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COVER TO COVER

Welcome to our final issue of Cover to Cover for 2019

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We wrap up the year with a deep dive into the Court of Appeal's recent decision permitting the plaintiffs in Ross v Southern Response to progress their class action claim on an 'opt-out' basis. Assuming the Supreme Court does not take a different approach, this decision is likely to change the landscape for class actions in New Zealand and increase the number of class actions against consumer-facing businesses and their directors and officers.

We also discuss some of the key legal risks facing directors and officers that will be of interest to both insureds and insurers, and we cover Tower Insurance's announcement of its fundamental change to the way it will require its customers to disclose circumstances affecting their risks. We look at the proposals for reform in this area, the different approaches in the UK and Australia and our view on what insurers should be thinking about.

Finally, we provide the usual update on case law and related developments, including:

- The Supreme Court's final word on the assignability of reinstatement insurance benefits;
- The Government's recently announced package for on-sold over-cap properties damaged in the Canterbury earthquakes;
- The High Court's approach to applications to transfer proceedings to the Canterbury Earthquakes Insurance Tribunal;
- The High Court's interpretation of a contract works policy as it related to property damaged upon practical completion of a building;
- The Court of Appeal's decision on the potential to claim "after the event" adverse costs insurance premiums against unsuccessful litigants;
- The High Court's application of an aggregation clause to the Canterbury earthquakes; and
- The Financial Advisers Disciplinary Committee's decision on complaints against an Authorised Financial Adviser in relation to duties under Code Standard 8 of the Code of Professional Conduct for AFAs.

We hope you enjoy this issue of Cover to Cover. If you have any suggestions on how we can improve the publication or topics you would like us to cover, please email us at covertocover@minterellison.co.nz

Court of Appeal opts-out of *'opt-in'* for class actions

The Court of Appeal's landmark decision in *Ross v Southern Response*, permitting the plaintiffs to progress a class action on an *'opt-out'* basis,[1] has brought New Zealand into line with class action frameworks in jurisdictions such as Canada and Australia. The effect of this decision is significant; everyone with the same type of claim as a representative plaintiff will automatically be included in the class unless they expressly opt-out.

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Why this case matters to insurers

This is the first true class action order of its kind in New Zealand and is likely to make such cases easier to instigate and result in larger damages claims. In a unanimous judgment delivered by Goddard J, the Court decided that to decline to make an *'opt-out'* order would go against the principles of access to justice, efficiency and incentives for consumer-facing entities to comply with legal obligations.

The decision will have significant implications for New Zealand's class action landscape. As long as the approach is not altered on any further appeal, we predict that this decision will:

a) pave the way for a greater number of class actions; and

b) make class actions more attractive for potential claimant group and litigation funders, as a larger class will likely result in an increase in the quantum of damages.

A rise in *'opt-out'* class actions is likely to have a particularly significant impact on insurers of insureds that provide goods or services, or otherwise owe obligations, to large groups of potential claimants. There will also be increased risk for insurers of directors of these types of entities. We see the New Zealand Directors and Officers (D&O) market as likely to respond in a similar way to the Australian market (see the discussion on page 11), as New Zealand is brought into line with similar class action jurisdictions. Insurers will no doubt be assessing the risks associated with the possibility of these claims succeeding and what the impact is on their businesses.

The Ross' claim

In May 2018, Mr and Mrs Ross commenced High Court proceedings against Southern Response. They allege that Southern Response provided them with incomplete information about the cost of rebuilding their Canterbury-earthquake damaged home, which caused them to settle their claims on a less favourable basis than they otherwise would have. Mr and Mrs Ross applied to bring the proceedings as representatives of a class of around 3,000 policyholders who also settled with Southern Response in similar circumstances.

The claimants allege that Southern Response received two different Detailed Repair/Rebuild Analyses (DRA) for Southern Response setting out the costs of repair or rebuild. One DRA set out the full costs for rebuild or repair. It is alleged that the other DRA (provided to the insured) did not disclose certain cost items – estimates for internal administration, demolition and design – showing a lower rebuild/repair cost.[2] The claimants allege breaches of section 9 of the Fair Trading Act 1986, misrepresentation, mistake and breach of the duty of good faith. Southern Response denies insurers the allegations saying (amongst other things) that it honestly held the belief that the omitted items were not payable and that there are reliance issues as customers obtained

their own legal and professional advice before entering into the settlements.

Both parties agreed that the case should proceed by way of a representative action, but could not agree on whether policyholders would be required to:

(a) *'opt-in'* by giving notice to the Court (Southern Response's preference); or

(b) *'opt-out'*, meaning that they were represented in the claim unless they gave notice to the contrary (the Ross' preference). It was agreed that the case would be split into two: firstly, a hearing of the common issues between all relevant policyholders and secondly, if the plaintiffs succeed at stage one, a separate hearing in relation to each class member's particular position, taking into account the findings on the common issues.

The High Court declined to allow the claim to proceed on an *'opt-out'* basis. *'Opt-in'* orders had been made in all other class actions in New Zealand and there was *'no cogent reason'* why the Court should depart from past practice.[3] The High Court also restricted the class to those members of the 3,000 policyholder class whose homes required rebuilding and excluded those whose homes could be repaired.

Mr and Mrs Ross appealed both rulings.

The Court of Appeal's decision

The Court of Appeal allowed the appeal. Its principal finding was that stage one of the case could, and should, proceed on an *'opt-out'* basis. There were several key reasons for this finding.

1. The relevant High Court Rule permits the making of an *'opt-out'* order: *"The rule clearly authorises a representative plaintiff to bring proceedings on behalf of other persons with the same interest in the subject matter of a proceeding without first obtaining their consent."*

2. The New Zealand courts should adopt the same liberal and flexible approach as the Australian and Canadian courts. The absence of a detailed legislative regime was not a sufficient reason to decline to make an *'opt-out'* order.

3. An *'opt-out'* approach Is likely to significantly enhance access to justice – the Court considered that: *"The courts should be slow to put unnecessary hurdles in the path of class members, depriving those who fail to take active steps to participate in the proceedings of the opportunity to have their claims determined by the courts, and of the possibility of obtaining some form of relief if their rights have been infringed."* It acknowledged that, whichever approach was ultimately adopted, many class members were likely to fail to take any positive action for a number of reasons that may not have to do with whether it is in their best interest to participate in the proceedings. As Goddard J said, the *"significance of inertia in human affairs should not be underestimated."*

   (a) An *'opt-out'* approach would *"strengthen the incentives for insurers and other large entities dealing with the public to comply with the law, as it increases the prospect that they will be held to account for any breaches of their obligations to large numbers of individuals in circumstances where individual claims may not otherwise be pursued."*

   (b) An *'opt-out'* approach may also provide some efficiency advantages over an *'opt-in'* approach, but the relative efficiencies were *'finely balanced'*. Many of the possibly problematic procedural issues would arise in both an *'opt-in' and 'opt-out'* process, including reviewing claimant notices by the courts, supervising litigation funding arrangements and ensuring that any settlement does not disadvantage a subset of class members. While dedicated legislation would be preferable, the courts had an appropriate supervisory jurisdiction under High Court rule 4.24 and their inherent powers to control procedure for both opt-in and opt-out classes.

4. A split trial gave rise to a stronger case for an *'opt-out'* order as the need to decide whether to participate would be deferred until the common

issues had been resolved. At that point the potential advantages and disadvantages of proceeding would be clearer and more immediate, and claimants would have more information to determine whether to opt-in at that stage. Claimants' interests would be protected in the meantime by inclusion in stage one.

5. The Court implemented a safety net for members of the class by directing that claimants must seek leave before settling and discontinuing the proceedings. This will give the High Court an opportunity to review any proposed settlement and ensure that there is no unfairness to a subset of class members.

While it remains open to a court to direct that a particular claim be brought on an *'opt-in'* basis, the Court went so far as to say that it anticipates that *'opt-out'* orders will be the norm, absent cogent reasons to adopt a different approach.

The Court also allowed the appeal of the High Court's restriction of the class to rebuild customers. The Court considered *"that there are significant questions of both law and fact which are common to rebuild and repair customers. Any relevant differences in policy entitlements arising from differences in the terms of the policy in relation to repair and rebuild scenarios can readily be addressed at stage 1 of the proceedings."* The Court found that a combined stage one trial for rebuild and repair claimants would be more efficient.

How the High Court may approach Issue 1 in the Ross case

The High Court has recently issued a decision on an earthquake insurance claim alleging misleading and deceptive conduct by an insurer: *Dodds v Southern Response Earthquake Services Limited.* The circumstances are the same as those dealt with in the *Ross decision*.

At the heart of both cases is Southern Response's practice of preparing two versions of its reinstatement cost estimates. One version was disclosed to insureds (Abridged DRA), while another was kept internal and included additional cost allowances (Complete DRA).

Background

The plaintiffs, the Dodds, insured their home with AMI Insurance Ltd (later Southern Response). Their home was damaged beyond economic repair in the Canterbury earthquakes. In 2011, the Dodds made insurance claims with EQC and Southern Response.

The Dodds' policy provided that if their home was damaged beyond economic repair, they could choose between four settlement options, one of which was to buy another house, with Southern Response paying the cost of buying another house, including the legal and associated fees, provided the cost is not *"greater than rebuilding your house on its present site"* (the Buy Another House Cap).

***The Dodds'* claim**

The Dodds settled their claims against Southern Response on the basis of the Abridged DRA provided to them. Years later, they obtained a copy of the Complete DRA following a request to Southern Response under the Privacy Act 1993. This included the additional costs allowances in an Office Use Section. On seeing this, the Dodds considered that they had been misled into settling for a sum that did not reflect the true cost of rebuilding their house. The Dodds issued proceedings for $217,181.07 that they said they should have been paid, plus interest and general damages.

The Dodds sought relief on three grounds.

1. **Misrepresentation**
   The Dodds said that they were induced to settle their insurance claims by a misrepresentation that the cost of rebuilding their house was $895,937.78 when, in fact, it was more.

   Southern Response said that it did not make any representation of fact. Rather, it told the Dodds its opinion as to their policy entitlement, that excluded certain costs Southern Response considered were not payable. Gendall J disagreed. He found that Southern Response falsely represented, first, that $894,937 was the full amount it would cost to rebuild the Dodds' house and, secondly, that the

Abridged DRA was the final and only rebuild cost estimate. It made no mention of reductions from another rebuild cost estimate.

Gendall J also rejected an argument that the Information Sheets made it clear that certain costs were not included in the DRA, and that it was not reasonable for the Dodds to rely on the Abridged DRA. The Judge said that an insurer cannot rely on fine print to cure a misrepresentation and accepted the Dodds' argument that the Information Sheets were only intended to explain their entitlement and did not clearly state that costs were excluded. They also repeated the representation that Southern Response would pay the purchase price of a new house *"up to the maximum it would have cost to rebuild your house on the current site"*.

Gendall J also rejected the argument that the Dodds should have reached their own view as to their policy entitlement by obtaining legal advice and engaging their own experts. The Dodds trusted the DRA and had no reason to obtain alternative costing. The Judge accepted the Dodds' evidence that they trusted the cost estimate because Southern Response was a government agency.

2. **Misleading and Deceptive Conduct**
The Dodds also alleged that Southern Response's conduct was misleading and deceptive and breached section 9 of the Fair Trading Act.

The Court agreed. It held that a reasonable person, reading the Abridged DRA and with the other material provided to the Dodds, would have thought that the $894,937 figure was Southern Response's estimate of the actual cost of rebuilding their house. The Information Sheets did not clarify the position sufficiently and a reasonable person in the Dodds' position would likely have been misled or deceived.

The fact that the Dodds could not show that they would have made a different election had they received the Complete DRA was not determinative. The Court held that at the very least, the Dodds lost the chance either to consider other settlement options or to achieve a higher settlement. Southern Response's conduct was an operative cause of the Dodds entering into the Settlement Agreement and, therefore, suffering loss.

3. **Implied duty of good faith**
Finally, the Dodds claimed that Southern Response breached its duty of good faith by not disclosing its actual assessed cost of rebuilding the house and by withholding material information. This aspect of the Dodds' claim relied on Gendall J's earlier decision in *Young v Tower Insurance*[4] where the Court held that the duty of good faith was an implied term in every insurance contract.

Gendall J did not need to decide the point, but said that he would have found for the Dodds under this alternative cause of action.

The basis of this duty and its parameters remain to be determined.

Full and Final Settlement Clause

Southern Response argued that, even if the Dodds' claims were made out, they could not recover any damages, because the settlement agreement they signed recorded that Southern Response was making payment in full and final settlement of their insurance claims.

The Court rejected this, noting that settlements induced by misrepresentation can be set aside. The misled party has not freely bargained, but instead has been induced to settle by affirmative misrepresentations by the other party. Even a well drafted settlement clause may be avoided if there is a positive misrepresentation.

Result

The Court held that the Dodds were entitled to receive the value of Southern Response's contingency allowance, architects and designs fees, Arrow Contract costs and Arrow construction costs. They were not entitled to receive the value of Southern Response's demolition cost allowance because Southern Response had in fact carried out demolition itself. Nor were they entitled to Arrow costs which were essentially administration costs.

The Dodds were awarded $178,894.30 plus interest under the Interest on Money Claims Act 2016. They were not, however, awarded general damages. The Court confirmed that a high threshold applies to general damages claims – and that threshold was not met in this case.

Southern Response has appealed the decision in Dodds.

Key lessons

This decision contains two key lessons for insurers:

1. The importance of insurers dealing transparently with insureds (who have wide-ranging rights to obtain information under the Privacy Act).
2. \Where an insurer makes a settlement offer based on its opinion of a customer's policy entitlement, it should make that clear.
3. A well-drafted settlement clause will not protect an insurer from allegations of misleading and deceptive conduct.

1. Ross v Southern Response Earthquake Services Limited [2019] NZCA 431.
2. This also had an impact on project contingency which was applied to the total cost entitlement.
3. The High Court specifically considered Houghton v Saunders (2008) 19 PRNZ 173 (HC).
4. Young v Tower Insurance Ltd [2016] NZHC 2956


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Directors and Officers Insurance – continued focus on risk

Company directors are facing increasing challenges. Substantial damages awards in the *Mainzeal* case, together with a greater presence of litigation funders and an increasing likelihood of class actions (read more on page 5), are increasing directors' and their insurers' risks.

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In this article, we discuss our views of four key legal risks facing directors and their insurers in the near future, being:

1. Climate change
2. Securities class action
3. Regulatory
4. Disclosure to insurers

Climate change risk

Climate change should be top of mind as giving rise to potential legal action against directors.

The Intergovernmental Panel on Climate Change's recent *Special Report on the impacts of global warming of 1.5°C above pre-industrial levels* has created a large amount of interest in the impact of climate change from a number of angles.

While the focus has largely been on companies and consumer behaviour, there are some clear indicators that directors may be in the firing line of potential plaintiffs in claims for breach of duty arising from the climate impact of the companies they lead. In a recent extra-judicial article, three judges of the New Zealand Supreme Court wrote on Climate Change and the Law and specifically addressed corporate governance and litigation beginning with:

> *Directors have a duty to consider the 'best interests' of the company in all of the colloquium jurisdictions. It remains to be seen how climate change impacts that duty. There have already been cases in Australia and the United Kingdom relying on corporate governance and company law to hold companies to account for their climate impacts and actions.*

While acknowledging that New Zealand legislation does not have an equivalent of the UK obligation on directors to consider the impact of the company's operations on the community and the environment as part of directors' duties to promote the success of the company:

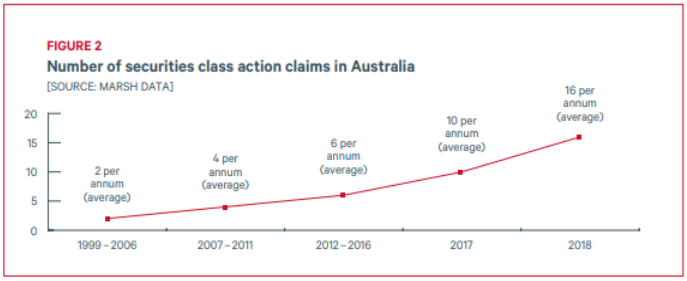
> *… academics have argued that, taken together, annual reporting obligations and the directors' duties of care may mean that directors could breach their duty of care by failing to consider and respond to environmental risks that later harm the company. The same arguments could apply in other colloquium jurisdictions. Climate change is no longer simply an ethical issue. As a material financial risk, directors are accountable under care and diligence duties to take account of the financial consequences of climate change and this applies whatever model of corporate governance is subscribed to. Further, the "business judgement rule" would not protect directors where the legal risk stems from inadequate information or lack of inquiry.*

These comments taken together make it clear that directors ought to be considering their risk profile in respect of potential climate change liability. Insurers will also need to consider the risk of climate change in the Directors and Officers (D&O) context, particularly from the potential class action perspective.

Securities class action risk

In a recent article by *Cover to Cover's* Chief Editor Andrew Horne, Marsh, and the Institute of Directors, the authors explored the impact of Australian securities class actions on D&O cover:

> *The D&O insurance market for publicly listed companies (especially where Company Securities 'Side C' cover or Statutory Liability is included) has incurred the greatest scrutiny over the last two to three years. This change has been driven predominately by the impact of Australian securities class actions claims on insurers' financial performance, where the losses incurred greatly outweigh the premium pool available and have done so for a number of years.*



While class or group actions in New Zealand have been relatively rare, they are on the rise (e.g. actions against Southern Response, James Hardie and the Ministry of Primary Industries). In 2018, the plaintiffs in a group action against the former directors of Feltex obtained a ruling in the Supreme Court that a forecast in a prospectus was untrue, opening the door to substantial claims against the directors.

We see the Court of Appeal's recent decision in the *Ross v Southern Response* case (discussed from page 5) is likely to produce a significant rise in class actions in New Zealand, particularly against D&Os, assuming it is not overturned by the Supreme Court.

Regulatory risk

Directors are well-aware of the increased focus on conduct and culture. In its 2019/2020 Corporate Plan, the Financial Markets Authority (FMA) identified two of three sector activities for banking and insurance:

(a) Bank Conduct and Culture and incentives follow-up

(b) Life insurance Conduct and Culture follow-up

The FMA's focus will clearly remain on the conduct of directors and senior management. Following the Bank Conduct and Culture of November 2018, the FMA and the Reserve Bank of New Zealand (RBNZ) said that they would:

> *… be expecting to see much deeper accountability of boards, executives and senior managers. We will be looking for progress and clear evidence of change and want to see this become part of the ethos of all banks in New Zealand.*

This presents a clear risk for directors and senior management to take into account when assessing their insurance needs. And for insurers when assessing whether, and on what terms and limits, they are prepared to insure against D&O regulatory investigation costs and liabilities.

Continuous disclosure risk also remains top of mind for directors of listed companies.

Disclosure to insurers

Directors will need to be vigilant in their disclosures to insurers in the current environment of heightened risk from multiple disparate angles. Close attention should be paid to circumstances that may give rise to claims, to minimise the risk of allegations of late notification. Insurers will also be looking more closely at insureds' records to determine whether they had knowledge of potential claims prior to the policy years in which claims arise.

The Court of Appeal's recent decision in the Ross v Southern Response case is likely to produce a significant rise in class actions in New Zealand.

High Court transfers proceedings to the Canterbury Earthquakes Insurance Tribunal

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Since the Canterbury Earthquakes Insurance Tribunal Act 2019 (the Act) came into force on 10 June 2019, two policyholders have successfully applied to transfer their earthquake insurance disputes from the High Court to the Tribunal. *Busby v IAG New Zealand Ltd, and Kitchen v AA Insurance Ltd*[1] demonstrates that in general, a broad approach will be taken to applications for transfer.

In both *Busby* and *Kitchen*, the defendant insurers opposed a transfer of proceedings on the basis that the underlying claims raised complex and novel issues and should be heard in court. The insurer in *Busby* further argued that the Tribunal did not have jurisdiction over the claim. The High Court rejected these arguments in both cases, demonstrating that generally, a broad approach will be taken to applications to transfer disputes relating to earthquake damaged homes. A third application in *Pinot v Vero Insurance New Zealand Ltd*[2] was rejected however the insured property was simply outside of the tribunal's jurisdiction being used for commercial purposes rather than residential.

Busby v IAG New Zealand Limited

In *Busby*, the insurer opposed the policyholders' application for transfer on the basis that:

(a) the Tribunal did not have jurisdiction to hear the dispute; and

(b) the case involved a novel point of law, so the Tribunal would have to refer to the High Court under section 16 of the Act.

The insurer advanced its jurisdictional argument on the basis that the underlying claim alleged that the property had suffered global settlement of 100mm. The insurer

said this constituted uninsured damage to the land, not the dwelling, relying on *Earthquake Commission v Insurance Council of New Zealand Inc*.[3] As the Tribunal can only determine disputes relating to *"physical loss or damage arising from the Canterbury earthquakes to a residential building or residential property"*, the insurer argued that it did not have jurisdiction in this case.

Associate Judge Lester rejected this. The Judge commented that whether global settlement constituted damage to the land, or the foundations was one of the *'ultimate issues between the parties'*. The insurer's jurisdictional argument assumed that global settlement is land damage, when there is really a dispute as to whether it is uninsured land damage, or insured property damage.

The Judge also rejected an argument that the case should not be transferred because the policyholders' argument that global settlement amounted to property damage required them to distinguish the *Earthquake Commission v Insurance Council of New Zealand* Inc case, and that this raised a novel and complex point of law. The insurer said that the Tribunal would be required to refer this question to the High Court for determination under section 53 of the Act.

The Judge rejected this, noting that it is up to the Tribunal whether or not to refer a question of law to the Court. The Judge further commented that:

> *The reality is earthquake cases that have not been resolved by this stage may well involve complex factual expert or legal issues. The disputes that remain outstanding are the cases which Parliament intended to give policyholders the ability to seek that their dispute be dealt with in the Tribunal. That a case may be legally complex or factually involved is not of itself a reason not to transfer a case when complexity is likely to be a factor as to why resolution was not reached years ago. That Parliament passed s 53 as a means to resolve involved or complex legal issues of itself is consistent with such cases being able to be transferred to the Tribunal. Parliament anticipated that complex legal issues may arise in cases transferred to the Tribunal and created a mechanism to deal with such issues.*

The Judge further considered that a transfer would meet the purposes of the Act. If transferred to the Tribunal, the case would benefit from the Tribunal's flexible procedures, its ability to instruct independent experts, the absence of hearing fees, and the Tribunal's ability to closely manage cases. These benefits outweighed the possibility that the Tribunal may refer the case back to the courts to determine a point of law.

Kitchen v AA Insurance Limited

In *Kitchen v AA Insurance Limited*, the insurer again argued that a transfer was inappropriate:

(a) First, the insurer argued that a transfer of the proceedings would result in delays, as a trial date had been allocated, and was just four months away. If the proceedings were transferred to the Tribunal, it would need to *"head back to a case management stage and would need time to conduct its inquisitorial functions such as appointing any expert advisor and convening an experts' conference"*.

(b) Secondly, the insurer argued that a return to the case management stage may outweigh any cost savings to the plaintiffs, notwithstanding that they would not have to pay any setting down or hearing fees in the Tribunal.

(c) Thirdly, the insurer argued that transferring the proceedings would not be in the interests of justice because the claim is complex and novel. There was an issue as to whether the insurer could obtain a waiver from an aspect of the Building Code and still comply with its obligations under the policy.

These arguments were rejected. First, Gendall J did not accept that a transfer would result in significant delay. While there may be some short delay associated with transferring the proceeding, the Tribunal would have regard to '*the significant steps already taken in the High Court"* at the first case management conference. Furthermore, briefs of evidence had not yet been exchanged in the High Court, and arrangements for the trial (such as flights and accommodation) had not yet been arranged.

Secondly, the Judge also had *'no doubt'* that a transfer would not increase the parties' costs. This was because:

(a) The proceedings had been set down for a 10-day trial, and if that trial went ahead, the plaintiffs would have to pay $32,000 in hearing fees and $1,600 for the scheduling fee. These fees would not be incurred before the Tribunal.

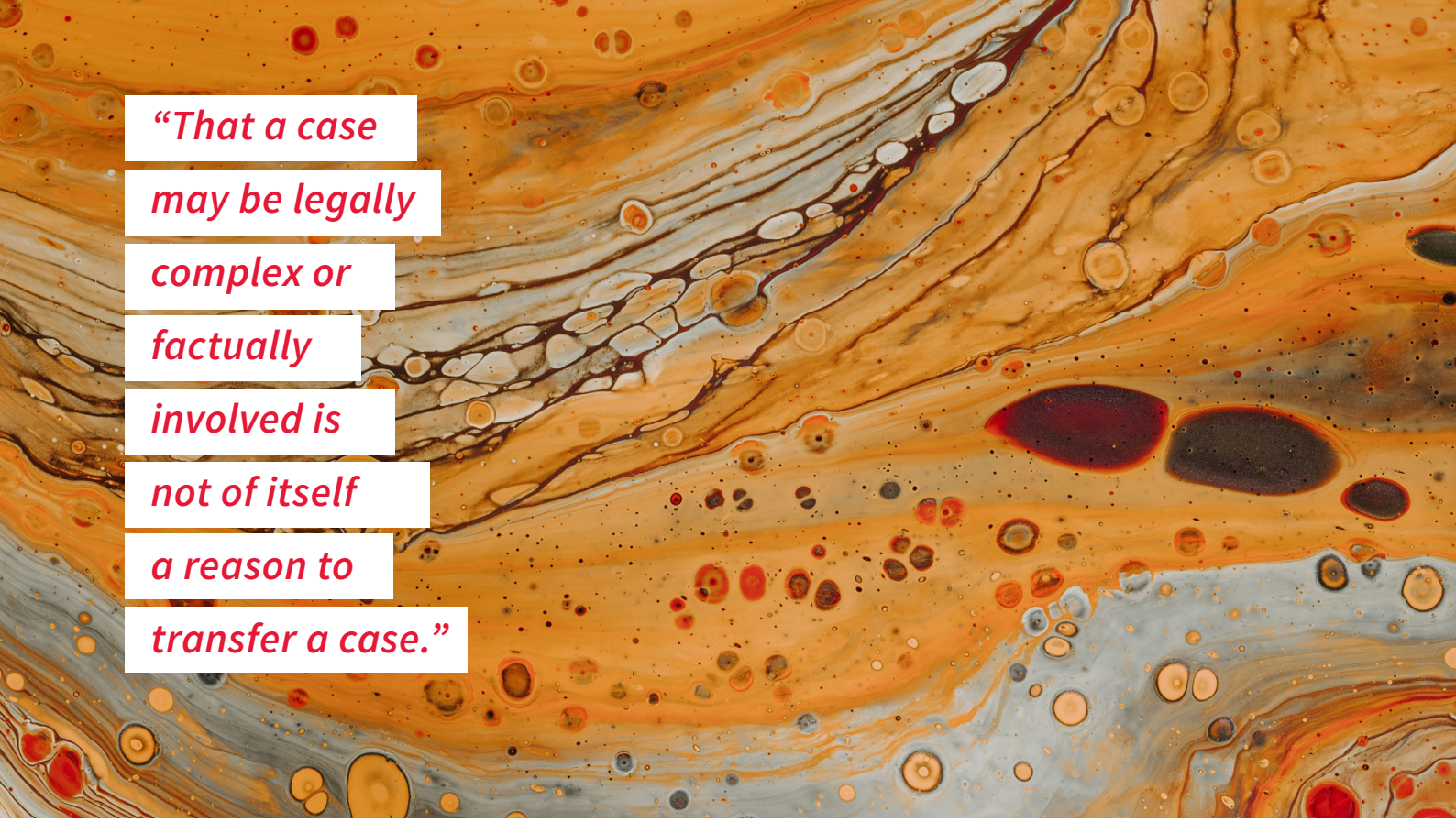
(b) The Tribunal would have regard to steps already taken in the Court and would not unnecessarily duplicate matters.

(c) The Act provides for a more flexible and informal process, that may result in cost savings.

(d) The Tribunal can direct the parties to mediation at no cost to the parties.

(e) The Tribunal has an inquisitorial function and can appoint its own expert, at its own cost, to facilitate a conferral. The Court considered that this could have significant advantages in this case.

Nor was the Judge persuaded that the case should not be transferred due to its complexity. Gendall J did not



accept that the question as to whether the insurer could satisfy its policy obligations by obtaining a waiver from Building Code requirements was novel or complex.

Pinot Properties Limited v Vero Insurance New Zealand Ltd

By contrast to the cases discussed above, the application for transfer in *Pinot Properties* was unsuccessful.

This dispute involved a building insured under a commercial material damage and business interruption policy. The insured building was leased to hospitality and office businesses. As the Tribunal only has jurisdiction over disputes relating to residential properties, this application for transfer was dismissed.

This decision did not adopt any narrower approach to that in *Bushby* or *Kitchen*- the dispute simply did not fall within the Tribunal's jurisdiction.

Key points

These decisions make it clear that the focus of the Tribunal is on the efficient resolution of disputes relating to damaged homes. While the courts will not refer cases involving commercial buildings which have the *"potential"* for residential use, they appear to otherwise favour the transfer of proceedings to the Tribunal. Complex legal issues and approaching trial dates did not, in these cases, preclude a transfer.

The impact of the establishment of the Tribunal on the number of matters before the courts is not yet clear, however, there have been a number of applications to the Tribunal since it was launched in June and it reportedly achieved its first settlement in August 2019.

As cases may increasingly be commenced or transferred to the Tribunal, insurers should keep a close eye on developments under the Act.

1. Busby v IAG New Zealand Limited [2019] NZHC 1852; *Kitchen v AA Insurance Limited* [2019] NZHC 1902. *2. Pinot Properties Ltd v Vero Insurance New Zealand Ltd* [2019] NZHC 2244.
3. Earthquake Commission v Insurance Council of New Zealand Inc [2014] NZHC 3138, [2015] 2 NZLR 381 at [87].

Earthquake Commission to make ex-gratia payments for “on-sold over cap” properties

The Government has announced a new package to assist purchasers of earthquake-damaged homes who have discovered that the property had incomplete or insufficient repairs after they settled their purchase.

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The announcement of this support package should help to resolve a number of claims currently before the courts including the resolution of a test case alleging that the Earthquake Commission (EQC) was negligent in completing repairs of earthquake damage to a residential property.

Details of the support package

The package is available to homeowners who meet the following criteria:

1. they purchased a property in Canterbury after 4 September 2010 (the date of the first earthquake), and/or on or before 15 August 2019 (the date of the Government's announcement);
2. before selling the property, the previous owner settled a claim with EQC on the basis that the damage could be repaired for less than $115,000 per earthquake event (the EQC cap);
3. after the purchase, the new homeowner discovered that the property had not been properly repaired (either because the repairs carried out were defective, or the damage was not properly assessed at the time);
4. the cost of the repair, together with the amounts previously paid by EQC, is more than the EQC cap; and
5. private insurance will not cover the cost of the repairs.

Eligible homeowners must also take an assignment of the previous owner's EQC claim to claim an ex gratia payment.

If a person is eligible under these criteria, then the ex gratia payment will be based on a scope of works taking into account the work required to repair the earthquake damage in accordance with EQC's statutory obligations, as well as any other reasonable cost of the repair work.

If the previous owner settled on a cash basis for some or all of the repairs, and:

(a) The purchaser also seeks an ex gratia payment for those repairs, then the purchaser will need to find out and notify EQC of who did the original work and which warranties are in place.

(b) The homeowner has reason to believe that the cash settlement was insufficient, did not include all earthquake damage, or will not repair the earthquake damage to the standard required by the EQC Act, then the homeowner can request that the EQC review the previous claim.

A claim for an ex gratia payment from EQC for an *'on-sold over-cap property'* must be submitted by 14 August 2020.

Scope of the support package

Under this support package, it appears that EQC is willing to make good any defective repairs – even if the cost of doing so is greater than the statutory cap.

It also appears that EQC will pay for unscoped damage, provided that these costs cannot be recovered from a private insurer.

Resolution of claims before the court

Shortly after this support package was published, EQC announced that it had settled *Gibling v EQC*, a test case brought by the purchaser of an earthquake damaged home that alleged EQC was negligent in meeting its statutory obligations by missing damage and / or failing to properly repair earthquake damage prior to the purchaser. This proceeding would have tested the extent of EQC's obligations to remediate defective repair – and, in particular, whether this obligation was subject to its statutory cap – and its obligations to pay for damage which had not been scoped. This support package allowed EQC to settle the case out of court and avoid a three-week trial.

This support package also provides a framework for the settlement of similar cases before the court. Reports have suggested that Shine Lawyers (who acted for the Giblings) had another 54 cases on their books.

EQC and private insurers may see a decline in claims from purchasers of earthquake damaged homes, who will have access to this support package until 14 August 2020.

Buyer beware: assignment of reinstatement benefits under insurance policies

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In *Xu v IAG*,[1] the Supreme Court upheld the longstanding principle in *Bryant v Primary Industries Insurance Co Limited*[2] that a replacement value benefit that is personal to the insured cannot be assigned without the insurer's consent.

This case will affect many on-sold insurance claims by purchasers of earthquake-damaged homes. The ability for assignee-purchasers to claim only indemnity value will be of particular significance to owners of buildings in old or poor repair, where the cost of replacement to an 'as new' standard is considerably more than the cost of repair to its pre-damage, indemnity, condition.

Facts

The case involved a home owned by Mr and Mrs Barlow, that they insured under a standard replacement policy issued by IAG. The policy entitled the Barlows:

(a) to be paid the actual costs of repairing their home to its condition when new if they reinstated the property, or

b) if they did not reinstate it, to be paid the lesser of the amount of the indemnity value of the loss or the estimated cost of restoring their home to its pre-loss condition.

The Barlows' home was damaged in the Canterbury earthquakes. Three years later, in 2014, they entered into an agreement to sell the property. They assigned all their rights in respect of their insurance claim to the purchasers.

The purchasers sued IAG claiming that they were entitled to the actual costs of reinstating the home. IAG accepted that the right to indemnity value was assignable, however the right to reinstate was personal to the Barlows and could not be assigned without IAG's agreement.

The Court of Appeal's decision

In agreeing with the High Court, the Court of Appeal held that the right to restore the damaged property and receive the restoration costs from the insurer was personal to the insured and could not be assigned. The Court of Appeal said that *'moral risk'* associated with the insured party is of critical importance to the insurer's decision to provide cover. Consequently, *"an insurer should not be held liable to a stranger to the insurance contract"*,[3] whose moral character it had not been able to assess and who may seek to profit from the loss. Therefore, the only

permissible assignment without the insurer's consent is the right to receive an amount to which the insured is entitled at the time of assignment. At the time of assignment, the insured was entitled to indemnity value only, as they had not taken steps to reinstate the property.

The Supreme Court's decision

The assignment of reinstatement benefits

Although the Supreme Court expressed some reservations, it declined to overrule or distinguish *Bryant* and confirmed that *Bryant* is correct in its statement of legal principle. One point of interest for legal scholars is that the Court expressed the view that *"it may be better to accept that replacement insurance is an exception to the indemnity principle".* This comment was made in the context of the reasons for the rule in *Bryant*, one of which was that the Court of Appeal considered the indemnity principle (that says the insured should not be put in a better position than it was in before the loss) could be rationalised with replacement insurance (that may result in the insured receiving a new item that is more valuable). The Supreme Court found the principles of moral hazard and the personal nature of the reinstatement entitlement to be more convincing reasons not to overrule *Bryant*.

The Supreme Court held that the wording of the IAG policy meant that the original insured must carry out the reinstatement to become entitled to the replacement benefit. References to the insured were to the Barlows and could not be interpreted as references to their assignees.

The judgment was a 3:2 decision as two of the Supreme Court judges dissented. They would have held that the assignee-purchasers had received a valid assignment of the replacement benefits under the policy on the basis that the Barlows had an accrued right to those benefits after the earthquakes, and that the assignee-purchasers could fulfil the condition of restoring the home. In their view, there was nothing obviously personal in the reinstatement condition in the policy that only the Barlows could undertake the reinstatement and claim the benefit. They would have overruled *Bryant*.

Secondary issue – sale and purchase condition

The Supreme Court also addressed a secondary issue - the meaning and effect of Condition 2 of the policy. All five members of the Supreme Court were unanimous on the result.

Condition 2 was headed *'Insurance during sale and purchase'*. It provided that, in some circumstances, the purchaser of a property could bring a claim under the vendor's insurance policy. The purchasers argued that their claim fell within Condition 2 so they were entitled to claim under it, irrespective of the validity of the purported assignment of the replacement benefit. The Supreme Court held that Condition 2 did not assist the purchasers because it applied only to damage that occurred after a purchaser had entered into an unconditional contract for sale and purchase of a property, and before the settlement of that transaction.

In the present case, the purchasers had entered into the sale and purchase agreement years after the damage had occurred. The purpose of Special Condition 2 was to protect the purchaser of a property who entered into an unconditional agreement before the damage was suffered.

Implications

The decision will be well received by insurers, many of whom are dealing with assignees of insurance claims who are claiming a reinstatement entitlement. Many of these claimants will now have to accept that their claims are likely to be worth significantly less, as they are limited to indemnity value.

In a number of these claims, the original insureds were satisfied with the repairs, yet assignees have made claims and issued court proceedings asserting that they were inadequate, sometimes with the support of claims consultants or litigation funders. Insurers view many of these assigned claims as unjustified and opportunistic. Where repairs have been carried out, the Supreme Court's decision means that it is likely to be more difficult for assignees to assert that an increased amount ought to be payable where their claim is limited to indemnity value.

The Supreme Court observed that what constitutes indemnity value will sometimes be difficult to determine. This will depend upon the circumstances of each case. The Supreme Court earlier provided guidance in *Prattley Enterprises Ltd v Vero Insurance New Zealand Ltd*[4]. Where a building is destroyed by an insured event and is not to be reinstated, the most obvious basis for calculating *'indemnity value'* is its market value. This will normally be less than the cost of reinstatement on a new-for-old basis, particularly where the building was old or in a state of disrepair before the loss. Where a claim is for the cost of repair or reinstatement, the estimated costs, less a betterment allowance or a deduction from the repair cost to represent the depreciated condition of the insured property immediately before the loss, may be the indemnity value. There may also be instances where a repair, or a complete or substantial reinstatement, does not result in betterment. In those cases, indemnity value may be the same as reinstatement costs without deduction.

Purchasers of earthquake damaged buildings will be disappointed if they purchased in the expectation of settling the insurance claim for the property on a reinstatement basis without the insurer's agreement. While some assignee-purchasers may reflect upon whether they have been properly advised, many sale and purchase agreements were entered into without an assignment in place and the assignment of insurance claims was recorded as an afterthought, sometimes upon or after settlement, or even after the issuance of legal proceedings.

We anticipate that a number of Canterbury earthquake proceedings by assignees will be settled or discontinued as a result of the Supreme Court's judgment.

1. Xu & Anor v IAG [2019] NZSC 68.
2. Bryant v Primary Industries Insurance Co Limited [1990] 2 NZLR 142 (CA).
3. At [19].
4. Prattley Enterprises Ltd v Vero Insurance New Zealand Ltd [2017] 1 NZLR 352.

Insurer pre-empts changes to the insured's duty of disclosure

In July this year, Tower Insurance announced a fundamental change to the way it will require its customers to disclose circumstances affecting their risks. The change foreshadows likely changes in the law for all insurers in New Zealand.

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Tower's Chief Executive, Richard Harding, has announced that Tower will remove the general duty of disclosure from its policies before the end of the year. He was reported as saying that, if customers answered truthfully all of the specific questions that Tower asked, they could assume that they had disclosed everything that was required. There was to be no further, general, duty of disclosure of all material facts and circumstances affecting the risk. Tower did not intend to ask a catch-all question along the line of *"is there anything else that we should know?"*

This approach recognises that there are a number of problems with the present obligation on customers to disclose circumstances that a reasonable insurer would regard as material to its decision to accept the risk insured[1]. These problems include:

- what the insured is obliged to disclose is uncertain;
- an insured's honest ignorance will not assist if it fails to make the necessary disclosure;
- where an insurer asks specific questions, the insured still has a general duty of disclosure in addition to answering the questions (which insureds may not appreciate); and
- a breach of the duty may have disproportionately harsh consequences for an insured, as the insurer is entitled to treat the policy as void from the outset even if it would have accepted the policy on different terms had it known the true position.

Law reform

In Issue 17 of Cover to Cover, we discussed the Ministry of Business, Innovation and Employment's proposals to reform the law relating to the insured's duty of disclosure. This followed 20 years of inaction following the Law Commissions' paper examining this issue and identifying the need for reform[2]. The Law Commission discussed a number of possible reforms, including:

- limiting the duty of disclosure or changing what was considered material;
- warning insureds of their duty more clearly;
- requiring insurers to set out expressly what they are required to know in questions (in effect, abolishing the duty and replacing it with an obligation to answer specific questions truthfully). (This is essentially what Tower have indicated it intends to do); and
- limiting the consequences for insureds of getting it wrong,

The proposals were, in short:

- insurers would pose questions to the insured; and
- only an inaccurate answer or blameworthy conduct (where an insured or a reasonable person would have known that the circumstances were material to an insurer) would entitle an insurer to cancel a policy.

1. *Marine Insurance Act 1908*
2. *Some Insurance Law Problems* NZLC R46, May 1998.

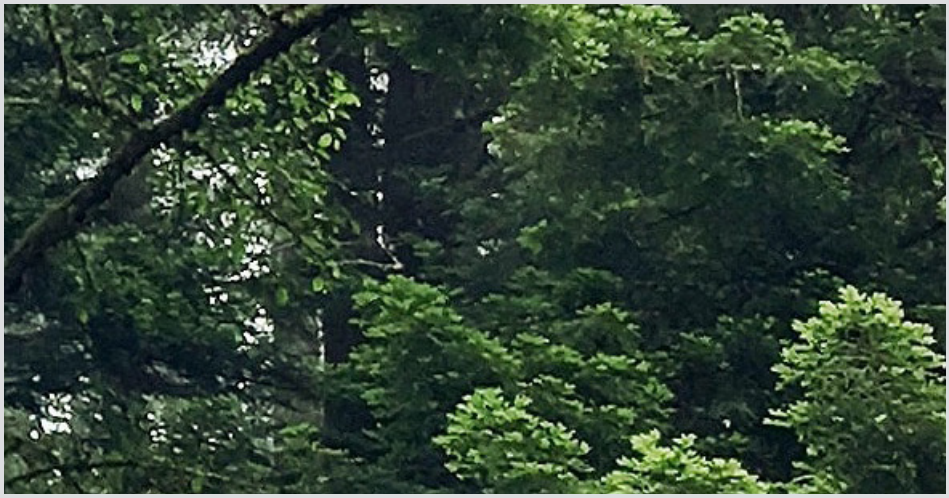
The approach in the UK and Australia

Both the UK and Australia have passed legislation to amend the duty of disclosure. Their approaches differ.

In Australia, the insured's duty is limited to disclosing circumstances that the insured, or a reasonable person in their position, knew or should have known were relevant to the insurer's assessment of the risk. This means that an insured need only know what a reasonable person who is not an insurer would know. The benefit of this approach is that insureds are no longer expected to know what an insurer would consider material. Many insureds do not know what insurers consider important. In addition, an insurer may cancel the policy for innocent non-disclosure only if it would have refused cover if the circumstances had been disclosed. Furthermore, where a claim is fraudulent, a court may order that the insurer pay what is *'just and reasonable'.*

In the UK, the approach taken is similar to Tower's initiative. There, the duty of disclosure has been abolished for consumers, who now owe a duty to take reasonable care not to make a misrepresentation when answering an insurer's questions. Insurers must ask questions about any circumstances that they wish to consider when deciding whether to offer cover[3]. Insurers may cancel consumer policies only for a deliberate or reckless misrepresentation by an insured (in which case they may keep the premiums unless it would be unfair to retain them) or a careless misrepresentation where the insurer would not have accepted the policy if it had known the true circumstances. Where, however, the insured made a careless misrepresentation, but the insurer would only have offered cover on different terms (such as limited cover or a higher premium) then the policy will be treated as if it was entered into on those terms. With business policies, the duty of disclosure is amended to a duty of *"fair presentation"*, where the insured must provide enough information to enable the insurer to make a fair assessment of the risk or identify a need to investigate further.

Tower's approach goes part of the way towards the UK approach. The insurer takes responsibility for asking questions about all of the matters and circumstances that it considers relevant. The customer is not obliged to disclose anything outside those questions, even if the insurer or the customer knows or ought to know that it would be relevant to the risk. However, Tower's initiative does not extend to offering the other benefits provided to customers under the Australian and UK approaches where the customer gets it wrong. Tower may still cancel the policy if an insured innocently gives an inaccurate answer, even where Tower would have offered insurance anyway on different terms.



Our view

In issue 17 of Cover to Cover, we predicted that the insured's duty of disclosure in New Zealand will either be reduced so that it applies only to circumstances that a reasonable person in the insured's position would have regarded as relevant to an insurer (the Australian approach), or removed altogether and replaced with a duty to answer an insurer's questions accurately (the UK approach).

We said that the UK regime may be preferable, at least for consumers, as a requirement that insurers ask questions should be easier for insureds to follow and should help them make full and honest disclosures. It seems that Tower agrees.

However, a significant disadvantage from an insurer's perspective, is the risk that an insured may be aware of a circumstance that is clearly relevant to the risk but is so unusual that it is not within any of the insurer's specific questions. There is also a risk that insurers may feel obliged to ask a large number of questions that insureds will need to answer. It remains to be seen how many questions Tower will ask.

We remain of the view that the Australian approach is problematic, as there will continue to be uncertainty for many customers as to what a reasonable person should know about what an insurer wants to know. This would leave unsophisticated insureds at risk.

What should insurers be doing?

We recommend that insurers prepare for the likely effects of changes to the law by considering whether they will take a similar approach to Tower.

It would also be worthwhile for insurers to consider:

- what detailed and specific questions they might need to ask insureds;
- whether they may be willing to offer the other protections now enshrined in the UK and Australia where an insured innocently gets it wrong;
- whether they prefer the Australian approach; or
- whether they would support different approaches between consumer and business insurance.

3. The Consumer Insurance (Disclosure and Representations) Act 2012 governs consumer policies and the Insurance Act 2015 provides for business insurance.

Corbett v Vero Insurance New Zealand Ltd

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Earlier this year, the High Court released an interesting decision concerning the interpretation of an exclusion clause in an insurance contract.[1]

The main issue in this case was whether there was a distinction between the terms *'defective'* and *'damaged'*. This issue arose because if the property in question was damaged but not defective, the cost to repair or replace it would be covered by a construction works policy. However if the property was defective, an exclusion clause in the policy would apply.

Background

The plaintiffs contracted with a building contractor for the construction of a new house. At the same time, the plaintiffs took out a Contract Works Insurance Policy with the defendant, Vero.

Upon practical completion, the builder, under the construction contract, engaged a subcontractor to clean the house. The cleaner did not remove dust and grit on the windows before the main clean, which scratched the windows. The windows were expensive as they were bespoke, high quality, triple-glazed joinery made in Germany.

The plaintiffs made a claim under the policy for the scratched windows. Vero declined cover on the basis that, as a result of being scratched, the windows were *"defective in workmanship"* and thus the exclusion clause contained in the policy applied.

The insuring clause and exclusion clause

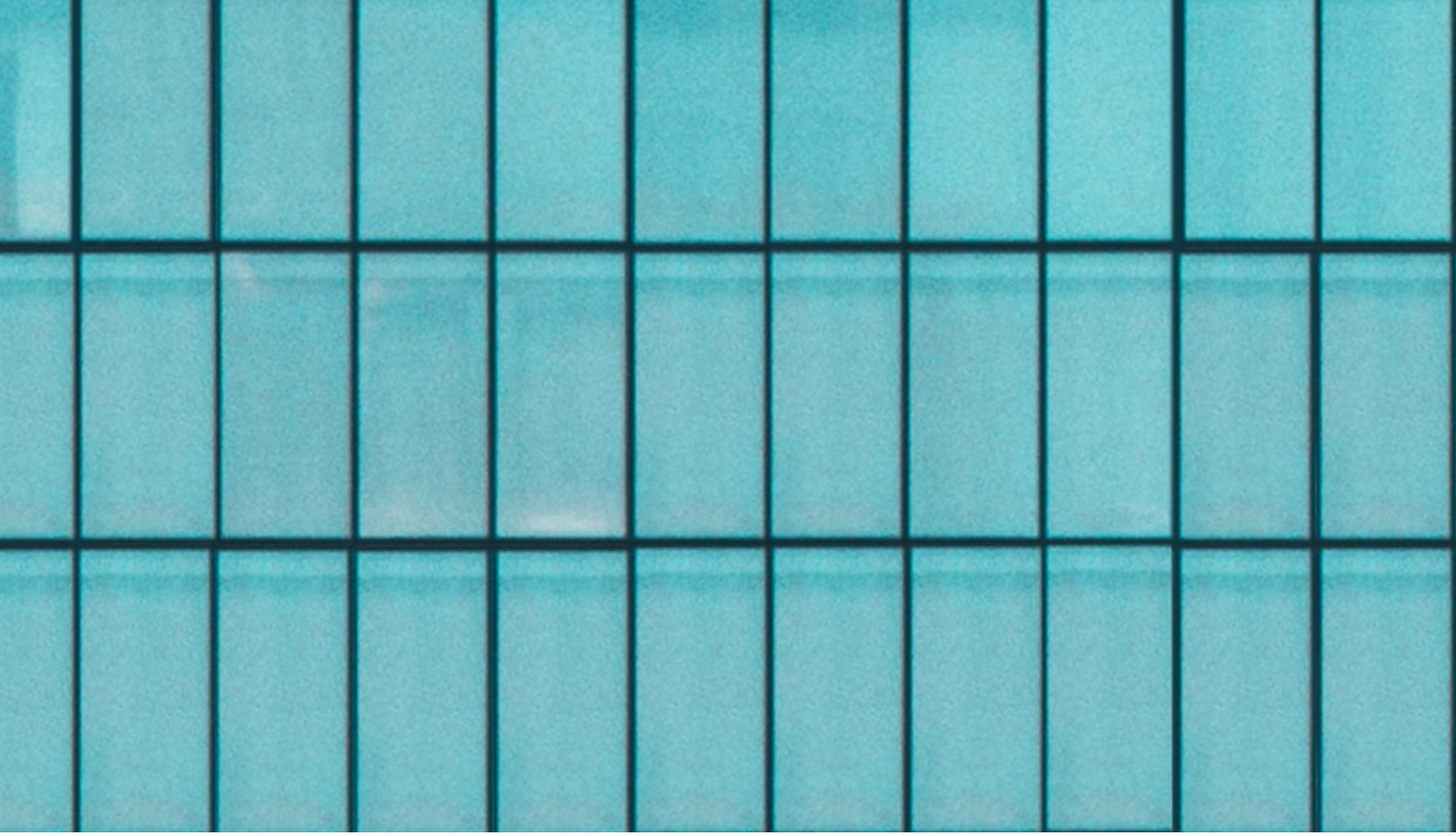
The policy's insuring clause was *"If at any time during the period of insurance physical loss of or damage occurs to any item of the property insured, then subject to the terms, conditions and exclusions of this policy the Company will indemnify the insured for such loss or damage."*

The policy also contained an exclusion clause that excluded the costs of repairing, replacing or rectifying any part of the contract works which are defective in material or workmanship. The exclusion clause included a proviso that provided the exclusion clause shall only apply to that part of the machine or structure immediately affected, and not to loss or damage to other parts of the contract works resulting therefrom.

The plaintiffs' argument

The plaintiffs argued that the scratched windows were not defective in material or workmanship but rather they were damaged, relying on the fact that prior to the cleaning the windows were not in any sense defective (either in material or workmanship), but were scratched during cleaning and thereby underwent physical damage.

The plaintiffs argued that the purpose of the exclusion clause was to ensure that where part of the contract works is defective, and the insured suffers loss or damage (thus triggering



the insuring clause), Vero would not have to pay for the cost of repairing, replacing or rectifying that part – given it would have needed to be repaired, replaced or rectified in any event. In this context, the plaintiffs relied on the English Court of Appeal decision in *CA Blackwell (Contractors) Ltd v Gerling*[2]. The plaintiffs argued that the exclusion clause does not apply where property that is not defective is damaged, even if the cause of the damage is defective material or workmanship.

Vero's argument

Relying on dictionary definitions of *'defect'* and *'defective'*, Vero argued that the scratching of the windows constituted a defect and there was no proper distinction between part of the works being defective and being damaged. Vero argued that it is a natural and ordinary use of language to describe the windows as defective in workmanship due to the shortcoming in the work performed.

Vero also argued that the commercial context to the policy favoured their interpretation, namely, that it is important there be normal business incentives on contractors to build high quality products and to discourage substandard workmanship. It was argued that liability policies are not intended to insure contractual performance or the quality of contract works.

Interpretation of the clause

Fitzgerald J held that the phrase, "*defective in material or workmanship*", seeks to convey that the exclusion applies to any part of the contract work which is defective due to the materials used in it, or workmanship carried out on it. Her Honour noted that the use of the word *'in'* is used as a way of saying *'due to'*.

Fitzgerald J pointed out that it is important to understand the distinction between items being in a defective condition, and being damaged because of defective workmanship. This distinction highlights the purpose of the exclusion and the differing coverage that results.

Before being scratched, the windows in this case had been installed correctly and there was no suggestion that they were not capable of performing and being operated as expected. Given this fact, Fitzgerald J held that the windows were not in a defective condition (due to either materials or workmanship) at the point in which they were then damaged, in the sense of having undergone a physical transformation. As a result of being damaged, (and even if due to defective workmanship), the windows did not become *'defective'*. The concept of something being defective conveys an *'inherent'* issue or fault with the windows or the way that they have been built. For these reasons, the exclusion clause did not apply to the damage.

Fitzgerald J concluded that the purpose of the exclusion clause was to exclude the cost of repairing, replacing, or rectifying any part of the contract works which are defective (either as a result of materials or workmanship), irrespective of separate damage done to it, and the cause of that damage.

Fitzgerald J accepted that there are some risks that are rarely insured by a construction contract, notably defective workmanship. The reason being, as pointed out by Vero, that this would make the insurer the guarantor

for the proper performance of the construction works, removing any incentive for the contractor to complete the works to the contract standard. However, Her Honour rejected the argument that the plaintiffs' interpretation would result in insurance of contractual performance. In the Judge's view, an outcome that the policy covers physical loss or damage to contract works caused by defective workmanship is not an unusual outcome in the circumstances. However, it was noted that Vero may have gained more traction had the plaintiffs sought cover for the cost of re-doing the defective workmanship itself, and not only the resulting physical damage or loss.

Key points

This case provides useful guidance on the meaning of the word *'defective'*. It also shows the role that business common sense can play in interpretation as a cross-check on meaning. Her Honour also highlights the importance of clear drafting in insurance contracts.

The plaintiffs made the argument that Vero could have, but did not, exclude damage caused by defective workmanship. The plaintiffs referred to a number of authorities to demonstrate that an exclusion clause for physical loss or damage caused by defective workmanship is not uncommon and to reinforce that this is not what the exclusion clause in the present case did. Fitzgerald J accepted that the exclusion clauses in the authorities referred to by the plaintiff swere in a form that was a much more natural and ordinary way of expressing the result Vero says should occur in this case.

An example of such a clause can be seen in *Pentagon Construction Co Ltd (Pentagon).*[3] In Pentagon the exclusion clause stated that the insurance does not cover loss or damage caused by:[4]

(i) faulty or improper material; or

(ii) faulty or improper workmanship; or

(iii) faulty or improper design.

Similarly in *Walker Civil Engineering Pty Ltd v Sun Alliance*[5] the exclusion clause excluded *"loss or damage directly cause by defective workmanship, construction or design".*

1. Corbett v Vero Insurance New Zealand Limited [2019] NZHC 1823.
2. CA Blackwell (Contractors) Ltd v Gerling Allegemeine Verischerungs [2007] EWCA Civ 1450.
3. Pentagon Construction (1969) Co Ltd v United States Fidelity & Guaranty Co [1978] 1 Lloyd's Rep 93.
4. At [16].
5. Graham Evans & Co (Qld) Pty Ltd v Vanguard Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-418.

After the event insurance - a new option to reduce litigation risk?

The Court of Appeal's recent decision in *Houghton v Saunders* [2019] NZCA 285 indicates that litigants in New Zealand may be able to benefit from an After the Event costs insurance policy (ATE policy). This may increase litigation before the courts, as litigants can issue proceedings with insurance against the risk of large adverse costs awards.

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After the Event policies have long been available in England, but they are not part of the New Zealand litigation landscape. The Court's decision highlights that they are available and acceptable, although they do not provide all of the benefits provided when first offered in England (discussed below). If the policies become widely accepted in New Zealand, this may change the way people approach litigation and assess litigation risk – and a rise in litigation is likely.

An ATE policy is insurance that protects a litigant (normally a plaintiff) against the risk of an adverse costs award if the litigant loses the case. In return for a premium, the insurer assumes the risk of a costs award against the litigant. This allows plaintiffs to bring proceedings without the risk of incurring a costs liability if they lose, in addition to their own legal costs. When ATE policies first became available in England, the courts allowed successful plaintiffs to include the cost of the ATE premium as a disbursement, so that the policy was effectively free to the plaintiff if they won the case and it protected them if they did not. Now, however, the rule has changed and a plaintiff must bear the cost of the ATE premium itself.

Background to ATE policies

ATE policies, unlike most forms of insurance, are purchased once a dispute has arisen or proceedings are contemplated. If the insured party is successful in the action and does not have to pay costs, the policy is not triggered. However, if the insured party loses and an adverse costs order is made against it, the policy will cover the insured party's exposure to the adverse costs order.

Subject to variations and exceptions on a case by case basis, the following is an outline of the basic principles upon which an ATE policy works:

(1) Cover is triggered when an insured party loses litigation.

(2) It usually covers:

(i) adverse costs orders requiring the insured party to pay the winning party's costs;

(ii) the insured party's own disbursements; and

(iii) a portion of the insured party's lawyer fees.

(3) The insured party could be bringing or defending the claim, but is normally bringing it.

(4) An ATE policy is available in theory regardless of the subject matter of the civil dispute and regardless of the type of relief or remedy being sought (monetary or otherwise).

(5) The main requirement for obtaining an ATE policy is to satisfy the insurers that the insured party's chance of success on the merits of the case is at least 60 percent (this minimum threshold can be higher) and that the insured party will be able to pay the ATE premium if required to do so.

(6) The ATE policy premium, often between 20% and 50% of the amount of costs being insured, may be "deferred and contingent upon success". This means that the insured party need not pay the premium up front and is only liable to pay it if it wins the case. If the insured party loses the case, there is no premium to pay and the insurer pays out any court costs and disbursements under the policy.

(7) The level of premium can also be staged, increasing in amount the further the litigation/arbitration progresses, so that if the case settles early, a lower premium is payable.

England's approach to recovering

In England, a winning insured party was initially entitled to recover ATE policy premiums from the losing party as a part of the costs award under the Access to Justice Act 1999 (UK) (AJ Act), meaning that insured parties were able to litigate essentially risk free in terms of costs awards. This principle originated from the argument that the ATE premium cost was incurred as a result of the losing party causing the winning insured party to incur the cost of the proceedings. Where they had lawyers willing to act on a *'no win no fee'* basis, or a litigation funder, they had no risk at all.

This changed when the Legal Aid Sentencing and Punishment of Offenders Act 2012 (UK) (LASPO) came into force on 1 April 2013. The LASPO repealed the AJ Act which allowed a winning insured party to recover ATE premiums from the losing party. Prior to this, there were growing concerns that ATE insurance was partly responsible for inflating legal costs, and contributing to rising ATE premiums, there being no incentive for insured parties to reduce their premium costs. There was also concern that this could breach consumer protection laws.

The LASPO now provides that premiums for ATE policies entered into on or after 1 April 2013 must be paid by the winning insured party, and will not be recoverable from the losing party. There are a few limited exceptions to this – ATE premiums can be recovered by the winning insured party in certain clinical negligence proceedings, and only to the extent that they relate to the costs of an expert report or reports. However, if the Court finds that the ATE premium is unreasonable to any extent, the winning insured party is liable for the shortfall.

The Court of Appeal's decision in Houghton v Saunders

The case involved an application for costs by Mr Houghton in the Court of Appeal, following a partially successful application for leave to appeal a Court of Appeal judgment to the Supreme Court. Based on his partial success in the Supreme Court, Mr Houghton sought recovery of his ATE premium of $47,000 from the respondents as a part of his costs award. Mr Houghton categorised his ATE premium as a disbursement.

Recovery of disbursements in the Court of Appeal is governed by rule 53 of the Court of Appeal

(Civil) Rules 2005, which provides that *"the Court may in its discretion make any orders that seem just concerning the whole or any part of the … disbursements of an appeal"*.

"Disbursement", has the same meaning as defined by rule 14.12(1)(a) of the High Court Rules, being "an expense paid or incurred for the purposes of the proceeding that would ordinarily be charged for separately from legal professional services in a solicitor's bill of costs".

The Court of Appeal accepted Mr Houghton's argument that the ATE premium was capable of being categorised as an expense reasonably paid or incurred by him for the purpose of the appeal.

However, despite that finding in principle, the Court of Appeal declined to allow Mr Houghton to recover the ATE premium as a disbursement. The Court held that recovery would not be in the interests of justice, because it seemed to be *"patently unfair that unsuccessful defendants should have to meet significant additional costs to cover a [litigant's] insurance against the prospect of their losing" (*at [26]).

In reaching that decision, the Court of Appeal was influenced by the approach now taken in England, where ATE premiums are no longer recoverable from a losing party. In particular, the Court referred to one of the reasons behind the LASPO, being that recoverability of ATE insurance premiums imposed disproportionate cost burdens on defendants, while plaintiffs were able to litigate risk-free.

What does this mean in practice?

New Zealand litigants are unlikely to be able to claim their ATE policy premiums as a disbursement in the event of a successful claim or defence. Despite this, the fact that ATE insurance appears to be available in New Zealand and the courts have not indicated that it is not effective is likely to encourage litigants who have a valid claim but cannot afford a costs liability in event of a loss, to press a case on to trial that they might otherwise not have started or may have settled.

Aggregation clauses and the Canterbury earthquakes

The High Court has released a helpful decision on the interpretation of an aggregation clause. In *Moore v IAG New Zealand Limited,*[1] the Court confirmed that the Christchurch earthquakes are a series of events with the same cause and were subject to an aggregation clause. Aggregating the losses, limited the insured to just one payment of the sum insured limit – and not payments of up to the sum insured for each earthquake event.

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Background

The plaintiff, Mr Moore, owned a large architecturally-designed home in the exclusive suburb of Scarborough Hill. Mr Moore's home was insured by IAG under a policy with a sum insured limit of $2.5 million plus GST per loss.

The home suffered extensive damage in the 22 February 2011 and 13 June 2011 earthquakes. IAG paid Mr Moore the full sum insured, however the estimated cost of reinstating the damage significantly exceeded that amount. Mr Moore said that he was entitled to be paid up to the sum insured for each earthquake event and that IAG had failed to pay him approximately $1.7 million.

The key issue in the dispute was whether the aggregation clause in Mr Moore's policy limited IAG's liability for damage caused by the two earthquakes to a single sum insured payment on the basis that they were *'one event'*. The aggregation clause in Mr Moore's policy provided that:

> *The most we pay for any loss (or any series of losses caused by one event) is the sum insured shown in the schedule.*

'One event' was defined in the policy to mean *"a single event or series of events which have the same cause".*

The parties sought a ruling on the following preliminary question:

> *On a proper interpretation of the aggregation clause in this policy, can it be said that the most IAG is required to pay for the loss on 22 February 2011 and the loss on 13 June 2011 is the sum insured?*

Mr Moore's arguments:

Mr Moore argued that the aggregation clause did not apply because:

1. the earthquakes were not a *'series';*
2. a *'series of events'* required a relationship of connectedness which did not exist;
3. the aggregation clause required a '*series of losses'* to be caused by a *'series of events'.* In other words, the losses suffered in both February and June must have been caused by both of the earthquake events and not just by any one of them, and they were not.
4. the events did not have *'the same cause'.*

Mr Moore also argued that IAG's post-contract conduct confirmed that neither party intended the aggregation clause to apply to the losses. In support of this, Mr Moore said that IAG assigned the claims different claim numbers and pointed to the fact that IAG had not raised the aggregation clause until November 2017. Unsurprisingly, the Court did not accept that this was evidence of post-contractual conduct or that the parties' conduct *'shed light'* on the interpretation of the clause.

Was there a *'series of losses'?*

Mr Moore first argued that the aggregation

clause required any losses to comprise a *'series'*. He said that this requires a connection between each loss, such as by natural succession, temporal proximity, spatial proximity and similarity in nature. He said that the only connection in this case was that the losses were both caused by earthquakes and happened to the same house.

Justice Dunningham rejected this. She considered that Mr Moore's interpretation of the word *'series'* read too many requirements into the phrase, and that the word required no greater connection between the two earthquakes than that they were, in some way, similar. For example, a person, in ordinary speech, would be considered to have suffered a *'series of mishaps'* if within a matter of months the person had two or more adverse events occur.

The Judge concluded that suffering more than one loss in a cover period would constitute a 'series' for the purposes of the policy's aggregation clause.

Was there a *'series of events'?*

Mr Moore further argued that the events which resulted in the losses must also be a series. He said that there was no suggestion that the June earthquakes occurred *'in succession'* to the February earthquake, and pointed to seismological evidence to the effect that the June event did not depend on the February event. Mr Moore said that the earthquakes occurred along distinct fault lines, were temporally distinct, and did not constitute a series.

Again, the Judge considered that Mr Moore's arguments read unnecessary requirements into the words *'series of events'*. The only connection required by the aggregation clause was that they have *'the same cause'*. If they did, then there was a sufficient connectedness to constitute a *'series of events'*.

Is the *'series of events'* required to cause the *'series of losses'?*

Mr Moore further argued that the *'series of losses'* must be caused by a *'series of events'*. That is, the losses suffered in each earthquake must be caused by both events, and not just one of them. In support of this, Mr Moore relied on the House of Lords' decision in *Lloyds TSB General Insurance Holdings Ltd v Lloyds Bank Group Insurance Co Ltd,*[2] in which it was held that the insurer could not aggregate losses where they were caused by a different act.

Justice Dunningham distinguished Mr Moore's case on the basis that the wording in IAG's aggregation clause differed. In Lloyds TSB the clause was properly read as the *"related series of acts or omissions"* being the unifying factor so that it was the series of acts or omissions which had to, together, result in each of the claims. In Mr Moore's case the unifying factor required by the wording of the clause was not a series of related events, but the cause of the events which led to the losses. Therefore, if the Court was satisfied that the series of events had the *"same cause"* it could aggregate the losses under the policy.

This led to *"the final, and… critical argument"*.

Do the events have *'the same cause'?*

Mr Moore's final argument was that the February and June earthquakes did not have the same cause.

Both parties led expert evidence on this issue. Both parties' experts agreed that it was statistically highly probable that the September 2010 earthquake caused additional loading on the faults which ruptured in 2011 and contributed to them occurring when they did.

IAG's expert said further that there was a 97 percent or greater possibility that the 2011 earthquakes were aftershocks, meaning that the September earthquake was *"the determinative trigger"*. Or, to use the words of the policy, it was *"the same cause"* for the 2011 earthquakes.

IAG's expert's calculations were not disputed, however Mr Moore's expert said that the 2010 earthquake contributed to *"setting the stage"* for the 2011 earthquakes, but said that it was not *"the straw that broke the camel's back"*. He reached this conclusion because of the temporal delay between the earthquakes and the fact that they occurred on spatially distinct faults. Mr Moore also argued that, to say that the first earthquake caused the 2011 earthquakes because it increased loading on the relevant faults would ignore *"millennia of stresses that continued to build"* on the faults.

Justice Dunningham considered that the answer to this question turned on the degree of connection required by the words *"the same cause"* and whether the evidence satisfied that requirement.

Her Honour interpreted the word *'cause'* in the *"usual way, as meaning a direct or proximate cause of the event"*. Although the question of causation was usually dealt with in terms of the cause of loss rather than the causation of an event, her Honour applied the same test – 'but for' the September earthquake would the 2011 Earthquakes have happened? She concluded that they would not. In reaching this conclusion, the Judge gave weight to the timing of the earthquakes, and the evidence that the 2011 earthquakes were likely aftershocks. Without the September 2010 event, it was extremely unlikely that the faults underlying the 2011 earthquakes would have ruptured when they did.

Accordingly, the 2011 earthquakes had '*the same cause'* for the purpose of the policy and the aggregation clause applied.

1. [2019] NZHC 1549.
2. [2003] UKHL 48, [2003] 4 All ER 43.

Key Points

This decision is a reminder to insurance brokers of how aggregation clauses may operate to limit coverage within a policy year – and the importance of advising clients to buy sufficient insurance coverage to fully reinstate insured property. Had Mr Moore selected a sum insured sufficient to rebuild his home, the aggregation clause would not have affected his insurance recovery.

Authorised Financial Adviser's obligations to advise clients of disclosure obligations

The Financial Advisers Disciplinary Committee (Committee) has released a decision on complaints against an Authorised Financial Adviser (AFA) regarding his duties under Code Standard (CS) 8 of the Code of Professional Conduct for AFAs (Code).

Jane Standage
Partner

Olivia de Pont
Senior Associate

This decision emphasises that AFAs must take care to:

(a) ensure their clients understand their obligation to make full disclosure to insurers;

(b) make full inquiries of their client's situation prior to arranging insurance coverage; and

(c) clearly communicate any limits on the advice provided.

Background

Mr T was an AFA who specialised in advising members of the building and construction industry on income replacement, health, trauma and life insurance cover. Complaints were made by two former clients, Mr P and Mr W, in relation to advice he had given them, and was focussed on the extent to which Mr T had inquired about their medical history.

The complaints engaged CS 8 of the Code, that provides:

"When providing a personalised service to a retail client an AFA must take reasonable steps to ensure that the personalised service is suited for the client."

The Committee noted that the overarching principle of the Code requires AFAs to apply the Code Standards *"in a way that encourages public confidence in the professionalism and integrity of financial advisers".*

In light of that, the Committee said that CS 8 requires an AFA to make:

- reasonable inquiries to ensure the AFA has an up-to-date understanding of the client's financial situation, financial goals and risk profile, having regard to the nature of the personalised service being provided; and
- where a client declines to provide some or all of the information required under CS 8, an AFA must take reasonable steps to ensure the client is aware that the personalised service is limited and specify those limitations.

Mr W's complaint

Mr W was a project manager for a company, and met with Mr T at his company's offices to discuss his life, income protection and mortgage protection insurance.

Mr W had been insured by Sovereign Assurance under a policy which contained an exclusion for *"disease, disorder of or injury to the lumbar Sacral Spine, its Intervertebral Discs, Nerve Roots or Supporting Musculature"* (lumbar exclusion). Mr W was looking to replace the Sovereign Policy with a policy with PartnersLife.

Mr W told Mr T that the lumbar exclusion was required because he had a slight back ache from putting up a curtain rail which he had disclosed to Sovereign. Mr W insisted that he would not allow the application for insurance to PartnersLife to include any mention of his back problem because, to do so, would be a 'misstatement' by him. Mr T took him at his word and made the application to PartnersLife.

Unbeknownst to Mr T, Mr W actually had an extensive medical history which he had not disclosed to Sovereign or PartnersLife. This medical history came to light when Mr W suffered an injury that required medical attention. At this point, PartnersLife withdrew all cover for Mr W.

Application of CS 8 to Mr W

The Committee held that Mr T knew that Mr W's Sovereign policy was subject to a lumbar exclusion, and this was information he was obliged to take into account when assessing the suitability of the PartnersLife policy he was recommending to Mr W. Mr T chose not to act on information he knew. Rather, he took Mr W at his word.

Although Mr T was not required to be *'on notice'* that Mr W might be withholding other information, given his knowledge of the lumbar exclusion, he should have made further inquiries before concluding that the PartnersLife policy was suitable for Mr W. Suitability in this context means *"the best outcome taking account of the full circumstances of the client, determined after reasonable inquiry".* The Committee commented that Mr T had allowed himself to be "suborned by Mr W's strong assertions when he should have tested the matter further".

The Committee also said that when Mr W refused to allow his application to PartnersLife to proceed, Mr T should have taken reasonable steps to ensure that Mr W was aware that Mr T's service was therefore limited and to specify those limitations.

Mr P's complaint

Mr T met with Mr P on three occasions. At the first meeting Mr T sought to complete his *'fact find'* on Mr P; at the second meeting Mr T presented his statement of advice; and at the third meeting an application to PartnersLife was completed. During these meetings there was some discussion of Mr P's medical history, however Mr P did not raise a previous ankle injury because *"it did not seem to be that big an issue".* It was unclear whether Mr P formed this view because of positive advice received from Mr T or whether Mr P decided it was not significant enough to be included because of what Mr T had advised about expected disclosure.

Insurance was then placed for Mr P, without disclosing Mr P's past medical conditions.

Application of CS 8 to Mr P

The Committee held that Mr P did not make any medical disclosures because Mr T failed to elicit those disclosures. This was either because Mr T did not ask about them directly or because he did not make the importance of full disclosure clear enough to Mr P. Knowledge of those matters was a necessary requirement to obtain an up-to-date risk profile. Therefore, it was irrelevant that a subsequent insurer had chosen not to limit Mr P's cover just as PartnersLife had not (and that arguably the risk profile presented by Mr P was the same with or without the disclosures).

The real issue was whether Mr T made reasonable enquiries about Mr P's risk profile at the time the application to PartnersLife was made. Mr T had not even requested that Mr P complete a list of prior medical issues. Therefore a breach of CS 8 was made/

Conclusion

This decision emphasises the importance of an AFA making reasonable inquiries of their client's risk profile. In some cases, all this may involve is the completion of a list of prior medical issues and explaining the importance of full disclosure.

Further, if a client refuses to make full disclosure to an insurer, an AFA must ensure that they are aware of the limits this will place on the AFA's service.

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