

Insurance Law Update

New Zealand Insurance Law Association 2004 Conference

Duncan Webb
Associate Professor University of Canterbury
Consultant Lane Neave Lawyers

A common thread in New Zealand insurance law “updates” is that little seems to happen. These islands are perhaps untroubled by the liability explosion which accompanies personal liability law, and the rest of the law of insurance seems to come before the courts only a few times a year. It is perhaps a pity that there has not been a tirade of hard cases to stimulate the legislature into ironing out some of the obvious wrinkles which exist. Indeed a cursory glance at the insurance law landscape in New Zealand may give this impression. However, a closer examination suggests that things are not standing still. Thankfully this area of the law does not change at the breakneck pace that seems the norm in Australia with further legislative reforms being contemplated there, and the High Court about to hear an important case on insurance against nefarious conduct.

The Law Commission has not been idle and its paper *Life Insurance: A Discussion Paper* (Preliminary Paper 53, December 2003) will stimulate discussion on the regulation of that sector of the industry. It might, however, be noted that the issues raised by that paper are less in need of attention than those raised in the Commission’s earlier paper (NZLC: R46, 1998).

Fraud: Some Questions about Onus

It goes without saying that where an insured makes a fraudulent claim the insurer need not pay out. Policies invariably provide that false statements in a claim will result in the claim being denied thus giving a contractual basis for refusal. It is also an established rule of the common law that a claim that is made in breach of the duty of good faith gives the insurer a right to terminate the contract and refuse to pay the claim.

A finding that an insured has misled the insurer in making a claim is a serious allegation, and one from which criminal charges could conceivably flow. The question therefore arises as to the standard of proof that is required to establish fraud in making a claim.

My own view is that the matter in hand is a civil one, and as such the normal civil standard should apply – if the insurer can show that the claim is more probably than not tainted with fraud then the claim should fail. The courts, however, have been less blasé. (As an aside I note that the professional rules offer protection against such allegations being lightly made – Rule 8.04 states that in litigation a person’s reputation should not be attacked without good cause.

These issues were considered in the lengthy case of *Blanshard v National Mutual Life Association of Australasia Limited* (High Court Auckland, CP 2654-SD01, 22 September 2003, Harrison J). That case concerned a claim by an insured under an income protection policy for continued cover. The insurer, which had paid \$639 342 out to date was of the view that there was no continuing disability and had declined further claims. In response to the insured’s action the insurer counter-claimed for all of the amounts paid to date alleging fraud in a number of guises. The gist of the allegations was that the insured had inflated the seriousness of his complaint and been economical in disclosing the kinds of activities he was and was not able to engage in.

The disorder complained of was Meniere’s Syndrome, which affects the ears and which can

result in hearing loss, vertigo, dizziness, and a ringing in the ears (tinnitus). The insured filed a claim under his policy and received payments from early 1996 until the end of 2000 when the insurer declined to accept that he remained totally disabled. A number of factors contributed to the decision to refuse to pay further, not least of which were the 10 skiing holidays (judicial notice was taken of the fact that “there is only one run at Treble Cone which is easy), the renovation and sale of several houses, and the high living involving \$25 000 on dining out over the period. The original decision to cease paying was of course prospective in so far as it alleged that there was no longer a permanent disability. The counterclaim, however, sought to impugn the claims made right back to the very first. One interesting side issue was the question of whether this policy contemplated one claim with many payments, or many individual claims. If it was the former one instance of fraud at the outset would taint the whole process. If it was the latter then fraud would arguably have to be shown in respect of each payment / claim that the insurer sought to recover.

The policy itself provided a clause which echoed the common law right to avoid a policy for fraud either at inception or in making a claim. In addressing the problem Harrison J stated that “an insurer alleging fraud assumes a heavy burden of proof” (para 51). He traversed the various authorities on the matter in including the House of Lords in *Re H and Others* 1 All ER 1 where Lord Nicholls broached the issue. There the idea of some kind of sliding scale (which could be inferred from the language used in a number of the authorities was rejected. Similarly it was noted that there was little to be gained from imposing a higher standard of proof than the usual civil standard of balance of probabilities.

Rather it was suggested that the intuition that something more is needed to prove fraud flows not from a different standard of proof, but from the inherent improbability of what is being alleged. This might usefully be considered as the opposite of the presumption of regularity. In the same way that we can properly presume documents to be regular in the absence of any contrary indications, so we can presume that insured do not act fraudulently. Moreover, the more egregious the conduct alleged, the less likely it is to occur in the normal course of events. As such to show, for example, that an insured burned down his house with his wife and children inside simply for the proceeds of an insurance policy, the insurer must adduce compelling evidence indeed, because such an event, while not impossible, is highly improbable.

In one sense this issue might be seen as a semantic problem rather than one of substance, and this was the view taken by Harrison J in *Blanshard* when he chose to adopt the test of being “convinced” or “sure and certain”. He was of the view that the adoption of the civil or criminal test was immaterial. This is perhaps stating too strongly what was observed by Somers J when considering allegations of fraud in civil proceedings:

This means that although this is a civil case to which the civil standard of persuasion applies the very gravity of what is alleged makes the probability of its occurrence more remote or unlikely and hence the more difficult to establish. The difference between the civil and criminal standards diminishes with the seriousness and in this case the criminality, of the issue. (*Budget Rent-a-car v Auckland Regional Authority*[1985] 2 NZLR 414, 425).

The result in *Blanshard* was unsurprising given the finding of facts made. It might be noted that there was never any suggestion that the insured never suffered from Meniere’s syndrome. Rather, the complaints were that at the outset there had been an inflation of the effect of the disorder on the ability of the insured to function. From the start it was found that the insured exaggerated the affect of the disorder as part of an “escalating pattern of exaggeration shading into fabrication”. This raises an interesting issue as regards what amounts to fraud in a claim sufficient to avoid a policy. It is now well accepted that in such cases a mere mistake will not suffice (unlike misstatements in entering into the policy). Not only must the statement of fact be false, a degree of intention must attach to the statement. In particular the insured must know it is false, or be reckless as to whether or not it is false. Cases of inflation raise some problems as insured’s may lodge a claim in the belief that the insurer will not accept at face value the claim as lodged. Accordingly the insured may give generous estimates of the value of the loss, or the impact of the disability on the ability to work. It is generally accepted that some hyperbole is consistent with the duty of good faith in making claims, provided it might conceivably be true. Thus to say in a claim form “my ability to

work has been seriously detrimentally affected” is a statement of degree and quite possible permissible. However, in Blanshard statements like “my doctor has insisted that I stop work within the month” were in fact simply false. It is also of note that the insured in this case had sold his shares in the business and agreed to a restraint of trade clause preventing him from working in the industry. As such Harrison J found that in making the claim the insured had fraudulently exaggerated the influence of his doctor/s advice and fraudulently concealed the fact that the further motive of the restraint of trade increasing work.

The question of where the onus lay in proving fraud has also recently been considered by the Supreme Court of Queensland in *Ocean Harvester v MMI General Insurance* (2004 ANZ Ins Cas 61 592). That case concerned the loss of a trawler “Ocean Harvester” in calm conditions. The insurer declined the claim on the basis that the insured had not proved that the loss had been caused by “accident” as defined in the policy, and also that the claim was fraudulent in that the loss had in fact been caused by the intentional scuttling of the vessel. These of course are two sides of the same coin.

The distinction is that the onus lay on the insured to prove that the loss occurred in a way which came within the terms of the policy – namely that the loss was caused by accident. Conversely, the insurer had the onus of proving that the loss was caused by the willful act of the insured if this was alleged. Moreover, the strength of the evidence that needed to be adduced to refute the claim that the loss was by accident was, arguably, lower than that which had to be adduced to decline on the grounds of scuttling. Some might suggest that this is perverse. McMurdo P disposed of the appeal in favour of the insurers as follows:

Under the contract of insurance the appellant had to establish the ship sank by accident; this was a matter to be determined by his Honour on the evidence at trial, which included Dobbins' evidence that Kerr and Thompson scuttled the boat. On the accepted evidence, his Honour was not persuaded on the balance of probabilities that Kerr and Thompson had scuttled the boat, a criminal offence, but nor did the evidence satisfy him on the balance of probabilities that the boat was accidentally sunk; the appellant's claim was unproved and failed. Whilst it is unusual for judges to be left in such a state of uncertainty as to evidence, it is not uncommon in cases of this sort where judges are not lightly persuaded to accept that protagonists have acted with criminal intent but nor are they necessarily satisfied to the civil standard that the claim is made out

This analysis seems to proceed on the basis that there are differing standards of proof as regards the two contentions. It does seem that this is problematic. Only two hypotheses were put to the court – either the boat sank by an unexplained accident or it was scuttled. The court ultimately found that neither of these was proved. The Supreme Court noted that in the court below that: “given the serious nature of the respondent's allegations against the appellant to which Thompson was said to be a party, his Honour was not prepared to reach a positive conclusion that the vessel had been deliberately scuttled”. Thus the court was left in the extraordinary position of there being an evidential vacuum.

It does seem that this resulted from the imposition of a higher than balance of probabilities standard on the allegation of scuttling. It is clear on the case that the account of the loss given by those on board was not accepted. As such the only tenable explanation was that the vessel was scuttled. While it may be that there was insufficient evidence to convict the insured of any crime in relation to the act, this is no bar to a finding that it was more probable than not that the loss was by scuttling. This would avoid the awkward situation of the court being presented with competing versions of events and effectively fence sitting.

Insurance and Nefarious Conduct

As the *Ocean Harvester* case illustrated, insurance cover will not be issued for intentional acts. Classically insurance contracts provide for indemnity where loss is suffered by some external event – tempest, fire, theft and so on. However, in modern times policies have issued to grant cover for losses caused by the acts of the insured or their agents. This has extended to cover for misconduct of the insured whether that is careless driving, or breach of statutory duties if reporting in corporate affairs. However, for obvious reasons insurers have drawn the line and will not (and quite possibly cannot) insure for fraudulent conduct.

This issue is particularly relevant in professional indemnity policies as those insured under them are frequently in positions of trust. Accordingly such policies generally have a specific exclusion in respect of losses caused by conduct of the insured which is dishonest or fraudulent. The parties are of course contractually free to set any standard of conduct they wish in respect of acts of the insured which cause loss. Indeed in *Holmden Horrocks v Royal SunAlliance Insurance NZ Ltd* (High Court Auckland, Civ 2004 404 587, 24 May 2004, France J) the professional indemnity policy of that law firm excluded loss in respect of the firms nominee company activities where the nominee company rules had not been followed and the assured had “not made reasonable efforts to comply with such requirements”. In that case there had been several breaches of the rules in respect of a particular advance including advancing funds without written authorisation, and a failure to inform contributors of the borrower’s defaults. The firm’s processes in place to ensure compliance were lax and it was held that reasonable efforts to comply did not exist and the insurer’s refusal to cover was legitimate. The effect of this clause was effectively to render Holmden Horrocks uninsured in respect of reckless or grossly negligent conduct.

More common are policies which provide that cover is excluded in respect of losses flowing from the “dishonesty or fraudulent act or omission of any Insured”. This was the formulation used in *Harle v Legal Practitioners’ Liability Committee* (2004) ANZ Ins Cas 61 605. In another case with quite extraordinary facts Mr Harle was duped by the equivalent of a Nigerian scam letter into advising his clients to invest some USD\$2m in a fictional investment. This was obviously something that no competent solicitor would do, however, it was always accepted that Mr Harle received no secret benefits, nor did he seek to dishonestly gain from the transaction (though he was in for windfall of 10% of the proceeds of the transaction which were projected to be USD\$20m). Predictably the funds “invested” were lost and the clients looked to their advisor for compensation. The insurer was joined as a third party. At first instance the decision of the insurer was upheld. The insured appealed to the Court of Appeal of the Supreme Court of Victoria.

The insurer declined the claim on the basis that the conduct of Mr Harle had been dishonest. A number of actors were relied on in this assertion of dishonesty on top of the gross negligence in believing the claims of the fraudsters. They were:

- Mr Harle had concealed from them the fact that a “prime bank guarantee” which had been promised had never been sighted nor was any bank named.
- The possible USD\$2m commission gave Harle a real motive to put his client’s interests behind his own.
- Harle “must have known” that there was a real risk that this was a scam, especially after he was warned of this by an officer of the ANZ who refused to assist in the transfer of funds.

Other signals of the fraud were:

- The outrageous returns quoted of 1000%.
- The nonsensical contractual documents.
- The fact that the governing “master contract” was confidential and unable to be viewed by the parties.

It is of course possible that Mr Harle had somehow slipped through that rigorous screening process that is law school and was so utterly stupid as to have not seen the flashing warning signs. It was therefore necessary for the court to determine what amounted to dishonesty in the words of the policy. It was noted as a starting point that it was not a technical word and it carried its plain and ordinary meaning.

Of particular note was the objective rather than subjective interpretation that Chernov JA gave the concept of dishonesty. While noting that the acts complained of must have been undertaken intentionally, the suggestion that the actor must know or herself know that they are wrong was rejected. Rather the standard of “ordinary decent people” was appropriate. Thus in the present case this was conduct which no honest person would engage in and therefore was dishonest. The fact that this may not have been appreciated by the insured was irrelevant.

Similar issues arose in *McCann v Switzerland Insurance Australia Ltd* (2001) 11 ANZ Ins Cas 61 – 479 where in a well known fraud a solicitor lost USD\$8.7m of the funds of the Naru Trust. There it was found that the mere fact that the wrongdoer did not intend any funds to be lost was irrelevant to the finding of dishonesty. That case was, however, distinct in that the wrongdoer was using the funds of his client without authorisation for the personal gain of a secret commission – a clearly dishonest activity. In the present case there was no secret commission.

The practical result in this case is probably not contentious in light of the fact that that the insured seemed to know that what he was doing was wrong in any event. However, the basis upon which it proceeded should be taken note of. Dishonest conduct does not mean some calculated course of fraud. It simply means conduct which no decent and honest person would engage in. Thus, in the words of Callaway JA who concurred:

folly and fraud are conceptually distinct, but in practice they are not so far apart. A solicitor who conducts himself as irresponsibly as the appellant has only himself to blame if his conduct is found to be dishonest.

Defending Fraud Allegations: Who Pays?

The issue of fraud in insurance cases has had occasion to trouble the Supreme Court of New South Wales Court of Appeal in *Silbermann v CGU Insurance Limited* (2003) 12 ANZ Ins Cas and *Wilkie v Gordian Runoff Ltd* the High Court of Australia heard the conjoined appeals of on 28 September this year. Both were appeals from the. As at 19 October the decisions of those appeals are pending.

These cases concern the liability of the insurer under a Directors' and Officers' Liability policy to advance legal fees where the allegations which are being defended involve fraud or dishonesty. In both policies the insurer was entitled to take over the defence of a claim, but failing that they had a discretion to advance the costs of defence to the insured (on the basis that they could claim them back if it later transpired that the loss was not an insured loss).

In *Silbermann* cover was excluded where loss was brought about brought about by, contributed to by or which involved "the dishonest, fraudulent or malicious act or omission or other act or omission committed with criminal intent of such Director or Officer, such Director or Officer having improperly benefited in fact from securities transactions as a result of information that was not available to other sellers and/or purchasers of such securities; or such Director or officer having gained in fact any personal advantage to which he/she was not legally entitled". However that clause was mitigated by the proviso that "this exclusion shall only apply to the extent that the subject conduct has been established by a judgment or other final adjudication adverse to the Director or Officer".

In *Wilkie* the policy excluded Loss (including costs) arising out of any Claim based upon, attributable to, or in consequence of any dishonest, fraudulent, criminal or malicious act or omission any deliberate breach of any statute, regulation or contract where such act, omission or breach has *in fact* occurred. "In fact" was defined to mean that "the conduct referred to in those Exclusions is admitted by the Insured or is subsequently established to have occurred following the adjudication of any court, tribunal or arbitrator".

Both cases concerned investigations by the Australian Securities Investment Commission which was alleging serious misconduct. In both cases the insurer refused to advance legal fees on the basis that there was no cover for dishonest or fraudulent acts. It must be observed that at one level these cases turn largely on the wording of the policy documents and large parts of the judgement are concerned with these questions.

At a policy level, however, these cases are interesting for a number of reasons. They reveal a concerning dilemma for the insured where the misconduct upon which the insurer declines to pay is the very allegation that the advance of defence costs is intended to refute. Further, the nature of the claim brings into play the rarely examined duty of the insured to enforce the policy terms in accordance with the duty of utmost good faith.

Hodgeson JA noted that one important function of the policy in *Silbermann* was to ensure that the insured officers would have a full and fair hearing in the event that allegations, including allegations of dishonesty were made against them. Accordingly the discretion of the insurer to advance costs must be exercised against this background. The conundrum for the insured is that the liability of the insurer to pay defence costs is dependant upon there being no fraud or dishonesty; however, to properly dispose of that matter it is necessary for the insurer to pay those costs to ensure that the company officer can be properly represented in the proceedings which determine the issue.

Of note is the fact that the insurer under such an approach may be required to advance funds which it is later found must be repaid, but which there is no chance of recovery. It was noted that there are similarities in this approach to the refusal of a stay on a judgement where the successful respondent needs to fruits of the judgement to respond to the appeal.

In *Silbermann* Tobias JA (with Beazley JA) found that that a refusal to assist the insured in defending an allegation of dishonesty on the basis of the very dishonesty alleged was not a breach of the duty of good faith. While the insurer's refusal to advance defence costs must be based on reasonable grounds, the Court was of the view that there was nothing fundamentally wrong with refusing to assist the insured in defending such an allegation. The policy, in his view, was not intended to provide "up front" cover for defence costs come what may. It was observed that there may be commercial reasons why an insurer would advance defence costs even though not strictly required to under the policy. However, this affirmation of the right of the insurer to stand on the rights created by the policy working will come as something of a relief to insurers (though we await the decision of the High Court).

Hodgeson JA made a dissenting judgement arguing that given the policy wording the insurer may exercise its discretion and refuses to advance legal costs to the insured on the basis that it had a defence to the entire claim under the policy. It was, however, noted that where the only defence to the claim was that the conduct causing the loss was dishonest or fraudulent then costs must be advanced to determine this question. Of course in the event that the insurer did not advance the costs then the insured would be entitled to sue the insurer and that action might itself resolve the issue of whether the conduct was dishonest. Hodgeson JA concluded that these issues might be at least partially resolved by judicious case management, for example by severing end expediting questions of fraud or dishonesty where possible.

The Credit Contracts and Consumer Finance Act 2003: Credit Related Insurance

In August 2000, the Ministry of Consumer Affairs released a consultation paper which discussed, amongst other things, credit-related insurance (*Consumer Credit Law Review - Part 4: over indebtedness, insurance and e-credit* - Ministry of Consumer Affairs, Wellington, August 2000). The paper identified a number of different types of credit-related insurance: goods insurance; consumer credit insurance (CCI); life insurance, and lender's mortgage insurance. Whilst the paper recognised that consumers and lenders benefit from credit-related insurance, it also pointed out that a number of problems existed.

First, credit-related insurance tended to be overpriced. Frequently less than half of the amount paid is actually needed for underwriting, the greater part being brokerage. This was due to a number of factors and was also influenced by lenders and suppliers only selling one insurer's insurance, especially in the case of consumer credit insurance.

Secondly, lenders, suppliers and insurers were under no obligation to disclose the terms and conditions of the insurance policy. As the Ministry's paper pointed out, this limited disclosure "prevents customers from understanding essential terms, such as the amount of the premium, claim entitlements, the extent of insurance cover provided, and the term of the policy" (*ibid*, at page 15).

Thirdly, debtors can sometimes be required to take out insurance that is inappropriate. The

cover may be inappropriate because it excludes a risk that may be the most relevant to the debtor, or because the insurance must be taken despite the fact that the debtor is likely to be able to service the loan even if the event insured against, e.g. unemployment, does occur.

Finally, debtors may be required by the creditor to purchase insurance even though cover for the goods is provided by an existing insurance policy. For example, the debtor may be required to take out insurance for a television in the event of the television being stolen or damaged, even though such an event is adequately covered by the debtor's contents insurance.

Following an analysis by the Ministry of these problems, the paper suggested seven possible areas for reform. Not all of these reforms have been adopted in the Act, and some of those that have been adopted represent a merger between some of the proposals. Those reforms that have been adopted in the Act are discussed below.

Defining credit-related insurance

An important point made in the Ministry's paper was that "any regulation of credit-related insurance will need to define 'insurance' for the purpose of credit legislation" (*ibid*, at page 16). Devices such as extended warranties (warranties) and repayment waivers (waivers) needed to be included as insurance contracts. The Ministry's paper recognised that "[i]f the warranty extends to risks that are unrelated to the quality or suitability of the product, an extended warranty contract can be considered to be insurance" (*ibid*, at page 17). Repayment waivers, as will be seen in the definition below, have the same effect as insurance contracts. Because of the effect of extended warranties and repayment waivers, the provisions of the Act that relate to credit-related insurance also relate to warranties and waivers. All these terms are defined in section 5.

Under section 5, credit-related insurance can be a number of different types of insurance provided that the insurance is in connection with a credit contract or consumer lease. First, it can be insurance that covers the value of the secured property or leased goods. This covers insurance where, for example, the creditor has a security interest in the property that is the subject of the consumer credit contract and requires insurance so that, if the property is damaged or destroyed, the creditor is not left without any form of security. The property insured could be the item for which the funds were advanced (for example where finance is advanced to buy a car the financier will usually require the car to be insured). Equally the property insured could be merely collateral (as where a mortgage is taken over a home in respect of funds advanced to purchase a car – in such a case the financier will usually require the home to be insured).

Secondly, credit-related insurance can be insurance that covers the shortfall between the proceeds of another insurance policy and the debtor's or lessee's obligations under a consumer credit contract or consumer lease if secured goods or leased goods are totally or substantially destroyed. This will cover situations where the debtor already has insurance, but that insurance does not cover the debtor's full obligations under the consumer credit contract. In such a case the debtor may be required to take out insurance to cover the shortfall.

Thirdly, credit-related insurance can be consumer credit insurance. Consumer credit insurance is insurance cover which meets the consumer's obligations under the credit arrangement in the event of some supervening event. Such events insured often include the insured's disability or death or the insured contracting a sickness, sustaining an injury or becoming unemployed. The defining feature is that unlike ordinary life or health insurance, under consumer credit insurance the liability of the insurer is determined by reference to the liability of the insured under the credit contract or consumer lease.

Repayment waivers

A repayment waiver has the same effect as consumer credit insurance. It is an agreement, either between a creditor and debtor or lessor and lessee, under which the creditor or lessor agrees, for additional consideration, to waive the creditor's or lessor's right to any amount payable under the credit contract or consumer lease in the event of the unemployment, sickness, disability or death of, or injury to, the debtor or lessee. The additional consideration is the equivalent of an insurance premium.

Extended warranties

An extended warranty means an agreement, either between a creditor and debtor, or a lessor and lessee, under which the creditor or lessor agrees, for additional consideration, to repair or replace defective goods outside of the warranty period that would otherwise apply.

No unreasonable insurance

The Act has avoided an outright restriction on a creditor's or lessor's ability to insist that the debtor or lessee take out insurance. The Act has also avoided restrictions on the creditor's or lessor's ability to choose the insurer. Instead, the Act adopts the proposal in the Ministry's paper that legislation should prevent a creditor or lessor making unreasonable requirements about the terms on which the insurance is to be taken out.

Section 69(1) provides that a creditor or lessor must not make any unreasonable requirement as to the terms on which the debtor or lessee is to take out, or obtain, credit-related insurance, a repayment waiver or an extended warranty in connection with a consumer credit contract or consumer lease. The section is worded broadly so that it applies not only to insurance, waivers and warranties arranged through the creditor or lessor, but also to such agreements arranged through an independent third party.

What is "unreasonable"?

Section 69(2) provides two circumstances in which requirements will be unreasonable. It is of note that while those circumstances are not stated to be exhaustive, the usual phrase "without limitation to the foregoing" does not appear and there is an argument that s 69(2) effectively defines unreasonableness as used in s 69(1).

A requirement is unreasonable in two situations:

- It is not reasonably necessary for the protection of the legitimate interests of the creditor or lessor; or
- It is not reasonably justifiable in light of the risks undertaken by the parties to the arrangement.

These definitions appear to be aimed at two of the problems that the Ministry identified. First, the definitions deal with the problem of inappropriate insurance cover. For example, let us suppose that Fred enters a consumer credit contract to purchase a lounge suite worth \$3,000. The creditor requires that Fred take out a repayment waiver. It provides that if Fred is made redundant, the creditor will waive its right to repayment of the payments due. Fred, however, is unemployed (or perhaps retired). The requirement that Fred enters a repayment waiver on such terms is likely to be unreasonable.

Secondly, the definitions deal with the problem where a debtor or lessee is required to take out insurance despite the fact that the goods insured are suitably covered by the debtor's or lessee's own contents insurance. For example, once again, Fred enters a consumer credit contract for a lounge suite, worth \$3,000. The creditor takes a security interest in the suite, and for its own protection, requires that Fred take out insurance for the suite. Fred, however, already has contents insurance for all items in his house. As Fred already has sufficient insurance to cover the interests of the creditor, the creditor's compulsory insurance is not reasonably necessary to protect the creditor's legitimate interests. It can be noted that specific insurance can be assigned to a secured party and this benefit is lost where the goods are only insured under a general policy. However, this is, of itself, unlikely to be enough to require a consumer to take out specific consumer credit insurance that effectively requires double insurance of assets.

There may be a number of other factors which might suggest that the requirements are unreasonable. For example the value of the goods may be so small as to make insurance inefficient, the consumer may be solvent and wish to be uninsured, or adequate security for repayment may exist so as to make consumer credit insurance unduly onerous.

These provisions will require significant consideration by creditors or lessors that usually require a debtor or lessee to take out, or obtain, credit-related insurance, a repayment waiver

or an extended warranty. Creditors and lessors will need to obtain substantial information about the debtor or lessee to ascertain whether the insurance, waiver or warranty offered is appropriate for the particular debtor or lessee. Consequently, the use of standard form contracts for such agreements may present a risk in some transactions.

Remedy

If a requirement in respect of insurance is unreasonable an application may be made by the Commerce Commission, a debtor or a lessee alleging that a creditor or lessor has breached section 69(1). If the Court is satisfied that there are unreasonable terms on which the debtor or lessee was required to take out or obtain insurance, a waiver or a warranty, then the Court has two options. The Court can order that the insurance, waiver or warranty be annulled on any terms and conditions that the Court thinks fit or the Court can order that all or part of the premium, or any amount payable, in relation to the insurance, waiver or warranty be reimbursed to the debtor or lessee. It is important to note that in this case, the reimbursement must come from the creditor or lessor. This reflects the possibility that the creditor or lessor may insist that the debtor or lessee obtain insurance, but the insurance is obtained through an independent company. That independent company may have done nothing wrong in arranging the insurance, as the insurance is on the terms on which the creditor or lessor insisted that the debtor or lessee obtain the insurance. The debtor or lessee obtains the reimbursement straight away. It is then the creditor's or lessor's task to try and obtain such an amount from the insurer. If the insurer does not reimburse the full amount, because insurance has been provided for a period of time, then it is the creditor or lessor, not the debtor or lessee, that is out of pocket.

Disclosure required

Section 70 deals with one of the problems the Ministry identified, that very often the terms of the insurance, waiver or warranty are not disclosed to the debtor or lessee. So, if a consumer credit contract or consumer lease involves credit-related insurance and the insurance was arranged by the creditor or lessor, the creditor or lessor must ensure that a copy of the terms of the insurance is supplied to the insured within 15 working days of the day on which the insurance is arranged (section 70(1)). Therefore, if the insurance is not arranged by the creditor or lessor, then the creditor or lessor is not responsible for disclosing the terms of the insurance.

Section 70(3) defines when credit-related insurance is arranged by the creditor or lessor. This will be the case where any one of the following exists:

- The creditor or lessor, or a related company, may be the insurer. (A related company has the same meaning as in section 2(3) of the Companies Act 1993 (section 5) and will include a wholly or more than 50% owned subsidiary, a parent company or a sibling company).
- The creditor or lessor, or a related company, may have acted as the agent of the insurer in relation to the insurance. Standard agency law rules are likely to apply in such cases.
- The creditor or lessor, or a related company, may have received a commission in relation to the insurance.
- The creditor or lessor have required the debtor or lessee to obtain the insurance from a particular insurer.

If one or more of these situations applies, then the insurance has been arranged by the creditor or lessor, and the creditor or lessor is responsible for ensuring compliance with section 70(1).

It almost goes without saying, but if none of the above definitions apply, it is likely that the debtor or lessor has arranged his or her own insurance. Obviously in such cases, the creditors and lessors do not have any responsibility to ensure that the terms of the insurance are disclosed.

The rule in section 70(1) also applies to repayment waivers and extended warranties, except that the waiver or warranty need not have been arranged by the creditor or lessor (section 70(2)). So, even if a waiver or warranty is arranged by the debtor or lessee, it is still the creditor's responsibility to ensure that the terms of the waiver or warranty are disclosed within 15 working days.

Notes on *Drake Insurance v Provident Insurance*

Despite the opening words of Lord Justice Rix no law professor would be so unkind as to use the facts of *Drake Insurance v Provident Insurance* [2004] QB 601 as an exercise for any but the most difficult of students.

The insurance policy at the core of the dispute was in many ways a standard motor vehicle policy, however, the manner in which it was underwritten was somewhat unusual. The insurer, Provident, had developed a formulaic method of categorizing risk which involved the allocation of certain demerit point values for risk factors such as speeding offences, historical collisions and so on. One purpose of this method was to enable brokers to enter into contracts on the insurer's behalf. By using such a formulaic system the broker only had to add up the demerit points to determine the appropriate premium. However, as this case demonstrates, such an approach has its shortcomings.

Facts

Dr Singh sought to insure his car through Hexagon Insurance Services (the brokers). In doing so he disclosed that he had been involved in an accident where a third party had run into the rear of his car. Final settlement of that collision had not yet occurred, though there was no doubt that Dr Singh had not contributed to the cause of the accident. Under Provident's demerit points system this was categorized as a "fault" accident as it had not yet been entirely resolved. Accordingly a score of 15 demerit points was noted. This did not cross the 17 demerit point threshold at which a premium loading would be added and a policy was issued at the normal premium.

A year later Dr Singh was offered a renewal of his policy. In accepting the renewal Dr Singh failed to disclose two matters. Firstly, he failed to mention that the earlier accident which had been categorized as a fault accident has been resolved in his favour and could now be categorized as a no fault accident (and therefore attract no demerit points). He also failed to mention that he had been convicted of speeding in the preceding year. This would have attracted 10 demerit points. Consequently a premium was fixed with no loading on the basis that original 15 demerit points did not cross the 17 demerit point threshold. Had the speeding conviction been disclosed, but not the resolution of the earlier accident he would have been accorded 25 demerit points and a premium loading would have applied. Had he disclosed both the speeding conviction and the resolution of the earlier accident been disclosed he would have attracted only 15 demerit points and there would have been no loading.

Of course a central issue was that there was an obligation to disclose the unfavourable fact of the speeding conviction, but no corresponding obligation to disclose the favourable fact of the resolution of the earlier accident.

Shortly after the renewal Dr Singh's wife, Mrs Kaur (who was a named driver in the policy) had a serious collision involving a motor cyclist who suffered significant injuries. A claim was made and as part of the claim investigation Dr Singh's speeding conviction was discovered. On the basis of this nondisclosure Provident wrote a letter purporting to avoid the policy, however, Provident continued to accept premiums on the policy and insured a new vehicle under the same policy. Dr Singh objected to the avoidance of the policy and refusal to meet the claim. Some time later the underwriting method adopted by Provident was explained to Dr Singh who, realizing the significance of the fault categorization of the accident explained the situation to Provident.█

Provident maintained its refusal to meet the claim and the avoidance of the policy. Dr Singh took the matter to an industry arbitration process but was unsuccessful.

Serendipitously Mrs Kaur had an insurance policy with Drake Insurance in respect of her own motor vehicle which extended to any liability incurred while driving another car with the

owner's consent. That policy contained a "ratable insurance" clause. Mrs Kaur claimed from Drake and disclosed the problems with Provident. Drake was of the view that Provident was liable on its policy and that accordingly each insurer ought to ratably contribute to the loss. Provident maintained its refusal to pay the claim and avoidance of the policy. Drake, in light of the considerable hardship caused to the injured party, and the possible harm to the reputation of the insurance industry, paid out the full amount claimed while protesting that Provident was liable to contribute.

This case was brought by Drake against Provident for that contribution.

Provident's right to avoid

The first question which arose was whether there was a material non disclosure by Dr Singh which entitled Provident to avoid the policy. It was accepted that if there had been a fault accident and Dr Singh had failed to disclose the speeding conviction then Provident would have been entitled to avoid the policy. Of course this is exactly the state of affairs that Provident thought existed up until a very late stage. The question in practical terms is whether the failure by Mr Singh to disclose the fact that the earlier accident had been resolved in his favour could now be visited on Provident. That is to say, in considering the right to avoid should the actual state of affairs be taken into account, or only those disclosed by the insured?

It is an established common law principle that there is no duty on an insured to disclose facts which decrease the risk. In general one would think the insured should bear any losses consequent on a failure to disclose an advantageous fact, whether that non disclosure was advertent or not. However, there were a number of factors in this case which meant that such an approach would cause considerable hardship. This was clearly a consumer contract. It was also noted that the matter had ramifications well beyond merely Dr Singh and his insurer. The victim of the accident was clearly entitled to significant compensation which, while the dispute persisted, he was denied. It was also clear that the Court had little sympathy for the underwriting system of Provident which was formulaic at best.

Pan Atlantic Insurance & Co. Ltd. v. Pine Top Insurance Co. Ltd., [1995] A.C. 501 established that for the right to avoid to arise the non disclosure must be both material (in the sense that a reasonable underwriter would want to know that fact) and it must have induced the conduct of accepting the risk (a reasonable underwriter would have refused the risk or increased the premiums had the fact been known). Drake argued that there was no such inducement. In particular it was maintained that had the speeding conviction been disclosed a train of events would have been put into motion which would have resulted in the resolution of the earlier accident also being disclosed – and led to no change in premium.

This enquiry was based on comments of the High Court judge made at trial. Lord Justice Rix criticised the speculative nature of the comments but then proceeded to treat them as findings which weighed in Drakes favour on the question of inducement. In contrast Pill LJ (at para 181) thought that such an exercise was inappropriate and it was not proper:

for this Court to rely on parts of the Judge's speculation and build its own speculation upon it to reach a conclusion adverse to the respondents.

Burden of proof

Buried in the detail of this issue is a difficult procedural question as regards the burden of proof in avoidance cases. It is clear that the insurer has the onus of establishing that the circumstances which give rise to the right to avoid existed. What though of a positive defence? Generally a litigant who asserts a fact in his or her own favour must prove it. However, Drake's argument rested on a counterfactual. As Rix LJ observed Drake's argument boiled down to the question of whether "if the conviction had been mentioned would the question of the status of the accident have been discussed?" (para 62). It would be onerous indeed for Provident to prove that it would have not raised the issue of the earlier accident if the conviction had been raised. However, Rix LJ, effectively found that Provident has the burden of *disproving* any positive facts raised in favour of the insured which would negate the right to avoid. (para 64). His honour noted that the court below had found that there was no evidence either way on the point and therefore, Provident had failed to establish that a right to avoid existed.

Rix LJ went even further and considered that it would have been “very likely” that had the speeding conviction been disclosed the earlier accident would have been raised and its no-fault status resolved. He concluded that even if the burden had been on Drake to discharge the onus sufficient inferences could be made from the surrounding evidence to discharge that onus.

True facts or disclosed facts?

Drake also argued that whether or not Provident had been induced must be tested by taking the facts disclosed and comparing them against the facts as they actually were. In most cases the only difference will be the addition of the undisclosed fact. However in this case the “facts as they were” would incorporate into the comparison the existence of the no fault status of the accident. The alternative is to look at the facts as disclosed and compare that scenario with the facts that the insured was obliged to disclose (i.e. including the non disclosure of the disadvantageous fact, but not the non disclosure of the advantageous fact).

Lord Justice Rix dealt with this point somewhat obscurely by framing the question of whether the test was objective (on the true facts) or subjective (in accordance with the insurer’s state of mind). This seems to miss the point that the right to avoid in respect of pre-contractual representations (and non disclosure) is entirely about what one party led the other party to believe. The actual belief of the insurer is of no relevance. Rather the key issue is what a reasonable insurer would have presumed the state of affairs to be given the representations and disclosures made. But to suggest that the insurers “subjective” state of mind is not important (para 66) seems to entirely miss the contractual underpinning of the right to avoid.

The better view, it is suggested is that of Pill LJ (at para 163) where he voiced dissent on the point saying:

I am not persuaded that an insured who fails to disclose a factor in his favour can at a later stage defeat a purported avoidance by revealing a fact in his favour upon the avoidance occurring. Attractive though the proposition is that the right to avoid should be judged according to the true state of affairs, the result would, in my view, be to devalue unacceptably the principle that the terms of the contract are those agreed by the parties.

In defence of Rix LJ, the bizarre underwriting system complicated matters considerably. In particular the categorisation of the accident in which Dr Singh was hit in the rear as a fault accident simply because full settlement had not been made was obtuse. It might be observed that Provident was in fact in possession of all of the disclosures it needed to fix the premium at the normal level if it had acted as a reasonable insurer. It was only because it had a formulaic and arguably quite unreasonable underwriting system that it would have charged a loading on the normal premium.

Attributes of the “prudent underwriter”

This raises a further important point of detail as regards the attributes of the reasonable underwriter. Is it a hypothetical underwriter using hypothetical underwriting practices which are sound and reasonable, or is it a hypothetical underwriter using the underwriting methods actually adopted? Of course there has to be a degree of specificity in the reasonable underwriter to reflect the industry sector under scrutiny. Thus in the present case there can be no objection to asking how a reasonable underwriter in the consumer motor vehicle insurance business would have acted. However, it strikes this writer as an anathema to the concept of a reasonable person to accord to them attributes which are wholly unique to the entity under scrutiny. It is therefore of concern that Clarke LJ stated that “it seems to me that it might be relevant to ask whether a speeding conviction would be material to the reasonably prudent insurer with a “points” system of underwriting”. Especially if it might be said that no reasonable underwriter would employ such a system!

An analogy may be helpful: to suggest that the test of reasonable underwriter should presume that the underwriter will use the irrational and arbitrary underwriting system used by Provident would equate to suggesting that the test of a reasonable doctor could presume that the doctor will use the same spiritual healing techniques of the actual doctor whose conduct is under scrutiny. To do so would undermine the whole utility of the reasonable underwriter test as an

objective measure of what conduct can be expected of the insurer in question. To look to the insurer's own underwriting standards would be to judge the insurer by its own, quite possibly flawed, standards.

Lord Justice Rix bolsters his argument by analogy with the avoidance of contracts generally. He argues that the law accepts that a party who purports to avoid a contract is obliged to show that at the time that the act of purported avoidance occurs there must have been actual facts which gave rise to the right to avoid. He observes (in Para 69) that "[i]f the termination is justified at the time it occurs, then it operates validly and effectively from that time - however long a dispute about it may take to resolve." From this he makes the leap (in para 70) to claim that "If this is so generally, why should the insurer's right to avoid a contract of insurance not similarly depend on the true facts of the case? Since the avoidance is a form of rescission from inception, the critical facts will be those in existence at the time of contract." This is a category error.

Rix LJ refers to *Brotherton v. Aseguradora Colseguros S.A.*, [2003] EWCA Civ 705 (May 22, 2003) in which an insured had failed to disclose the existence of rumours of serious misconduct and was precluded from adducing evidence to show that the rumours were baseless and therefore there was no non disclosure. There the English Court of Appeal held that the insured was precluded from seeking to prove that the rumours were without foundation on the basis that the only proper questions for decision at trial were whether there had been non-disclosure which was material and which had induced the insurance. This is the correct approach.

The issue is not the actual state of the world at the relevant time (which is of course frequently unknowable even with hindsight). Rather it is whether the insured has failed to disclose some material matter which, at the time the contract was entered into, would have influenced the decision of the insurer as to the terms of the insurance.

Consider, for example, an insured who seeks life insurance must disclose the fact that he is to undergo tests to establish whether a skin abnormality is a malignant melanoma. This is a matter which should be disclosed to the insurer and a failure to do so would be a material non disclosure. If that fact is not disclosed and the tests in fact show that there is no malignant melanoma this does not cure the original non disclosure. The insurer was denied the opportunity to set a premium that reflected the risk based on the knowledge held by the insured at the time the contract was entered into. It is not open to the insured to take the risk that the tests will turn out favourably. As was stressed by Lord Justice Buxton in *Brotherton* there is no place for hindsight in determining whether or not a nondisclosure induced the conduct of the insurer.

Good faith in avoidance?

The relationship between the insurer and insured when a claim is made is significantly different from that which exists when the contract is entered into. In making the claim the insured will be seeking to obtain all he or she is entitled to under the policy. The insurer will be seeking to ensure that no more than this sum is paid. In practice a disputes as to that amount are not infrequent and the parties are entitled to act with that in mind. As such the duty of good faith in making a claim has generally been interpreted fairly narrowly and applied in specific contexts.

The argument in this case took the matter further. It was suggested that if a right to avoid a contract had arisen then that right was to be exercised only in good faith. Some support for this proposition is gained from *Carter v Boehm* (1766) 3 Burr 1905 where Lord Mansfield noted that there may be circumstances in which an insurer, by asserting a right to avoid for non-disclosure, would himself be guilty of want of good faith. It was also noted by Rix LJ that the purpose of the duty of good faith would not be achieved if a breach of the duty by the insured was allowed to be used as an "instrument for enabling the insurer himself to act in bad faith" (citing *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd. (The Star Sea)*, [2001] 2 W.L.R. 170 per Lord Hobhouse at para 57).

One suggestion seemed to be that the actions of an insurer on non disclosure must be proportionate to that non disclosure. The approach of an innocent party being limited to a remedy which is proportionate to the breach is not familiar to the common law. This was rejected as a too uncertain approach for commercial dealings. However, it was noted that many insurance contracts (including the one under consideration) are not in reality commercial contracts, but consumer contracts and Rix LJ opined that in the future such a doctrine of proportionality may have a place.

In a more concrete fashion the question was put whether it would be bad faith to avoid the policy if Provident had known that the historical accident was in fact a no fault accident. It was accepted that this was not known at the time of avoidance and therefore there was no bad faith at the time of the avoidance. However, Rix LJ opined that:

Knowledge or shut-eye knowledge of the fact that the accident was a no fault accident would have made it a matter of bad faith to avoid the policy.

This is in many ways an extraordinary opinion in that it is premised on a right to avoid existing that, given subsequently acquired knowledge, may not be exercised. The assertion seems to be made on the basis that if Provident had become aware that the risk that it was in fact undertaking was substantially that which it had thought it was undertaking (with the non disclosure) then with that hindsight reliance on the non disclosure would be in bad faith. This utilises, once again the benefit of hindsight to infect the rights of the parties created by the non disclosure at the outset and must be flawed.

The issue of exactly what amount to “blind eye” “shut eye” “Nelsonian” knowledge or wilful blindness was discussed by Pill LJ. He referred to the words of Lord Scott in *Manifest Shipping* (at para 116 of that case) where it was stated that a mere vague suspicion that something was amiss will not suffice. Rather, the suspicion must be “firmly grounded and targeted on specific facts” that a deliberate decision is made not to confirm. This approach was taken to distinguish a degree of knowledge of actual facts from a mere failure to enquire, however grossly negligent.

The discussion then proceeded to the issue of what level of knowledge was required to trigger the bad faith of the insurer in seeking to avoid the policy. In particular would some kind of constructive notice of the facts which would make avoidance bad faith be enough? Lord Justice Rix was reluctant to suggest outright than anything other than actual knowledge or wilful blindness would be enough when he said:

Notice was not enough unless there were to be a general principle that, at any rate where there is notice, it would not be in good faith to avoid a policy without first giving the insured an opportunity to address the reason for which the insurer is minded to avoid the policy.

Here he is suggesting that there is a real possibility that the law could recognise a duty on an insurer to enquire of the insured as to the strength of the grounds for the avoidance and presumably invite the insured to show why avoidance would be inappropriate. While (as is noted) there may well frequently be an exchange of information between insurer and insured prior to any avoidance, to suggest that a duty to engage in such discussions may be triggered by a suspicion that additional facts exist is novel.

On the other hand Pill LJ was of the view that on the facts Provident had facts which put it on enquiry as to whether the earlier accident was in fact a fault accident. Applying the *Manifest Shipping* test he was of the view that Provident was wilfully blind in not enquiring into this matter when making the decision to avoid. On this basis he found the decision to avoid was made in bad faith and should not be upheld.

Waiver or failure to avoid

It is well accepted that if an insurer knows of a non disclosure and communicates to an insured that it does not intend to rely on that disclosure in avoiding the policy it is not entitled to later resile from that stance and avoid. In practice the vexed question is always whether the conduct of the insurer amounted to an adequate communication of a waiver. It is not necessary that the insurer actually intend to waive. In accordance with accepted contract principles of objective evidence, it will be enough if a reasonable person standing in the shoes of the insured would think that the words or conduct communicate an intention to waive.

In the present case there were numerous conflicting signals as regards the intention of the insurer. On August 2 Provident wrote to Dr Singh and said:

The conviction is a material fact which was not disclosed to us. Had you informed us of the conviction we would not have insured you on the terms given. We regret to advise that we are unable to deal with any claims arising under the policy, which shall now be made void from inception, therefore no contract of insurance has been deemed to be existent since renewal 1996.

This, of itself, would be a clear indication of the intention to avoid. It was observed that while the letter of 2 August was taken alone was clear, it must be taken in context with other evidence of the intention of the insurer. There were a number of other matters which were contrary indication: nothing was said about the return of premiums paid; premiums were still being paid under Dr. Singh's direct debit; the avoidance was not recorded on Provident's computer records; Dr Singh's new car was insured under the same policy number as his old one (which was written off) and with the same expiry date.

It was also clear that there was some internal to-ing and fro-ing internally within provident subsequent to the 2 August letter as to whether that purported avoidance would be relied upon or rescinded. Thus in response to questioning the claims manager was clear in his understanding that the policy had not been avoided as regards the internal administration of Provident.

This issue was addressed by Rix LJ in terms of whether there had been a waiver of the non disclosure, but in fact it might better be framed as whether or not the avoidance had been properly communicated (which is how it was framed by Clarke LJ in his one line disposal of this issue). This is of importance because it is arguable that the two questions are quite different. In respect of waiver the onus lies on the person relying on the waiver to establish that communications were made (by words or conduct) which a reasonable person would conclude evinced an intention to waive the right to rely on the non disclosure and avoid. However, if the issue was one of whether Provident had effectively avoided the onus lies on the person avoiding to establish that the communications evinced an intention to avoid the policy.

On this analysis it is hard to see how the equivocations of Provident could be said to communicate an intent to waive. Conversely, it could be said that due to the equivocations there was no adequate communication of the avoidance. The problem for the court with this latter issue is the election to avoid ultimately became abundantly clear and if the right to avoid had not been waived then, by definition, it subsisted until clearly exercised.

In the court below the letter of 2 August had been considered decisive. When it was received there could be no doubt in the mind of the insured as to the intention of Provident. Consequently in the High Court it had been concluded that the avoidance was effective. It was only events subsequent to that letter which were contra-indications of that intent. However Rix LJ was of the view that this was unduly restrictive and the subsequent events should be taken into account in determining whether avoidance had occurred (para 100).

In taking this stance he drew an analogy with the law of contract formation noting that when addressing such an issue "In order fairly to estimate what was arranged and agreed, if anything was agreed between the parties, you must look at the whole of that which took place and passed between them". This is true in respect of contract formation; however, it does not fit with the termination of a contract. Up until a contract is formed all dealings are relevant to determine the content of the contract. The conduct of the parties subsequent to the moment of formation is of no relevance. Similarly the crucial moment in the present case is avoidance.

The conduct of the parties subsequent to that avoidance cannot change the legal fact that avoidance occurred. While it may be possible, by agreement, to reinstate the policy, there is no suggestion that this happened here.

The difficulty with the approach suggested by Rix LJ is demonstrated by asking what the legal position was on 2 August - immediately after the letter was received. It would appear that there were no contrary indications and therefore the letter was effective to avoid the contract. If Rix LJ's stance is taken it amounts to a finding that the later confusion has the effect of un-avoiding the contract without any agreed reinstatement.

Was Drake a volunteer?

The final question to be addressed was one of considerable complexity and was founded on the assertion that the equitable right to contribution only existed where one party was obliged by law to make a payment that the other party should in equity contribute. If the Drake was only under a legal obligation to pay 50% of the claim then in paying the full amount it was a volunteer as regards the balance. It will be recalled that Mrs Kaur, who was a named driver under Mr Singh's policy with Provident also had an extension on her own policy with Drake which insured her when driving any other car with the owner's consent. The Drake policy had a rateable proportion clause by which it was proportionately liable in the case of double insurance. Importantly, if Provident succeeded on this point it was an absolute defence to Drake's claim, even though it may have lost on any number of the prior points.

The conundrum was that if Provident had a right to avoid the policy then there was no double insurance and Drake had no claim against Provident. Conversely, if there was no right to avoid the policy then Drake was only ever liable to pay 50% of the claim and the balance was paid gratuitously and was not recoverable. Expressed thus this seems to be an irrefutable argument for Provident. Moreover a similar issue had arisen in *Legal & General Assurance Society Ltd. v. Sphere Drake Insurance Co. Ltd.*, [1992] Q.B. 887 in which it was held that there was no right to contribution in respect of gratuitous payments. Ironically in that case Drake was arguing that there was no liability to contribute on similar grounds.

The matter was complicated because as between Provident and Mr Singh there was no liability to pay due to the binding arbitration decision. Moreover, as between Mrs Kaur and Drake she was clearly insured. As such the *Legal & General* case could be distinguished on its facts.

However, the more general point of policy was also addressed. Drake had clearly acted responsibly in paying the full amount of the claim to the injured party while protesting its position to Provident. To take any other course would have put a deserving injured party out of his damages due to a technical dispute between insurers. It would also have reflected poorly on the insurance industry as a whole. This would be particularly so in light of the fact that as between the two insurance companies it was clear that the injured party was entitled to a full indemnity. If, because they couldn't agree how the loss was to be borne, the injured party had to wait for the matter to be resolved by litigation it would be truly reprehensible.

Lord Justice Clarke also observed that the situation could be tested by asking what the situation might have been if Drake had paid only 50% and Mrs Kaur had sued for them for the balance. He opined that in such a proceeding the relationship between Dr Singh and Provident would not have affected the rights of Mrs Kaur and as such she would have been entitled to recover and Drake would be liable at law for the whole amount. It was on this basis that Clarke LJ decided the point for Drake.

In contrast Rix LJ cut the Gordian knot by finding that a party who pays the full amount while protesting the obligation of another to contribute is not a volunteer when their protest is later vindicated by litigation. Both Clarke LJ and Pill LJ agreed with Rix LJ on this approach. This may not be analytically neat, but it reflects the fact that in substance when a payment made under protest it is anything but gratuitous: there is a clear signal of an intent to seek recompense from the other insurer. On this analysis it was found that Drake was not a volunteer and could recover from Provident.