to the Insurance Law Reform Association Conference, in April 2012, at Norton Rose Solicitors, London. ‘The Price of a Lie’ was also commended by Professor Merkin QC and Dr Bugra for its exacting analysis and critique of the Australian position on fraud and judicial discretion.

In the ‘Price of a Lie’, it was argued that there was a problem where the insurer treated the insured in such a deplorable way in refusing a claim made years earlier and fighting the insured (in a way that some may consider *mala fides*) at every point. In *Aviva v Brown*, after losing the first rounds to the insured through FOS, the insurer then fired 22 allegations of fraud against Mr Brown but could only prove one count of dishonesty. The article argued that there should be a provision included in the Insurance Bill to replicate the position, in English law, of that in Australia under Insurance Contracts Act 1984 s 56, where there is a just and equitable provision to allow a just and equitable sum to be paid by the insurer if the insured has acted fraudulently. This was suggested forcefully by the academics to the Law Commissions during their consultation process, but ultimately the provision was not included in the Insurance Bill due to the substantial opposition of the insurers. Privately, those at the Commission did sympathise and were not happy with the *Brown* decision. This is regrettable and yet understandable, for if this was included in the bill it would have made its passing contentious and, therefore, it would not be possible to pass the bill using the procedures for Law Commission bills that are non-contentious. But, perhaps, the last word on the issues in *Aviva v Brown* was that when asked privately, the Head of Technical Claims at Aviva said that the decision to take the case to court was that of his predecessor and he fully accepted that if the case could have been resubmitted to the FOS for a decision, the fraud would have been immaterial and the company would have had to pay the claim in its entirety.

Further Developments of ‘Means and Devices’

⁵⁹ Wills Building, London.

Since writing 'The Price of a Lie', there has been a challenge to determine the extent of this rule in the case of *Versloot Dredging BV and another v HDI Gerling Industrie Versicherung AG and others*.⁶⁰ This is an important case for a number of reasons: first, not only does it seek to establish 'whether the rule by which a fraudulent insurance claim precludes recovery under the policy applies to means and devices?' but, second, if it does, was this contrary to Article 1 of the First Protocol of the European Convention on Human Rights (ECHR)?'

Perhaps what is interesting about the *Versloot* case is that it involved a reckless misrepresentation. In this case, the manager of a ship told the insurers that an alarm had sounded on the bridge. Unfortunately, this was not accurate, although the manager had genuinely convinced himself that this was the case, and so the issue was not one of a dishonest representation; however, it still cost the claimant €3.2m in that the statement was made recklessly.

At first instance, Popplewell J had criticised the law. He was regretting the very position that he argued for in *The Aegeon* when he was leading Counsel for the successful insurers.⁶¹ In the Court of Appeal, Christopher Clarke LJ upheld Popplewell J. Christopher Clarke LJ confirmed that the insurer is owed a duty of good faith when the insured presents the claim, that is, one of honesty. If the claim is not honest, it will trigger the fraudulent claims rule that is also extended to 'means and devices', as means and devices can be seen an extension, or sub-species, of a fraudulent claim. By treating means and devices as a sub-species, it renders the forfeiture of the claim rule applicable to the whole area. This forfeiture rule has a public policy justification, as insurers are entitled to be protected against fraud (including means and devices). The sanction of forfeiture is designed to be draconian. If it were removed, the fraudulent insured would stand to make gains and would lose nothing by their fraudulent acts. This was proportional to achieving a legitimate aim of preventing fraud, and was not contrary to the ECHR A1, P1 which

⁶⁰ [2013] EWHC 581 (Comm); [2014] EWCA Civ 1349; Case ID: UKSC 2014/0252.

⁶¹[2013] EWHC 1666 (Comm) [146]. It is, perhaps, possible to suggest that this was the reason he provided significant points of protest over the harsh operation of the law. This probably constituted Popplewell J's points of appeal to the Supreme Court.

states that a person is entitled to the peaceful enjoyment of his property of which he cannot be deprived of his possessions except in the public interest and subject to the conditions provided for by law.⁶²

Dishonesty

Dishonesty is relevant to representation made pre-contract and post-contract. Since the decision in *Aviva v Brown*, it has been suggested that the law has developed in a pro-insurer manner.

In accordance with *Pan Atlantic Insurance Co Ltd and another v Pine Top Insurance Co Ltd*,⁶³ the House of Lords was clear that the insurer can avoid the policy *ab initio* if

⁶² The right to property was not included in the ECHR. Instead, the signatory states completed this in 1952 and it became law in 1954. Protocol 1 was aimed originally at preventing people being dispossessed of their property in incremental steps such as the Jews were under Hitler's Germany.

Generally there are three principles that apply to the protection of property: (1) lawfulness; (2) legitimate aim in the public interest; and (3) fair balance.

(1) Lawfulness requires that there is an infringement of a right to property and that this infringement has the basis of domestic law. This basis should be accessible, precise and foreseeable.

(2) Deprivation of property is permitted if it is in the public interest and the control of that property is in keeping with the general interest. The court must read these two issues together, and decide if deprivation of the property serves a legitimate aim. Legitimate aim is a principle from Article 18 of the ECHR. This can be inferred (see *Beyeler v Italy* [2000] Ap. 33202 [111]).

'Any interference with the enjoyment of a right or freedom recognised by the Convention must, as can be inferred from Article 18 of the Convention (see paragraph 128 below), pursue a legitimate aim. The principle of a 'fair balance' inherent in Article 1 of Protocol No. 1 itself presupposes the existence of a general interest of the community. Moreover, it should be reiterated that the various rules incorporated in Article 1 are not distinct in the sense of being unconnected and that the second and third rules are concerned only with particular instances (see paragraph 98 above). One of the effects of this is that the existence of a 'public interest' required under the second sentence, or the 'general interest' referred to in the second paragraph, are in fact corollaries of the principle set forth in the first sentence, so that an interference with the exercise of the right to the peaceful enjoyment of possessions within the meaning of the first sentence of Article 1 must also pursue an aim in the public interest.'

(3) The level of state interference must not be disproportional or excessive. To determine proportionality the interests of the individual have to be contrasted with the interests of the general public.

⁶³ [1995] 1 AC 501(HL).

fraud has induced the insurer at the contracting stage.⁶⁴ This way, the Law Commissions could broadly adopt the ratio from *Derry v Peek*⁶⁵ and effectively incorporated it into statute under s 5(1)(a) of the Consumer Insurance (Disclosure and Representations) Act 2012 and s 8(4) Insurance Act 2015.

In the consumers' case, the Consumer Insurance (Disclosures and Representations) Act 2012 defines a qualifying misrepresentation as deliberate or reckless if the consumer:

- (a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading; and
- (b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.⁶⁶

Honesty is crucial to knowledge and carelessness which is so reckless that the insured simply does not care about the consequences of what is said. It had been argued in both the second and third articles as part of this work and by other authors (ie, Dr Aysegul Bugra and Professor Robert Merkin QC)⁶⁷ that the combined test for dishonesty should be the one as adopted by Eder J in *Aviva v Brown*. Since the writing of these articles, however, doubt has now been cast by Popplewell J in

⁶⁴ The provisions in statute have a close degree of similarity in their approach to fraud in both consumer and non-consumer insurance; however, in neither case has 'fraud' been defined. The Law Commissions wanted to allow the common law to develop this. If statute provided a definition it would be easier to challenge that the insured did not fall within that criteria, and so the Commissions chose to adopt terminology such as 'qualifying misrepresentation'.

NB: the need for inducement in fraudulent claims was removed by Mance LJ in *Agapitos v Agnew The Aegeon (No 1)* [2003] QB 556.

⁶⁵ (1888) LR 14 App Cas 337.

⁶⁶ In a similar vein, non-consumer insured will have committed 'fraud' if the insurer can prove that there has been a qualifying breach which is deliberate or reckless under s 8(4) of the Insurance Act 2015. The insurer will then have to prove that the insured:

- (a) knew that it was a breach of the duty of fair presentation; or
- (b) did not care whether or not it was in breach of the duty.

⁶⁷ Bugra and Merkin technically made the point first, although the article the writer had written was independent. "Fraud' and Fraudulent Claims" (2012) 125 Journal of the British Insurance Law Association 3; and G Swaby, 'Insurance Law Reform: deterring fraud in the twenty-first century' [2011] Int JLM, 413.

Versloot, where he stated that honesty was only an objective test.⁶⁸ Thus, it is easier to prove that an insured has been dishonest by reference to a reasonable man.⁶⁹ This, again, swings in insurers' favour, if this is the position of the law. Professors Philip Rawling and John Lowry, nevertheless, cite Professor Merkin's article and the second article as being the position of the law.⁷⁰

Agents Fraud and Innocent Principals

In the fourth article, 'Blurring Distinctions; should the innocent insured be tarred with the same brush as their agents?', the argument was advanced that there needed to be flexibility in the law so that the insured was not punished for the frauds of his agent. The Law Commission was consulted during the writing of this paper. The commission specifically requested evidence through case studies that illustrated the injustice of the situation. When asked as to how many case studies the commission would need to help it formulate a change in the law, it replied 'six'.

During the research of this paper, a number of insurers were contacted and there were varying degrees of response. None of them, however, wanted to go on record and be quoted. There was a great deal of suspicion and distrust that had to be overcome in order for the insurers to provide examples of instances where the agents had committed fraud without the knowledge of their principals.

One insurer specifically informed the writer that they did not want to provide examples as this would give the Law Commission the justification it needed to

⁶⁸ "The subjective element requires the assister to know facts which make his conduct, objectively viewed, dishonest, but there is no subjective element of conscious dishonesty; the test for dishonesty does not require that the assister considers that he is acting dishonestly.' Per Popplewell J [2013] EWHC 1666 (Comm) [153].

⁶⁹ This position remains to be clarified by the Supreme Court, although it is doubtful whether this will be the case in *Versloot* since the misrepresentation was made recklessly as the manager of the ship in that case had convinced himself as to the truth of his statement to the insurers.

⁷⁰ PJ Rawlings and J Lowry, 'Insurance fraud: the 'convoluted and confused' state of the law' [2016] *The Law Quarterly Review* vol 132, 96, 119, fn 20. It should also be noted that the combined approach to dishonesty has also been adopted in New Zealand Supreme Court in *Jackson v IAG New Zealand Ltd* [2014] NZSC 12.

change the law, and that it was not in the insurance industry's interest to do so. Solicitors acting for the insurers, however, were happier to provide anonymised examples provided that they were not on record. One body that wanted to help with the research was the Chartered Loss Adjusters Association (CLAA). CLAA confirmed that there was a problem, as one loss adjuster phrased it: 'at the 'coalface'' in this regard. CLAA had many different examples, but one area that was of concern to the association was the fact that whilst it acted for the insurers, many insured wanted a second opinion as to the insurer's liability and/or the value of the loss that they had suffered, and so to these ends they had instructed their own expert. These experts are the loss assessors.

When the loss assessor provides a professional opinion as to liability and the value of the loss it sets the stage for an adversarial battle. On the one hand, the insurer, via their agent the loss adjuster, sets the loss value. This can be an under valuation, and as such they will not want to pay out on anything more than they absolutely have to. A loss adjuster may act competently at the bottom end of the scale. They may also act negligently, however, and even fraudulently. Thus, any second opinion that the loss assessor provides does question the stance of the insurer, and so it is understandable that insurers would claim that there has been an over exaggeration by a loss assessor. The truth, perhaps, lies somewhere in between.

The Law Commissions noted that the examples in the fourth article 'Blurring Distinctions' were the only ones to be provided of an innocent insured being tarred with the fraud of their agent.⁷¹ This could indicate that they have terminated this area of enquiry too soon, and the anecdotal evidence should have been the lynchpin for further investigation.⁷² This article, however, did more than that: it compared and contrasted international jurisdictions' approach to the use of fraudulent agents and the varying degrees to which the principal could be protected. It established that there was a hierarchy of remedies provided, and strongly suggested that the UK's

⁷¹ Law Commission, 'Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment' (Law Com No 353, 2014) [22.38] and fn 24.

⁷² R Merkin and I Enright, *Sutton on Insurance Law* (4th edn, Thompson Reuters, Sydney 2015) p1154, fn 446.

approach was very harsh, if not the harshest in the common law world, and a more equitable position was needed. No reform was ultimately forthcoming however. The six examples that the Law Commissions requested could not be treated as anything more than anecdotal, due to the fact that no insurers provided any case studies. If this lack of response were viewed cynically, it would generate the question as to why an insurer would want to cooperate, for if they did they would be shooting themselves in the foot. The Law Commissions implied, from their silence, that there were no problem examples, and therefore, in practice, this was not a problem area. The contrary was most definitely the truth.

The law has developed in this area since the writing of the article. In the following year, 2014, there was a development in this area of agency and gross exaggeration involving a father-and-son relationship in a burglary claim. In *Savash v CIS General Insurance Ltd*,⁷³ Akenhead J had to get to the truth. An insurance claim was made by Sozem Savash (the son) for an alleged burglary that took place on 29 May 2009 at 30 Minchenden Crescent, London. The case was originally listed before the Central London County Court on 25 Oct 2012, but given the complexities and allegations of fraud and dishonesty it was transferred to QBD's Technology and Commercial Court.

In this case, Mr Savash (the father) and his then wife bought No 30. The family lived there for 20 years. The father decided to sell the house, and his son bought it. The son eventually moved out in 2006, but his parents lived there until they divorced whereupon his mother and sister continued to live there until their relationship with the son broke down and they were evicted by a court order in July 2008. The father was then alleged to have returned to the home at the time of the burglary.

The burglary was a sophisticated attack, with the burglars gaining entry by drilling out the garage door lock and drilling through the UPVC kitchen door. The sight that greeted the police officers in attendance was not that of a typical burglary. The burglary was committed between 10 am and 4 pm. The damage was extensive. There was water coming through the ceiling from a pipe that was cut. A fridge

⁷³ [2014] EWHC 375 (TCC).

freezer, washing machine and dishwasher had been tipped over, and all the rooms had been 'smashed up'. In addition, large items of heavy furniture, such as a large king-size bed, were allegedly stolen. When the police questioned the neighbours, no one had seen any vehicles at the property during this time.

The son notified the insurer of the claim. The insurer's representatives, Cunningham Lindsay loss adjusters, attended the site. They concluded that the large-scale damage was consistent with malicious damage and not that associated with a burglary. The loss adjusters calculated that the whole damage and thefts would have taken one to two days to complete.

The father put forward many invoices covering the repair of the building and replacement of goods to the insurer on his son's behalf. After reviewing the law on fraudulent statements in *Derry v Peek*,⁷⁴ Akenhead J held that the rules on fraud and fraudulent devices were as stated in *The Aegeon*.⁷⁵

Akenhead J then considered that it was well established by Lord Hobhouse in *The Star Sea*⁷⁶ that '... the insured who has made a fraudulent claim may not recover the claim which could have been honestly made'.⁷⁷ Akenhead J held that there had been a genuine burglary and it had caused the water damage. The son and his father had, nevertheless, presented the claim, which included items that were not stolen, and thus the claim was deliberately exaggerated. Fraudulent invoices for repair works

⁷⁴ (1888) LR 14 App Cas 337.

⁷⁵ [2002] 1 Lloyd's Law Reports 573.

⁷⁶ [2003] 1 AC 469 [62].

⁷⁷ Lord Hobhouse continued: 'The principle is well established and has certainly existed since the early 19th century: *Halsbury's Laws of England*, 4th edn reissue, vol 25 (1994), p 284, para 492, Welford & Otter-Barry, *Fire Insurance*, 4th edn (1948), p289 et seq. This result is not dependent upon the inclusion in the contract of a term having that effect or the type of insurance; it is the consequence of a rule of law. Just as the law will not allow an insured to commit a crime and then use it as a basis for recovering an indemnity (*Beresford v Royal Insurance Co Ltd* [1937] 2 KB 197), so it will not allow an insured who has made a fraudulent claim to recover. The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.'

were also presented to the insurer. Perhaps more damning was the fact that Akenhead J held that the son knew about the fraudulent claims.⁷⁸

What is more important, however, is what Akenhead J said *obiter* as to the position of the son, with regards to the fraudulent acts of the father. Akenhead J considered: 'Both Counsel, rightly, accept that, if the son in those circumstances recklessly adopted and pursued deliberately exaggerated claims, he would be 'guilty' of fraudulent devices because recklessness also amounts to civil fraud.'⁷⁹ Akenhead J approved of defence counsel approach that relied upon Professor Merkin QC in *Colinvaux's Law of Insurance*,⁸⁰ and then considered Buxton LJ judgment at [41], where the latter refers with approval to Lady Justice Arden in *Direct Line v Khan*,⁸¹ who stated:

As my Lady has described, Mrs Khan cannot escape from the application to her case of the combination of two legal principles: (1) a principal is bound by fraudulent acts committed by his agent unless he can show that that fraud was outside the scope of the agency, which Mrs Khan cannot demonstrate; and (2), as provided by *Galloway*, a claim which is fraudulent in any sufficiently substantial part is invalid in respect of the whole of the claim, and all monies paid under the claim are thereby recoverable. That is all that the insurer in our case needs to establish in order to succeed. Its claim for return of the payments that it has made does not depend on showing that because of the fraud the contract was rendered void *ab initio*.

It is therefore clear from Akenhead J's judgment that even innocent insured continue to be tainted with the acts of their fraudulent agents, as a matter of public policy, to deter fraudulent claims even if the insured are seeking no more than that to which they are entitled. As an *obiter* reflection of the law, it is clear that the court considered that family relationships of father and son can bear an agency relationship, whereby the father's fraudulent acts would be imputed as a matter of

⁷⁸ [2014] EWHC 375 [55].

⁷⁹ [2014] EWHC 375 [58].

⁸⁰ 9th edn at 9.024: 'A claim can only be fraudulent if the assured is dishonest or at the very least culpably reckless. Mere negligence on the part of the assured will not suffice. The fraud must be that of the assured himself and not that of a third party for whom the assured is not responsible. Within an organisation this principle will raise a question of imputation of knowledge. An assured is, however, responsible for the fraud of an agent acting within the scope of his authority.'

⁸¹ [2001] EWCA Civ 1794.

agency law onto the principal son's claim as they would be committed within the scope of the father's authority. This is also consistent with the analysis of the law of agency in the fourth article, 'Blurring Distinctions'. The law is clearly in the insurers' favour.

This article was the first to consider agency law and its specific application to first party claims in insurance law. Overall, all of the articles on fraud were sent to the Law Commission, and as a result, whilst they may have stimulated debate, opposition from insurers was substantial and, resultantly, the position that the papers argued for was too generous to be acceptable. Participation as a consultee resulted in a special acknowledgement/consideration from the Law Commission for the articles submitted over and above that of normal consultees.⁸²

A Comparative Analysis of the Position with Fraudulent Third Party Claims

In the fifth article, 'Cheek by Jowl; fraudulent insurance claims and counter measures enacted in personal injury cases',⁸³ the position of third party negligence insurance claims was considered and contrasted to first party contract claims to see if lessons could be learned from this position. This was the first article to consider this position in relation to fraud and the new statutory introduction and operation of 'fundamental dishonesty'. The article was the first to identify that there could be a difference, viewed as a percentage, in the requirement of substantiality for a tort claim (which involved a fraud or fundamental dishonesty) and a contractual claim that required the fraud to be substantial. The article identified that a greater degree of latitude was needed in personal injury claims to take into account the inaccuracies of calculating damages for personal injuries.

In addition, the article identified that there was a significant contradiction on the point of a costs order between fundamental dishonesty in the Civil Procedure Rules

⁸² The Law Commission, 'Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims and Late Payment' (Law Com No 353, 2014) p393.

⁸³ This article was originally presented as a paper at the annual conference, in 2015, of the Society of Legal Scholars in York.

and fundamental dishonesty under s 57 of the Criminal Justice and Courts Act 2015. Specifically, the article criticised the relationship between ‘substantial injustice’ and ‘fair and just’ requirements. It noted that the significant inconstancy between the two would result in the primary legislative Act overruling the secondary legislative statutory instrument.

The article was not the first to comment on the current, leading county court decision in *Gosling v Screwfix Direct Ltd*,⁸⁴ as numerous websites, blogs and industry journals (not peer reviewed) had made short mention of it. The article was, however, the first highly detailed critical review of the subject matter, and it also considered other County Court approaches to examine whether the County Courts were following the Cambridge County Court in *Gosling* and compared the law with that in Ireland, where similar provisions existed. No published paper had considered this before.

There is a cautionary tale as regards the development in this area since the publication of the article in the decision of *Ravenscroft v IKEA* (2015).⁸⁵ This decision was reported in various industry journals (not peer reviewed), websites and populist press. In this case, Mrs Ravenscroft was shopping with her 2-year-old grandson in Warrington IKEA when she saw a mirrored-wardrobe fall towards her grandson. She stepped in front of the falling unit to prevent it hitting her grandson. She absorbed its full force, injuring her neck, shoulder, arm and wrist. She brought a personal injury action, but it was defended by IKEA, which alleged that Mrs Ravenscroft had been fundamentally dishonest, as her account did not match that of the IKEA staff. Mrs Ravenscroft had no option, however, but to pursue her claim, for conceding that she was fundamentally dishonest would have dire consequences for her employment, such was the severity of the stigmatization. Furthermore, looking beyond this claim, such an allegation of dishonesty would have additional consequences as she would find it extremely difficult to ever again qualify for domestic insurance, such as buildings and contents, or for car or life insurance cover.

⁸⁴ *Gosling v (1) Hailo (2) Screwfix Direct Ltd* (2014) 29 April, Cambridge Cty Crt (unreported).

⁸⁵ Case No B08YX421 (2015) 17 December, Manchester Cty Crt (unreported).

The claim came before Bernadette Stonier HHJ. She held that Mrs Ravenscroft's evidence was honest and more persuasive, on the balance of probabilities, than that of the IKEA employees. She criticised the defence adopted by IKEA as deplorable and believed that the company had taken a stance of suspicion rather than one of sympathy. She awarded £3,500 in damages and interest. Perhaps what was more concerning was the fact that costs were in the order of £100,000. Mrs Ravenscroft was not awarded indemnity costs or aggravated damages. Stonier HHJ did state, however, that only a small number of claims were fundamentally dishonest and that insurers were now using fundamental dishonesty tactically to either coerce the claimant into dropping their claim or as a means to an end for under settling it. Thus, in general, the law is tactically in the insurer's favour since the introduction of fundamental dishonesty.

Fraudulent Counter Measures

'Fundamental dishonesty' forms part of a raft of recommendations for curbing fraud and preventing the claims culture that is said to exist in the UK. The insurance industry is more than happy to shout about this in order to get headlines in the populist tabloid press, with general statistics provided without any independent verification. The problem for future claimants is that the industry has the ear of the government. Therefore, the government announced in its Spending Review and Autumn Statement (2015) that it proposes lifting the small claims limit to £5,000 for personal injury claims and banning all claims for road traffic accident soft tissue injuries.

It remains highly questionable as to whether there is a compensation culture. This was addressed in the eighth article, 'Personal injury law update: proposed reforms'. By reference to the government's own Department for Work and Pensions Compensation Recovery Unit (CRU) figures, it is not apparent that there is a

compensation culture.⁸⁶ Furthermore, Lord Young’s report in 2010⁸⁷ for government also concluded that there was no compensation culture in the UK. This has also been concluded academically in the past, but what is perhaps more significant is the figures from the CRU for all registered whiplash cases, which show very significant drops in registered whiplash cases.⁸⁸ This information was published in the *CILEx Journal* article on the main provisions recommended by the Treasury’s Insurance Fraud Taskforce report published in January 2016 (see the ninth article).

The Taskforce report makes 26 recommendations; summarising the main points: recommendations 1 and 2 covered the need for improved communication across industry using a variety of media to promulgate the message that insurance fraud is unacceptable whether it be first party or third party insurance claims; recommendation 3 required greater integration of databases holding client information, making it easier to see a person’s claims history; recommendation 8

	Clinical	Employer	Motor	Public	Other	Liability unknown	Total
2014/15	18,258	103,401	761,878	100,072	12,972	1,778	998,359
2013/14	18,499	105,291	722,843	103,578	14,467	2,123	1,016,801
2012/13	16,006	91,115	818,331	102,984	17,695	2,175	1,048,309
2011/12	13,517	87,350	828,489	104,863	4,435	2,496	1,041,150
2010/11	13,022	81,470	790,999	94,872	3,855	3,163	987,381
2009/10	10,308	78,744	674,997	91,025	2,806	3,445	861,325
2008/09	9,880	86,975	625,072	86,164	3,415	860	812,348
2007/08	8,876	87,198	551,905	79,472	3,449	1,850	732,750
2006/07	8,575	98,478	518,821	79,841	3,522	1,547	710,784

⁸⁷ Common Sense Common Safety

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60905/402906_CommonSense_acc.pdf (Accessed 2 June 2016)

⁸⁸

	2011-2012	2012-2013	2013-2014	2014-2015
Whiplash Cases Registered with CRU	547,405	488,281	410,215	376,513

was aimed at the personal injury defence practice of making pre-medical offers as full and final settlement of a claim (effectively preventing insurers 'buying off' the injured claimants before they have started to run up legal costs); and recommendation 10 is aimed at the personal injury industry and the action that can be taken to prevent late claims by reducing damages by 50% and reversing the burden of proof so that the personal injury claimant has to prove that he was injured.

Recommendations 14, 15 and 16 are aimed at the Solicitors Regulation Authority (SRA). The fifth article, 'Cheek by Jowl', considers the case of *Impact Funding Solutions Ltd v Barrington Support Services Ltd (formerly Lawyers at Work Ltd) and AIG Europe Insurance UK Ltd (formerly known as Chrtis Insurance UK Ltd)*.⁸⁹ In this case, it can be clearly seen that where a solicitor acts negligently when accepting a personal injury claim and then promoting that claim, the solicitor will have to repay the third party claims funder either out of their funds or their indemnity insurance; this should make solicitors think twice. The Taskforce's recommendation will allow the SRA to investigate such practices that promote fraudulent claims with the Insurance Fraud Bureau. Then, in conjunction with the lowering of the standard of proof from beyond reasonable doubt to the balance of probabilities, it will make it easier for insurers to make allegations of fraudulent or dishonest behaviour against firms of solicitors.

Recommendations 20 and 21 deal with what are perhaps the biggest driving force promoting many different heads of claims: the Claims Management Companies (CMCs). At the time of writing, this is going through a separate review, but these CMCs have created a niche for themselves where there was none before. People who had legal problems simply went into a high street solicitor for help, but these CMCs have been effective recruiters of clients for cases, such as personal injury; mis-sold financial products and services (eg. payment protection insurance claims); employment and redundancy claims; criminal injury claims; industrial injury claims and housing disrepair claims. It is their practices, however, that the Taskforce seeks

⁸⁹ [2015] EWCA Civ 31.

to address, with coordinated action from the regulators policing the referral fees ban to coordination with Ofcom to prevent nuisance calls and texts.

Whilst all the provisions are not without comment (see the ninth article), the law also needs to protect the innocent and negligent claimants. If insurers seize on inaccuracies and alleged fraud such as in *Hayward v Zurich Insurance Company Plc*,⁹⁰ then they may well be justified, but litigation is tactical positioning. Limited exaggeration can be permitted, as mentioned in the second and fifth articles, but in general, the law is in the insurers' favour.

⁹⁰ See the fifth article, 'Cheek by Jowl', and the seventh article, *CILEx Journal*, 'Personal injury practice update'. NB: Appeal to the Supreme Court has been granted, and at the time of writing a date is yet to be set.

3. Claims Handling Duty of Insurers

One thing that may curb insurers pleading fraud is that a claim will have to be paid within a reasonable period of time. The unfairness of English law on this point is critically examined in the sixth article, 'Re-balancing the kilter'.⁹¹

There is a legal fiction that the insurer has to hold harmless the insured, so that the insurer is liable to pay the claim immediately when the loss occurs. The problem occurs when the insured's loss is not made good immediately. A delayed payment can often result in the insured suffering further losses. There can be many reasons why a late payment and an often deliberately late payment should occur, perhaps attempting to hit internal targets.⁹² Clearly, businesses may fail as a result, and this is a way insurers force businesses, or at least place undue pressure on them, to accept a lesser indemnity than that to which they are entitled. The most a court can do is award interest from the time of the loss. This is because the insured cannot recover damages on top of indemnity damages. This has caused a number of unfortunate decisions that ensures the continued dominance of an industry which has the law skewed in its favour. Since the Court of Appeal decision in *Sprung v Royal Insurance (UK) Ltd*,⁹³ there have been no further challenges.

⁹¹ This article was delivered as a paper at the Association of Law Teachers Annual Conference in Cardiff, in 2011.

⁹² The Law Commission has not recommended abolishing the 'hold harmless' principle. They did not consult on this point and feared that any abolition would have recurring consequences outside the insurance sphere Law Commission, 'Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment' (Law Com No 353, 2014) [28.80]. Instead the commission recommended retaining the principle so that the insurer is liable at the moment the risk/loss materialises, so that interest can be awarded from that date and limitation period commenced. The Law Commission feared that if it abolished the hold harmless doctrine it would result in only a contractual duty to compensate the insured. This would impact the limitation period and the 'options would be to:

- (a) abandon the policy of starting limitation at the date of loss and allow it to start running at the date at which a cause of action accrued (ie a reasonable time after the claim is made); or
- (b) legislate specifically to counter the presumptive position that limitation would start running at the date the cause of action is accrued.' Law Commission, 'Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment' (Law Com No 353, 2014) [28.81].

⁹³ [1999] 1 Lloyd's Rep IR 111.

Bringing a claim for a loss is not going to be easy; it will be an uphill struggle and can falter on so many points along the way. Litigation always involves risk, and a certain outcome cannot be guaranteed; however, it is not impossible for the insured.⁹⁴

The Law Commission intended to include a clause in the Insurance Bill 2014, but the Lloyd's Market openly opposed the provision. This would, therefore, make the inclusion of this clause controversial, and as the bill was using a non-contentious procedure, the whole bill risked failure. All was not lost however: the Law Commission, at its earliest opportunity, included initially two clauses in the Enterprise Bill 2016 to amend the Insurance Act 2015 and include the amendments before the Insurance Act comes into force on 12 August 2016. As of Wednesday 4 May 2016, the bill received royal assent and became effective immediately, and so the Insurance Act 2015 has been amended, but this provision within the Insurance Act does not come into effect until 4 May 2017.

The new provisions are contained within Part 5 ss 29, 31 of the Enterprise Act 2016. These introduce ss. 13A, 16A into the Insurance Act 2016 and s 5A into the Limitation Act 1980. The reasoning behind the 4 May 2017 time delay was to provide a period of adjustment to allow insurers to make provisions in their policies, and to consider whether they want to contract-out in the case of non-consumers. If they chose to do this, the terms must be transparent and prominent (in accordance with the contracting out principles in s 17 of the Insurance Act 2015 that have previously been discussed above), although it is not possible to contract-out in the case of consumers (s 16A(1) of the Insurance Act 2015 as amended).

⁹⁴ Retrospectively, Mr Sprung would have been successful but, first, the insured will have to prove that he has a valid claim. Secondly, he will have to prove that the insurer did not pay the claim within a reasonable time. This is going to be very fact dependent. It will have to take into account the type of insurance involved and allow the insurer a reasonable period to conduct an investigation to establish their liability and whether they have reasonable grounds for not paying the damages (eg, an excluded risk or fraud). Thirdly, the insured will have to show that he has suffered a loss resulting from the failure to pay and that this loss was foreseeable at the time of contracting. This will have to take into account both limbs of *Hadley v Baxendale* [1854] EWHC J70. Finally, the insured must mitigate his loss.

The Lloyd's Market did not like this type of implied term and lobbied hard. The Market gained a concession from the government that introduced an additional clause, which placed a time limit upon an insured to bring a claim for late payment within 12 months of the insurer closing its books under s 5A of the Limitation Act 1980 as amended. The wisdom of this is not necessarily clear, for most lawful claims before a court would probably include a claim for a breach of the implied term to pay a claim within a reasonable period of time. This could be an area, however, where claims management firms could interject themselves and start promoting claims for late payment. It is questionable, though, as to why the Lloyd's Market had taken such a staunch stance, especially given all the complexities in bringing a successful claim on the very rare occasions where it occurs. By not having this principle, damage to the international reputation of the London Market and, as a consequence, other nations' laws are preferred as the basis of the contract where insurers are obliged to pay damages for late payment.⁹⁵

The Law Commission also considered whether damages should be awarded for distress and inconvenience caused by the insurer in consumer insurance. In the sixth article, 'Insurance Reforms: re-balancing the kilter' it was argued that this should be an implied term in consumer contracts, but unfortunately the Law Commissions chose not to reform this area as they did not want to create a specific right through an implied term separate to the general right in damages. Their justification is that damages for late payment will be available, and in consumer cases damages for distress and disappointment can be recovered where the consumer will not have had the peace of mind that an insurance policy should bring.

(Financial Ombudsman Service)

⁹⁵ When David Hertzell, the then Law Commissioner, gave evidence to the Special Public Bill Committee in 2014 as the Insurance Bill was progressing, he provided some anecdotal evidence as to the Lloyd's Market and perceptions and the need to protect its reputation. He referred to a magazine article in *Commercial Risk Europe* where he stated 'whilst most insurance claims are paid on time, this is not the case in the London Market where a policyholder company making an insurance claim might face an argument with 20 lawyers.' See Law Commission: *Late Payment of Insurance Claims: Briefing for the House of Lords Committee on Enterprise Bill*, 2 November 2015, [1.13–1.15].

This is purely an artificial justification. It is difficult to foresee a circumstance where a consumer would suffer from an insurer's late payment. Perhaps if the insurer permitted the insured to instruct their own builders to effect house repairs and then refused to repay the bill without justification, there could possibly be a claim if they could satisfy the criteria; however, this is extremely difficult for a consumer to show a loss. This, therefore, needs to be a separate implied term. It should operate in a similar way to that approach used by FOS. Here the law and practice differ: there are going to be few if any cases in which a precedent could be set, for appeals to FOS are free to consumers and are now binding on all parties.

This position was previously considered to be binding on the insurers only, and only up to the claims value of £150,000.⁹⁶ After that sum, FOS can only make a recommendation, and so insurers do not have to follow this. And why should they? They are a business, not a charity, with shareholder dividends to pay on shares traded on the stock exchange for profit. Why should they do something which is not strictly binding upon them? It would be naïve to think that they would. It makes the whole situation contemptible, and this was made worse by the Court of Appeal's ruling in *Clark v In Focus Asset Management & Tax Solutions Ltd.*⁹⁷

In this case, the Court of Appeal ensured that the FOS award would not be used to fund further litigation action to recover sums over £150,000 awarded, as this would leave the insured with nothing if they lost. Therefore, the Court of Appeal's decision was considered a public policy matter. As a result of this cap, both law and practice favour the insurer.⁹⁸ Therefore, if a house in London was lost along with all its

⁹⁶ This was the limit after 1 Jan 2012. Before that date the limit was £100,000.

⁹⁷ [2014] EWCA Civ 118.

⁹⁸ The £100,000 cap that had been in place since 2001 is woefully out of keeping with inflation, and simply increasing the limit to £150,000 is too little too late. The Insurance Ombudsman Bureau originally used the £100,000 figure in 1981, when the voluntary scheme was established. According to the Bank of England inflation calculator, had this kept pace with inflation it would now be worth £3,45762.71 in 2015, and if it was taken from 2001 (when FOS replaced the IOB under the Financial Services and Markets Act 2000) this would have been £1,49188.24 in 2015. Therefore, FOS is woefully failing consumers restricted by figures set by the Financial Services Authority, and now its replacement the Financial Conduct Authority. Generally, it would make perfect sense to increase this limit by inflation, for a detached house in London was, on average, £60,433 in 1981. According to

contents to fire damage and a dispute arose, the insured needs the law to follow the approach of the FOS. Perhaps the only consolation would be that an insured, owning a property in London, could be financially stable so that a claim could be brought to court. Sadly, the reality is that FOS is of absolutely no use whatsoever to any consumer insured whose indemnity is over £150,000, unless the insured is prepared to accept a loss. Whilst it could be argued that the rate should not increase above the £150,000 mark as it begins to become a commercial issue, this is frankly irrelevant as the original IOB was set at a figure well in excess of that that was needed at the time when the scheme was envisaged.

GLAEconomics, *Market Failure and the London housing market*, Greater London Authority (2003), a detached house in London had risen to an average of £493,978 in 2001, and finally the *Financial Times* indicated that £1.5m would be needed as a minimum in 2014 (Francesca Steele, 'Four London boroughs where house prices are set to take off' (London, February 28 2014). This excludes contents.

General Conclusions

Overall, the law still strongly favours the insurer in relation to fraud, and so it should for deliberately calculated deceit. However, discretion is needed for minor culpability in 'means and devices' cases and those of exaggeration under 2% so as to be *de minimis*: dishonesty should be considered on a subjective basis. This has some support in Ireland (see the fifth article) and should be welcomed in England.

In addition, inducement of the insurer should be a requirement; this would then follow the common law and pre-incorporation representation to insurers. This is also a requirement in settlements with third party insurance claims based on *Hayward v Zurich Insurance Company Plc*. Therefore, there should be equality across all areas of law and inducement should be reintroduced in 'means and devices' cases.

There is probably no compensation culture across first and third party claims. With the number of whiplash cases significantly decreasing and house insurance claims, there is going to be fluctuation. Indeed, the government's own case for a compensation culture is inherently usurped by the CRU's own figures.

There also needs to be significant differentiation between the promotions of claims that may be 'weak', but these are not fraudulent. Weak claims need to be challenged, but not on fraud grounds. Thus, claiming that there is a compensation culture cannot be true when insurers want to treat both issues synonymously.

Overall, there needs to be scrutiny of any claim, but tempered harshness when fraudulent culpability is very low and generosity when the insurers obstructively conduct themselves, delaying payments on valid claims.

Finally, the FOS desperately needs the compensation limit to be increased above the £150,000 set on 1 January 2012. The ridiculously low limit means that consumers and small businesses are losing out, and this loss is a significant injustice. It is farcical to say that FOS can 'recommend' payments above these limits when there is no obligation on the insurer to pay.

Appendix 1

Australian criticism of the state of the common law

The Australian Law Reform Commission investigation into insurance law resulted in criticism (of the then) state of the law. Imperial statutes such as the Fires Prevention (Metropolis) Act 1774 (Imp) were in 'archaic and obscure language'.⁹⁹ The State legislation was 'piecemeal and sporadic' and generally ineffective. The common law and the Federal legislation such as the Life Insurance Act 1945 (Cth) were remedying issues of a bygone age.¹⁰⁰ From the consumer perspective, there was 'widespread dissatisfaction' referring to complaints in the annual reports of the State and Territorial consumer affairs authorities and the annual reports of the Life Insurance Commissioner. Complaints were also made directly to Members of Parliament. The answer was clear, there needed to be a single consistent approach across the Commonwealth and to this end the Commission published *Report No 16: Insurance Agents and Brokers*¹⁰¹ in 1980, which resulted in Insurance (Agents and Brokers) Act 1984 (Cth)¹⁰² and *Report No 20: Insurance Contracts*¹⁰³ in 1982, which in turn resulted in the Insurance Contract Act 1984 (Cth). Both documents had to be read together to form the complete picture. It was not clear sailing for the bills according to Hon Michael Kirby as the 'Australian insurance industry was almost unanimous in its opposition to any change'.¹⁰⁴

⁹⁹ Other examples include the Life Assurance Act 1774 (Imp) and the Marine Insurance Act 1788 (Imp).

¹⁰⁰ The Insurance Act 1973 (Cth).

¹⁰¹ (ALRC 16).

¹⁰² This was later re-enacted in the Corporations Act 2001 (Cth).

¹⁰³ (ALRC 20), AGPS, Canberra, 1982, p xv.

¹⁰⁴ M Kirby, 'Insurance Contract Law Reform – 30 years on' 2 (2014) 26 Insurance Law Journal.

Appendix 2

Australian approach to good faith

The Australian Law Commission Report No 20 was a thorough branch-and-root review. In relation to utmost good faith, it was important that the principle remained the “touchstone” of insurance contracts,¹⁰⁵ but stated that it should be made clear that ‘the insurer should show the utmost good faith as much as the insured’.¹⁰⁶ Utmost good faith is fundamentally incorporated into the Insurance Contracts Act 1984 through ss 12, 15. These sections change the nature of utmost good faith from an extra-contractual duty to being a contractual duty.

Section 13 states the duty of utmost good faith: ‘(1) A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.’

This section makes the duty of utmost good faith a contractual implied term. It divorces non-disclosure and misrepresentation from the duty of utmost good faith. This requirement applies equally to both parties, but for the insurer it is less friendly as a breach of the section will not give rise to avoidance *ab initio*, it sounds in damages. It does not give the insurer the right to expect the insured to volunteer pre-contractual information. If the insurer wishes to know something, then he must ask specifically. This causes a problem in that the duty of disclosure under s 21 takes effect before the contract has been entered from when s 13 applies. This problem is addressed in s 12.

Section 12 states: ‘The effect of this Part is not limited or restricted in any way by any other law, including the subsequent provisions of this Act but this Part does not have the effect of imposing on an insured, in relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure.’

¹⁰⁵ XXII/summary.

¹⁰⁶ Ibid.

This is saying that utmost good faith is a dominant part of the Act, which the Act and other law must be read with it. It has been suggested in *Sutton*,¹⁰⁷ that there are two possible readings of this clause. First, is that there is a separate statutory duty of disclosure that falls under s 21 and not utmost good faith in s 13. Secondly, there exists ‘a parallel duty of utmost good faith applying to disclosure under s 13(1), although that duty is no more extensive than the specific duty set out in s 21’. Both of these readings could form an insurer’s defence against a non-disclosure action, but in each case the remedy is different.¹⁰⁸ What is clear is that both s 21 and ss 12, 13 can be pleaded together rather than relying on s 12 or s 21 in isolation.¹⁰⁹ This demonstrates that utmost good faith still has a place in litigation, as s 21 allowed for disclosure and tested it against the reasonable insured. This position has been amended by the Insurance Contracts Amendment Act 2013, which has introduced s 21A that allows for disclosure, but only after the insurer has asked a question.

¹⁰⁷ R Merkin and I Enright, *Sutton on Insurance Law*, (4th edn, Thompson Reuters, Sydney 2014) [6.5].

¹⁰⁸ A breach of s 21 is governed by the provisions in s 28 where ‘the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred ...’ (s 28(3)). A breach of s 13 will result in damages.

¹⁰⁹ *CIC Insurance Ltd v Barwon Region Water Authority* [1998] VSCA 77 per Ormiston JA.