An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0219
Sector:	Insurance
Product / Service:	Other
Conduct(s) complained of:	Rejection of claim
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a contract of insurance between the Complainant and the respondent. The contract at issue is a "motor trade combined" contract of insurance under which indemnity insurance is provided with respect to of a variety of liabilities including employers' liability. In respect of the employers' liability aspect of the insurance, the indemnity limit was €13 million. In March 2012, the Complainant was informed that a previous temporary employee was bringing legal action against it for alleged personal injuries sustained during the course of his employment on about 4 March 2010. The employee alleges that he sustained a fracture dislocation of his right ankle when he slipped and fell on the forecourt of the workshop of the Complainant. When the claim was brought to the attention of the respondent Provider, the Provider repudiated any liability under the contract of insurance on the basis of a notification provision in the contract of insurance. In the respondent's view, the incident should have been brought to its attention within 90 days of the date of the accident. As the Complainant did not notify it of the occurrence of the incident until more than two years had elapsed, the Complainant was in breach of the relevant condition which was described elsewhere as a condition precedent to the insurance contract.

The Complainant alleges that it did not breach the relevant notification provision as it was not aware that the ex-employee was holding it responsible for the injury that he suffered. The Complainant argues that it was not in breach of the relevant notification provision and that, even if it had been, the decision of the Provider to refuse any indemnity to the Complainant under the contract of insurance was contrary to law, inappropriate,

unreasonable and unfair. The Complainant has requested that the Provider is directed to indemnify it in relation to the relevant personal injuries action.

The Complainant's Case

A large volume of submissions have been made on behalf of the Complainant in relation to the present complaint, much of which encompasses detailed legal submissions. It is not therefore appropriate to recite all of the many arguments made which have been considered in detail by this office but rather I will present a summary of some of the main points.

The Complainant argues that there is no factual basis for the Provider's contention that it breached general condition 7(a) of the insurance policy. It states that on the day of the alleged incident, KW approached the injured party who was in apparent discomfort, supporting himself on a motor vehicle. The injured party informed KW that he had hurt his ankle and that the injury was entirely his own fault and had nothing to do with the business i.e. the Complainant. The Complainant argues that the injured party is a morbidly obese man who has consequent difficulties with mobility and in the circumstances of the injured party's own statements and his presentation, the Complainant reasonably believed that the injured party had rolled his ankle. There was no suggestion that anything in relation to the Complainant's premises or any other factor relating to the Complainant played any causative role in relation to the injury. Far from it, the Complainant argues, the injured party expressly informed it that his injury had nothing to do with the Complainant and was his own fault. The Complainant states that it contacted the injured party on a number of occasions during his recovery and at no time was any suggestion made that the injured party held the Complainant in any way responsible for the injury or had any intention of bringing a claim against the company. The Complainant states that it first received notice of the potential claim by letter dated 23 March 2012 and thereafter promptly informed its broker and the Provider. It argues therefore that its notification was well within the 90 day period provided for once it became aware of the potential claim.

The Complainant argues that case law suggests that a breach of notification clauses such as clause 7(a) does not entitle an insurer to refuse its contractual obligations. Rather if it can show real and demonstrable prejudice, it may have a remedy in damages by reference to any prejudice caused to its ability to defend the claim as a consequence of late notification. The Complainant argues that there was no prejudice caused to the Provider in the present complaint and that it had ample opportunity to investigate the circumstances with no relevant evidence having become unavailable because the claim was not notified before April 2012.

The Complainant argues that the Provider's assertion that compliance with general condition 7(a) is a condition precedent under the policy is not conclusive of the legal effect of the clause. It argues that general condition 9 constitutes a blanket clause which purports to make compliance with each and every clause of the contract conditions precedent and such blanket clauses will often not be upheld. Furthermore it argues that stipulations as to time in the contract are not generally deemed to be of the essence unless they would be treated as such in equity.

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The Complainant further argues that knowledge of the occurrence of an injury alone is not sufficient to give rise to a claim and the claim will only arise where there is some attribution or allegation of fault against an insured party for that injury and where there is a real possibility that a legal claim will be bought it against the insured as a consequence. It argues that neither of these two elements arose in the present case.

The Complainant argues that the Provider failed to properly consider and apply the test encompassed in the words "may give rise to a claim". The Complainant argues that this requires knowledge that a person is intending to or is at least contemplated the making of a complaint.

The Complainant draws attention to the definition of "event" for the purposes of interpreting general condition 7(a) of the policy. Event is defined to mean "an occurrence or series of occurrences consequent on or attributable to one source or original cause giving rise to indemnity under this policy." Therefore it argues that awareness of the existence of circumstances which may give rise to a legal claim or the happening of an occurrence attributable to a cause which may give rise to a legal claim is necessary before the notification obligation can arise. Knowledge or awareness that a person has sustained an injury is not sufficient of itself to give rise to a claim. Rather, the Complainant argues, the claim can only arise if there is attribution or an allegation fault against the insured for the occurrence of the relevant injury. It argues that there was no knowledge or awareness that any attribution or allegation of fault was being made in respect of the Complainant for the relevant injury on 4 March 2010 until solicitors acting for the injured party wrote to the Complainant on 23 March 2012. The Complainant relies on UK case law to argue that knowledge of a serious injury having been sustained by a customer is not sufficient to require notification of a potential legal claim.

The Complainant argues that the Provider is incorrect in its assertion that the word 'event' must be given its usual ordinary meaning rather than the meaning provided in the definition clause of the contract of insurance. It argues that where the parties have agreed the meaning of particular words used in a contract by expressly defining what those terms will mean, the intended meaning has been made clear. Further the contract of insurance provides that a word to which its particular meaning has been given will bear the same meaning wherever it appears in the policy. The use of the word 'event' is therefore as defined as attributable to a cause giving rise to indemnity under the policy. The potential indemnity under the policy is "against legal liability to pay compensation for bodily injuries sustained by any employee arising out of or in the course of employment by the insured in connection with the business". Only if the definition of event is satisfied is it necessary, according to the Complainant, to consider whether the relevant event "may give rise to a claim" for the purposes of clause 7(a). It accepts that the word may does not mean the claim must arise or is likely to arise. Rather it requires an estimation of the likelihood that the legal claim may be brought and it argues that there must be a real possibility that such a claim will be made as distinct from a remote risk. It argues that it is concerned with whether a legal claim may be made as distinct from whether there is the existence of legal liability.

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The Complainant argues that it is not the case that any incidents which could give rise to a claim are required to be notified under general condition 7(a) and notification is only required "if circumstances should exist and/or on the happening of any event which may give rise to a claim under this policy". It argues that notification is required:

(i) "if circumstances should exist . . . Which may give rise to a claim under this Policy" and/or

(ii) "on the happening of any Event which may give rise to a claim under this Policy".

The Complainant points out that the Provider has relied on the second of these requirements i.e. the happening of any event to justify its decision.

The Complainant argues that the attitude of the injured party and whether the injured party attributed any blame regarding the incidents are relevant here. It argues that the true legal position is that all the surrounding circumstances must be taken into account and that the attitudes, knowledge and beliefs of the persons involved are critical. It argues that where it genuinely believed that the injured party was not intending to bring a claim, this belief cannot be dismissed as unreasonable having regard to the circumstances including the statements of the injured party so there was no obligation to notify the Provider of the incident on 4 March 2010. It further argues that legal liability can only arise against an employer if it fails to exercise a reasonable standard of care towards its employees. It argues that no suggestion was raised in this case that it had failed in any way to exercise a reasonable standard of care. Further it was not clear that the incident occurred while the injured party was undertaking any duties of his employment.

The Complainant argues that the contra proferentem rule whereby the terms of an exclusionary exemption clause are to be construed strictly against an insurer is not restricted to cases where there is an obvious ambiguity in the meaning or interpretation of a clause or word. It argues that exclusion clauses will only be enforced by the courts where there is only one potential interpretation of the relevant provisions so it can be said that the insurer's liability has been excluded in clear and unambiguous terms. It argues that the Provider could have required that an insured notify it of any injuries sustained by employees on its premises but chose not to do so and only required notification if a relevant event occurred.

In reference to the opinion of the loss adjuster that KW was naive in accepting the injured party statements and that he should have notified the Provider, the Complainant suggests that these are the personal opinions of the loss adjuster which are not based on any analysis of the legal requirements of the insured under the contract of insurance. It further argues that they do not withstand objective analysis that the injured party said the accident wasn't the Complainant's fault and had nothing to do with the business. Further the Complainant highlights the loss adjuster's conclusion that the Provider's opinion has not been unduly prejudiced by the late notification as the same information is available today as it was in the weeks after the incident.

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The Complainant argues that it is well-established that terminating or avoiding a policy of insurance is deemed to be unreasonable except where there is evidence of fraud or where there has been non-disclosure of facts which are material to the risks arising from the particular contract of insurance. It argues that where no prejudice has been caused to an insurer by late notification of a potential claim, it is unreasonable for an insured to reject an otherwise valid claim under a contract of insurance. The Complainant argues that where no prejudice has been caused, there are strong grounds for this office to find that the complaint is substantiated on the basis that the conduct complained of is unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant.

The Provider's Case

The Provider informed the Complainant by email to its broker dated 8 June 2012 that it was not in a position to indemnify the Complainant in relation to the claim due to a breach of general condition 7(a) of the insurance policy which required the Complainant to notify potential claims to it within 90 days. In response to a solicitors letter sent behalf of the Complainant, solicitors on behalf of the Provider responded by letter dated 19 August 2013 referring again to general condition 7(a) of the policy and general condition 9 which provides that the due observance of terms relating to anything to be done by the insured will be a condition precedent to any liability of the Provider to make payments under the policy. The Provider notes that KW [a director of the Complainant] was aware of the incident at the time that it occurred and was aware that the injured party had suffered a serious injury to his ankle. The Provider expressed its view that a reasonable person would have appreciated on 4 March 2010, given the seriousness of the injury suffered, that it was clearly an event that may give rise to a claim and accordingly notification over two years later as well outside the 90 day term set out in general conditions 7(a). The Provider further argues that it was not required to show prejudice in the case of a breach of condition precedent which relieves its liability to pay a claim but that the Provider had been unduly prejudiced by the failure to notify. It expresses a view that the purpose of notification clauses is to enable insurers to test the genuineness of the claim within a reasonably short time of the occurrence and to ensure immediate steps were taken to mitigate the loss.

In its response to queries raised by this office, the Provider states that a temporary employee of the Complainant covered under the policy of insurance was injured while on the Complainant's premises on 4 March 2010. It states that the incident was not notified to it until 23 March 2012, over two years later. It argues that the policy requires that any incidents that could give rise to a claim are notified within 90 days of the incident occurring and that, therefore, indemnity was denied by it. The Provider informed the relevant broker on 2 April 2012 that it preserved its rights in respect of the claim due to the late notification of the claim but instructed a loss adjuster to investigate on a without prejudice basis. On 8 June 2012, the Provider made the decision to refuse to provide indemnity in respect of the personal injury claim on the basis that the Complainant had breached general condition 7(a) of the insurance policy.

The respondent argues that KW was aware of the incident at the time it occurred and was aware that the ex-employee had suffered a serious injury to his ankle. It states that TM of Associated Loss Adjusters submitted his report to the Provider on 11 May 2012 and

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expressed the opinion that the incident was clearly a matter which should have been reported to the Provider at the time it occurred. The Provider argues that a reasonable person would have appreciated on 4 March 2010 (i.e. the date of the incident), given the serious of the injury suffered by the ex-employee, that it was clearly an event that may give rise to a claim and accordingly notification over two years later was well outside the 90 day term set out in general conditions 7(a).

The Provider argues that condition 7(a) is a condition precedent and a breach of a condition precedent relieves it of liability to pay the claim. Notwithstanding that it does not have to show prejudice in such circumstances, the Provider argues that it has been unduly prejudiced by the failure of the Complainant to notify the incident on 4 March 2010.

The Provider states that the purpose of a notice clause is to enable insurers to test the genuineness of the claim within a reasonably short time of the occurrence and to ensure immediate steps are taken to mitigate the loss. It argues that in this case it has been denied the key opportunity of examining the incident locus, taking contemporaneous statements from the individuals concerned, and testing the evidence of the claimant. As a consequence, it reiterated to the Complainant that indemnity would not be forthcoming.

Similar arguments were repeated in a letter dated 17 October 2017. The Provider argues that no issue arises that the incident on 4 March 2010 was an event under clause 7(a) and it states that if there was an event then there has to have been an occurrence consequent on or attributable to a source giving rise to an indemnity under the policy. The Provider says it is incorrect to suggest that notification is only required where the insured knows that the event was caused by fault or wrongdoing. The Provider argues that an insured is under an obligation to notify an insurer of any incident irrespective of fault or wrongdoing and that often claims are reported where an insured has no legal liability. The Provider argues that the use of the word ‘may’ does not mean that a claim must arise or is likely to arise but rather that the circumstances may reasonably be regarded as a matter which may give rise to a claim. It is therefore not needed to have a genuine belief that there is a real possibility of a claim as the chance of the claim in the circumstances is less than 50%. The Provider argues that the Complainant knew that the injured party had injured his ankle on the insured premises during the course of his employment. This was, the Provider argues, an incident which may reasonably have been regarded as a matter which may give rise to a claim. The Provider seeks to distinguish some of the case law relied on by the Complainant in that the notification clauses in those cases were different than the ones in the present complaint and notification was required where the incidents were ‘likely’ to give rise to a claim. The Provider asserts that there does not need to be a genuine belief that there is a real possibility of a claim. The Provider further argues that the word ‘event’ should be interpreted on the usual and ordinary meaning of the words of a policy or contract. The Provider argues that the principle of contra proferentem only arises in situations of ambiguity relating to the interpretation of the clause or word in the policy. It further argues that the notification of the incident was a condition precedent so it is not required to show prejudice but that in any event there must at least be presumed prejudice. It further argues that case law indicates that a breach of notification clause is a basis for refusing cover.

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Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties 12 July 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of the Preliminary Decision, both parties made numerous additional submissions.

Having considered those submissions I set out below my final determination.

The essence of the within complaint is one of the interpretation of the insurance policy in question. It is important therefore to first consider the relevant clauses of the policy and any relevant legal principles before applying them to the facts as presented in the complaint.

The Contract of Insurance

The contract of insurance in question was effective from 5 March 2009 to 4 March 2010 inclusive. The Complainant is in the business of car sales, servicing and repairs. According to the master schedule, the insurance contract covers property damage, money and personal accident, business interruption, employers' liability, public and products liability, and road risks. The limit of indemnity for employers' liability is €13 million. The policy wording document is lengthy at 79 pages and notes that it is important for an insured to ensure that the policy is in accordance with the insured's requirements and that the insured understands its terms exclusions and conditions. The claims procedure is also set out on the first page.

As regards general interpretation, page 4 of the policy wording provides as follows:

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> "*The Policy and the Proposal shall be read as one contract and unless otherwise stated any word or expression to which a particular meaning has been given in the general definitions or specific Section definitions in this Policy shall bear the same meaning wherever it appears in the Policy or specific Section respectively . . . .*"

The word "Event" is defined in the general definitions as follows:

> "*The word "Event" shall mean an occurrence or series of occurrences consequent on or attributable to one source or original cause giving rise to indemnity under this Policy.*"

Under a section entitled "Claims (Duties owed by the Insured)", general condition 7(a) of the insurance policy states:

> "*In respect of all incidents (including all Employers' Liability related accidents and/or work-related illnesses) if circumstances should exist and/or on the happening of any Event which may give rise to a claim under this Policy the Insured shall within 90 days give notice thereof to the Company in writing*."

Section 7(b) requires that any letters of claim indicating an intention to claim against an insured or any court summons or like document be immediately forwarded to the Provider unacknowledged so is treated separately under the contract to notification of a circumstance or event contemplated under general condition 7(a).

General condition 9 entitled "Condition Precedent" provides as follows:

> "*The due observance of the terms provisions and amendments of this Policy by the Insured insofar as they relate to anything to be done or complied with by the Insured and the truth of the statements and answers and information supplied on in connection with the Proposal shall be a condition precedent any liability of the company to make any payment under this Policy*."

In relation to the terms of the employers' liability insurance, the Section Cover is expressed as follows:

> "*1. Bodily Injury*
>
> *The Company will indemnify the Insured subject to the Limit of Indemnity stated in the Schedule against legal liability to pay Compensation for Bodily Injury sustained by any Employee arising out of and in the course of employment by the Insured in connection with the Business and caused during the Period of Insurance*
>
> *a) within The Republic of Ireland Great Britain Northern Ireland the Isle of Man or the Channel Islands.*

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> *b) elsewhere in the world where any director or non-manual Employee normally resident in the territory stated in (a) above is temporarily working in connection with the Business*."

Section Cover 2 goes on to state that the Provider will indemnify the insured subject to the limit of indemnity against legal liability for claimants' costs and expenses in connection with the indemnity provided under Section Cover 1.

Legal Principles

Condition Precedent

Generally a breach of a condition precedent will entitle the insurer to deny liability for the claim, without the need to establish any prejudice.

Where a notification provision is not a condition precedent, it appears from cases such as *Friends Provident Life & Pensions Ltd v Sirius International Insurance Corporation* [2005] EWCA Civ that the appropriate remedy for breach of a notification provision is damages based on the level of prejudice suffered by the insurer due to the late notification.

In *Re Butler* [1970] 1 IR 45, the applicant was a motorist who held a valid policy of insurance that had been issued by an insurance company engaged in vehicle insurance business. A condition of the policy required the applicant to give written notice to the company "*as soon as practicable*" after the "*occurrence any event in consequence of which the Company may become liable under this Policy with full particulars thereof . . .*". The insurance company became insolvent and was ordered to be wound up, and a liquidator was appointed.

Thereafter, a motor car driven by the applicant was involved in an accident which resulted in personal injuries being sustained by a passenger in the car. Notice of the accident was not given to the insurance company until a year later. It was held that no sum was due to the applicant on foot of his policy as he had failed to give written notice of the accident to the insurance company shortly after the accident had occurred. The applicant's belief in the futility of giving due notice shortly after the accident was held to be irrelevant to the determination of the proper issue which was whether any other circumstance had prevented him from giving due notice shortly after the accident. Relevant also in the present case is the clause creating the condition precedent:

> "*6. The due observance and fulfilment of the terms provisions and conditions of this Policy and/or of any Endorsement thereon in so far as they relate to anything to be done or complied with by the Insured and the truth of the statements and answers in the said proposal shall be conditions precedent to any liability of the Company to make any payment under this Policy*."

According to Budd J at p. 52:

> "*Condition No. 6 made the due observance and fulfilment of the conditions of the policy a condition precedent to the liability of the company to make any payment*

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> *under the policy. If the applicant did not comply with Condition No. 1, the company was under no liability to him*."

In relation to the delay of 13 months in providing notice of the accident, the applicant argued that he was not aware of the intention of injured party to bring proceedings, that he thought the injured party's insurers would indemnify him or that the injured party would proceed against them. According to Budd J at p 53:

> "*The obligation under the condition in question, I may observe, was not to give notice of anyone's intention to proceed nor to give notice of proceedings against him. It was to give notice of the accident as an event in consequence of which the company might become liable under the policy*."

Budd J accepted that the object of a notification clause is to give the insurer some reasonable protection against unsustainable or fraudulent claims by giving him the opportunity to investigate the circumstances of an event which may give rise to liability, such as an accident, at the first opportunity when the facts can be ascertained most easily and the insurer can thus ascertain his position as regards liability. The Court concluded that (p 56):

> "*It being a condition precedent to the liability of the company that notice should be given as soon as practicable after the occurrence of an event in consequence of which the company might become liable under the policy, and such notice not having been given, there has been a breach of the conditions of the policy and the company, in my view, are not liable to indemnify the applicant. It follows that there is no sum due to the applicant under the policy . . .*"

In the UK decision of *Aspen Insurance UK v Pectel Ltd* [2009] 2 All ER (Comm) 873, the defendant was obliged under condition 4(a) of an insurance policy to give "*immediate written notice with full particulars of any occurrence which may give rise to indemnity under this insurance*".

Condition 13 provided that the claimants' liability was "*conditional on*" the defendant "*paying in full the premium demanded and observing the terms and conditions of this insurance*". It was held that compliance with condition 4(a) was a condition precedent to the insurer's liability to indemnify and as the defendant had not complied with the relevant condition, the insurer was not obliged to indemnify them.

I note the decision of the Privy Council in *Diab v Regent Insurance Co Ltd* [2006] UKPC 29, at para 14, Lord Scott of Foscote observed obiter, with reference to an insurance clause which stated that "*No claim under this policy shall be payable unless the terms of this condition have been complied with*" that –

> "*It does not necessarily follow, however, that every element of condition 11 must be treated as a strict condition precedent with any failure to comply barring the claim. Their Lordships have particularly in mind the 15-day period after the loss or damage*

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> *has been incurred within which a claim in writing accompanied by the requisite details is required to be delivered to the insurer.*"

It was accepted, however, that the provision constituted a condition precedent to the defendant becoming liable to pay on a claim. Equity might or might not have a role to play in regard to the flexibility or inflexibility of the 15-day period, but it had no role to play in relieving the claimant of the need to have performed the condition precedent before requiring payment of a claim under the policy.

General condition 9 is clear in its terms that the observance of the terms relating to anything to be done by the insured is a condition precedent to any liability of the Provider to make any payment under the policy. This includes compliance with the notification provision under general condition 7(a). Relevant notification within 90 days is therefore a condition precedent to the Provider's liability under the policy. If the Complainant has breached general condition 7(a), therefore, the Provider would not be under a duty to indemnify the claim under the terms of the contract. There is no obligation for the insurer to demonstrate prejudice where there has been a breach of a condition precedent.

Contra Proferentem Rule

In *Analog Devices BV v Zurich Insurance Co* [2005] IESC 12, the Supreme Court confirmed that any ambiguity in the exclusion clauses in insurance policies had to be construed contra proferentem , that is, against the insurer who, having drafted the policies, then sought to rely on such clauses. Geoghegan J held as follows (at para 14):

> "*A fundamental principle which appears to be particularly relevant to this case is the principle of contra proferentem. Clark in Contract Law in Ireland (4th ed.) at p. 149 sets out the general principle as follows:-*
>
> > *'If the exempting provision is ambiguous and capable of more than one interpretation then the courts will read the clause against the party seeking to rely on it*."

Similarly in *Rohan Construction v ICI* [1986] ILRM 419, Keane J held:

> "*It is clear that policies of insurance, such as those under consideration in the present case, are to be construed like other written instruments. In the present case, the primary task of the court is to ascertain their meaning by adopting the ordinary rules of construction. It is also clear that, if there is any ambiguity in the language used, it is to be construed more strongly against the party who prepared it, i.e. in most cases against the insurer. It is also clear that the words used must not be construed with extreme literalism, but with reasonable latitude, keeping always in view the principal object of the contract of insurance*."

In *McMullan Brothers Ltd v McDonagh* [2015] IESC 19 the Supreme Court held that the mere fact that the parties to a contract did not provide for a particular issue does not necessarily

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mean that the contract is ambiguous. Charleton J stated (at para 24) in respect of the contra proferentem rule that:

> "*That doctrine traditionally derived in part from take-it-or-leave-it standard forms being foisted in some transactions on the other party to an agreement. The degree to which minds might truly be said to have met in such a situation and the repugnance of exclusion clauses that effectively denied the very service contracted for could also have motivated the courts in their approach to contracts that were drafted by one side to a bargain with minimal or no input from the other. But, for that rule of construction to be operative, some ambiguity has to be found in the term in question*."

It is clear, therefore, that the contra proferentem rule only covers cases of genuine ambiguity, or, in the words of May LJ, "*ambiguities which are not fanciful*"; *BHP Petroleum v British Steel* [2000] 2 All ER (Comm) 133 at 147. While I accept that it is incumbent on an insurer such as the Provider to bring itself within an exemption clause that it seeks to rely on and that such a clause, if ambiguous, will be construed against the insurer, I do not accept that the rule has any application in the case of a clause which has a clear meaning.

Notification of Claims

In *HLB Kidsons (a firm) v Lloyd's Underwriters* [2008] EWCA Civ 1206, a dispute arose in relation to notification arising out of a professional indemnity insurance policy. An internal concern had been raised in relation to the particular scheme promoted by a subsidiary company but no claims had been made. General Condition 4 ("GC4") provided as follows:

> "*The Assured shall give to the Underwriters notice in writing as soon as practicable of any circumstance of which they shall become aware during the period specified in the Schedule which <u>may give rise</u> to a loss or claim against them.*" (emphasis added)

The clause was expressly written in terms of the assured's awareness (which general condition 7(a) is not) but is comparable in that it mandates notification of circumstance which '*may give rise*' to a claim. Rix LJ noted that in determining whether circumstances 'may give rise' to a claim, the question is on objective one: "*the insured may have his own views about the complaint, but the question has to be looked at objectively*" (para 72).

In terms when the notification obligation would arise, Lord Toulson noted that the notification condition contained two parts: the awareness of a circumstance (a matter of fact), and the characterisation of the circumstance as one which may give rise to a claim against the insured. As to what degree of appreciation of the risk of a claim must exist, Lord Touslon held as follows:

> "*137. The question whether a circumstance may give rise to a claim is not a matter of simple knowledge, a question of fact of which a person may or may not be "aware"; rather, it involves a degree of crystal ball gazing, an estimation of the likelihood of a claim.*

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138. At one end of the spectrum, there may be cases in which an insured seeks to notify a circumstance which is too vague or remote to be reasonably capable of being regarded in itself as a matter which might give rise to a claim. This is not as unlikely as it might sound, because an insured at the end of a policy period may have an incentive to give a notification in the widest possible terms for which there may be no real justification. The insurer would be entitled to refuse to accept such a purported notification.

139. In the middle of the spectrum, there may not uncommonly be cases in which different people, possessed of the same knowledge, might reasonably form different views about whether a claim was a real possibility as distinct from a remote risk. In such cases an insurer could not reject a notification of the circumstance, but nor could an insurer complain if the insured did not give such a notification.

140. At the other end of the spectrum are cases in which any reasonable person in the insured's position would recognise a real risk of a claim. If so, the insured would be duty bound to give notice of it to a prospective insurer. He would also in my view be bound to give notice of it to the current insurer if the terms of the policy required him to give notice of any circumstance of which he became aware and which might give rise to a claim.

141. In short, in my judgment the right general approach to a policy clause which entitles an insured to give notification of a circumstance which may give rise to a claim, and thereby cause the risk to attach to that policy, is to treat the right as subject to an implicit requirement that the circumstance may reasonably be regarded in itself as a matter which may give rise to a claim. The right general approach to a policy clause which goes further and imposes a duty on the insured to give such a notification is to treat it as implicitly limited, not only by the requirement that the circumstance may reasonably be regarded as a matter which may give rise to a claim, but to a circumstance which either the insured notifies or which any reasonable person in his position would recognise as a matter which may give rise to a claim and therefore requiring notification to the insurer."

In *Rothschild v Collyear* [1998] All ER (D) 431, Rix J held that the words "*which may give rise to a claim*" in an insurance policy "*laid down an objective test, which required that there must be a real, or material, risk, something more than a de minimis risk, something more than a negligible, fanciful or speculative risk, that the circumstance notified may lead to a claim*."

In *Aspen Insurance UK v Pectel Ltd* [2009] 2 All ER (Comm) 873, the defendant was engaged as a sub-contractor to work on a deep level tunnel facility in Manchester. In March 2004, there was a fire in the tunnels. In March 2007, the contractor contacted the defendant alleging that it was liable for the fire seeking damages of £15m. The defendant had liability insurance cover with Aspen. Clause 4(a) of the policy provided that the defendant was obliged to give "*immediate written notice with full particulars of any occurrence which may*

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give rise to indemnity under this insurance". Condition 13 provided that the claimants' liability was "*conditional on*" the defendant "*paying in full the premium demanded and observing the terms and conditions of this insurance*". The defendant sought to claim under the policy and notified the claimants of its intention to do so in March 2007. The insurer refused the defendant's claim and sought a declaration that they had no liability under the policy. It was held that compliance with condition 4(a) was a condition precedent to the insurer's liability to indemnify. The phrase "*any occurrence which may give rise to indemnity under this insurance*" was held to mean that there must be a real as opposed to a fanciful risk of the underwriters having to indemnify the assured. In determining whether there was such a risk, the court should apply an objective test, taking into account the knowledge that the assured possessed in order to determine the extent to which the assured was aware of, and hence capable of notifying, occurrences which may give rise to an indemnity. On the facts, it was further held that the fire was an occurrence that gave rise to a real risk that the defendant might claim an indemnity under its policy of insurance and that such a risk was one which would have been recognised by a reasonable man having the knowledge possessed. Although it was unclear when the fire occurred who was responsible for it, inquiries focused in part on work done by the defendant's employees at the relevant time. The insurer was entitled to decline liability as notice of the fire and the potential claim ought to have been given by April 2004.

I would accept that the use of the words "*may give rise to*" places a stronger emphasis on the obligation to notify compared to "*likely to give rise to*". As can be seen in the cases below, "*likely*" has been accepted as being an issue with greater than a 50% chance of giving rise to a claim. There is less clarity in relation to what degree of likelihood is required where the notification clause is drafted in terms of "may give rise to" but it is clear that it must be a real or material, risk as opposed to a fanciful or speculative risk of a claim arising.

In *Jacobs v Coster* [2000] EWCA Civ 3042, the claimant fell over on the forecourt of the defendant's petrol filling station and injured her leg in March 1994. She did not then blame the defendant or refer to any diesel or any other substance on the forecourt floor but in October 1994, her solicitors wrote to the defendant intimating a claim on the basis that the plaintiff has fallen because the forecourt of the filling station was slippery. The defendant notified the insurers of the accident shortly after receiving the letter. The insurers denied liability on the basis that the insured had failed to comply with condition 5 (a) of the policy which obliged the insured to give immediate notice "*if any event gives or is likely to give rise to a claim*". Laws LJ was prepared to assume that clause 5(a) "*must be construed and applied objectively, but taking account of such knowledge as the insured had*." Laws LJ held that the burden lies on the insurer to prove by evidence that as at March 1994, the plaintiff's accident was likely to give rise to a claim. He noted that in the case of *Layher v Lowe* (The Times, 8 January 1997), the Court of Appeal rejected the proposition that the bare fact that a claim was in fact brought (in that case two years after the relevant event) of itself demonstrated that the relevant event or incident was one that was likely to give rise to a claim.

Laws LJ also adopted that approach that "likely" in the clause of the policy meant at least a 50% chance that such a claim would eventuate. Laws LJ rejected the reasoning of the trial judge that just because the plaintiff had had to be carried by two men into the payment kiosk and removed to hospital in an ambulance, a reasonable man would have realised that

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there was a likelihood of a claim. There was no evidence that the insured knew of anything wrong with the forecourt and they had not been blamed for the accident at the time. This case suggests that the mere fact of an injury and the seriousness of the injury do not in themselves mean that notification must be made, though I accept that the notification obligation in Jacobs was couched in terms of '*likely'* to give rise to a claim which is a less onerous standard than '*may'* arise.

In *Zurich Insurance Plc v Maccaferri Ltd* [2016] EWCA Civ 1302, the Court of Appeal was asked to determine the meaning of a condition in an insurance policy which required the insured to notify its insurers "*as soon as possible after the occurrence of an event likely to give rise to a claim*". The insured was an engineering firm which held a combined public and products liability policy, covering accidental death and/or personal injury. It supplied Spenax guns, used to assemble woven steel wire mesh products, to a builders' merchant which, in turn, hired them out to a building company. In September 2011, an employee of the building company was injured when a Spenax gun went off accidentally. The insured was informed of the incident but, at that time, there was no indication or allegation that the gun had been faulty, nor that anyone had been seriously injured. The injured employee brought a claim against his employer in July 2012 and the insured was notified that it had been joined as a defendant to the proceedings on 22 July 2013. The insured notified Zurich of the claim on the same day. Zurich denied cover on grounds that the insured had failed to comply with the condition precedent relating to notification.

The Court held that in order for the condition to apply, there must be an event i.e. something happening at a particular time, in a particular place and in a particular way. Second, "*an event likely to give rise to a claim*" means an event with at least a 50% chance that a claim against the insured would eventuate. The Court decided that the insured had an obligation to assess the likelihood of a claim being made immediately after any given incident.

The fact that a claim was possible was not enough:

> "*34. The question therefore is whether, when the event occurred (an occasion not limited to the exact moment) it was likely to give rise to a claim. That will depend on whether in the light of the actual knowledge that the insured then possessed a reasonable person in his position would have thought that it was at least 50% likely that a claim would be made*."

It was held that the insurer was not entitled to refuse to indemnity the claim on the facts of the case. According to the Court, a number of factors mitigated in the insured's favour:

- the insured knew very little of what had happened at the time of the incident;
- there were limited grounds for alleging that the insured's product was faulty; and
- the allegation of fault was not even made until a year after proceedings were first issued.

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The Incident and Notification in the Present Complaint

An initiating letter was sent on behalf of the injured party to the Complainant dated 23 March 2012 which appears to have been promptly forwarded to the Provider. By email dated 2 April 2012, the Provider notified the Complainant's broker that it was appointing a loss adjuster to investigate the incident but it was reserving its rights due to late notification and seeking that the Complainant provide a written explanation for late notification.

The Complainant was informed by letter dated 10 April 2012 by the injuries board that an application was received in relation to the incident. The Complainant submitted a formal employers' liability claim form to the Provider on 11 April 2012 in relation to the claim being made. In relation to the circumstances of the claim, the form provides as follows:

> "*I do not know what happened to cause the injury. [The injured party] was inside the open roller shutter door and said he hurt his ankle so I got him a chair to sit down. He said it was his fault and he went to hospital*."

In answer to a question of when the occurrence was first reported, the response of the Complainant was "*it was not*".

In the application for assessment of damages to the injuries board dated 1 February 2012, the injured party described how the accident occurred in the following terms:

> "*I was asked to move a car out to the court in order to make space to bring in another car to be worked on. I walked over to take the car out of the workshop when suddenly I slipped on engine coolant and water which had spilled on the painted workshop floor. I fell hard on my right ankle which broke in eight places and became dislocated. I rang my sister who lives nearby and she brought me to Tallaght hospital*."

By email dated 16 April 2012, the Provider noted that in its view the "*Complainant should have been aware of this incident and reported it as a potential claim.* The response of the brokered dated 1 May 2012 notes that the Complainants were told that the incident was nothing to do with them so they took it that they didn't need to do anything.

A report was prepared for the Provider dated 11 May 2012 by a loss adjuster. The report notes that the injured party worked in the Complainant's business for 8 to10 weeks and was based on the front office of the building, primarily dealing with customers over the telephone. The report suggests that the Complainant advised that on an occasional basis, the injured party delivered cars from their garage to customers after work had been completed on them. The Complainant advised that moving a car out of the garage did not form part of the normal work of the injured party in that he was not involved in movement of cars in and around the workshop/forecourt on a day-to-day basis but the Complainant accepts it was possible this scenario arose or that the injured party had some reason to be on the shop floor at the time of the incident. The Complainant advised that when work is being carried out on a vehicle that might involve the removal of fluid from the engine or any part of the vehicle or where there is leakage of fluid from a vehicle, they would always use

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cardboard underneath the vehicle on the ground surface for the purpose of soakage of the fluid.

Furthermore the cleaning policy in the workshop area is 'clean as you go' policy so that where a spillage arises or any fluid gets onto the ground surface, it should be cleaned immediately and that mops are located at various points around the workshop for this purpose. The Complainant indicated that there is normally a full clean of their workshop first thing in the morning or last thing in the evening or both if required. The Complainant did not complete any accident report investigation documents in the aftermath of the incident involving the injured party so there is no documentation available.

The loss adjuster's report records an interview with KW, co-owner of the Complainant business who met the injured party in the aftermath of the incident. KW advised that when he accessed the workshop, he saw the injured party standing leaning against the car just inside the roller shutter doors in the workshop. He advised the injured party was in obvious pain and discomfort in the area of his right ankle. KW could not confirm what the injured party was doing in the workshop at the time and that neither he nor any other person working on the premises at the time witnessed the accident. To the best of his recollection, KW states that he spoke to the injured party and asked him what happened and that the injured party's reply was "*I think I broke my ankle*". KW has no recollection of the injured party alleging he slipped on engine coolant and water on the ground surface as he is now alleging. KW believes that if such an allegation was made it was something he would recall and he did not examine the ground surface at the time. KW advised the injured party is quite overweight and he was of the opinion the injured party simply went over on his ankle. In those circumstances, KW did not question the injured party in any detail about what happened. KW does not believe there would have been engine coolant and water on the ground surface at the time but he has no evidence of this. KW advised that in the aftermath of the accident, the injured party called his sister who called to the garage to collect him and take him to hospital. KW specifically advised and was very adamant that the injured party indicated after the accident that the accident "*had nothing to do with him*" (meaning that the injured party was not alleging the accident occurred through any fault or negligence of the Complainant). KW advised in the circumstances he didn't consider the accident has been connected with or involving the business at all.

The loss adjuster concludes as follows:

> "*We would have to accept the insured's explanation for late notification is genuine.*
>
> *Unfortunately the insured were very naive in accepting the claimant's word or reading into the claimant's comments in the manner they did. Clearly the matter should have been notified to insurers at the time. In fairness to the insured we can say insurer's position has not been unduly prejudiced by the late notification as the same information is probably available today as it was in the weeks after the accident. It is more the lack of investigation by the insured in the immediate aftermath of the accident and the lack of questioning of the claimant as to the accident circumstances and cause and location by the insured that had led to the problem in terms of evidence or a lack of evidence in this case*"

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I note that in the signed statement of KW from 1 May 2012, he states as follows:

> "*He was obviously in pain in the area of his ankle. When I asked him what happened he said he thinks he broke his ankle. He did not point out anything to me that was a cause or factor in any accident.*
>
> *He said it had nothing to do with me or the business and that it was his own fault. I did not question him any further about the matter. His sister collected him and took him to hospital. Any time I spoke to him after this he never referred to the accident as being our fault or responsibility and we felt in the circumstances the accident had nothing to do with our business*."

By email dated 8 June 2012, the Provider wrote to the broker stating that having reviewed the investigation report and the policy document, it wished to notify the broker that it would not be in a position to indemnify the insured for this incident due to a breach of policy conditions. The email referred to general condition 7(a) and the obligation to notify incidents within 90 days. The email requested that the broker advise the Complainant of the position and advise it to act as prudent insured. By email dated 2 July 2012, the broker replied and stated that if the Complainant had known that the injured party was holding them responsible they would have notified the Provider immediately. The Complainant advises that the injured party's first response was that the incident had nothing to do with the Complainant and that was his own fault. The Complainant did not know how the incident had happened or what had happened but all indications from the injured party were that it was his own fault and that was the end of the matter. The broker asks that the Provider reconsider the declinature in light of the above. Thereafter solicitors were appointed on behalf of the Complainant who called upon the Provider to reconsider its decision. Solicitors were also appointed on behalf of the Provider and exchange of correspondence took place between the parties prior to the complaint being made to this office.

To determine whether a breach of general condition 7(a) occurred here, it is necessary to return to the policy wording. The obligation on the Complainant was as follows:

> "*if circumstances should exist and/or on the happening of any Event which may give rise to a claim under this Policy the Insured shall within 90 days give notice thereof to the Company in writing*."

The expression '*event*' is defined under the policy; '*circumstances*' are not. I do not consider there to be any real debate as to the meaning of 'event' but, for the sake of clarity, the expression 'event' as defined in the policy is operative. "Event" is defined as "*an occurrence or series of occurrences consequent on or attributable to one source or original cause giving rise to indemnity under this Policy*". As a claim has now been made giving rise to indemnity under the policy, it can be considered that an 'event' or circumstance did arise. More pertinent, however, is whether the Complainant ought to have been aware on the occurrence of the injury that it '*may give rise to a claim*".

There is no reference in the relevant condition to knowledge of the insured party, but the awareness of the insured of the happening of the event or the circumstances in question

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must be implied into the obligation to notify. No one can be expected to notify an insurer of something of which he or she is unaware. The case law set out above (such as *Aspen Insurance UK v Pectel Ltd* [2009] 2 All ER (Comm) 873 and *Zurich Insurance Plc v Maccaferri Ltd* [2016] EWCA Civ 1302) makes it clear that the obligation on the insured to assess the likelihood of a claim being made must be determined in the light of the actual knowledge that the insured then possessed. It is equally clear on the basis of the case law that this assessment is an objective one; what a reasonable person in the position of the Complainant would have appreciated.

I am satisfied that the awareness has to encompass an appreciation of the possibility of a claim being made. The relevant policy condition is premised on circumstances or an event that '*may give rise to a claim'*. If the circumstances were not such that would indicate a claim may be brought, the obligation under general condition 7(a) would not arise. I am further satisfied that the use of the words "*may give rise to*" in the contract places a stronger emphasis on the obligation to notify compared to "*likely to give rise to*". Although the notification obligation does not require a likelihood that a claim will be brought of more than 50% as in the case of '*may give rise to*', I am also satisfied on the basis of the case law (such as *Rothschild v Collyear* [1998] All ER (D) 431) that there must be a real or material risk that a claim would be made, rather than a speculative risk.

Relevant considerations based on the evidence before me include the following:

1. *The injured party was primarily a front-office worker with no official duties in the workshop.*
2. *KW was unaware of what the injured party was doing in the workshop when he came across him.*
3. *There were no witnesses to the accident.*
4. *The injured party was obese with consequent mobility difficulties.*
5. *There was no obvious spillage on the floor near where KW happened upon the injured party*
6. *The injured party indicated that he had hurt or broken his ankle but gave no indication of how this had happened.*
7. *The injured party assumed responsibility for the injury himself.*
8. *The injured party assured KW that the injury had nothing to do with the Complainant.*
9. *The injured party gave no account of why he was present in the workshop or any indication that he was performing a duty of employment there.*
10. *The injured party gave no indication that he had fallen or slipped in the workshop.*
11. *The injured party made no reference to a spillage of oil or water in the workshop.*
12. *The injured party made no reference to a spillage or the fault of the Complainant in the weeks following the injury.*

The question becomes, is it sufficient for the purposes of the obligation to notify under general condition 7(a) that the Complainant was aware that one its employees had injured himself in the course of his work day, though it was unclear how or where the injury had

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occurred, and in circumstances where the injured party assured the Complainant's representative that the injury was his own fault and nothing to do with the Complainant?

This is a finely balanced assessment but I have found the case of *Jacobs v Coster* [2000] EWCA Civ 3042 to be instructive in this regard. There, the claimant fell over on the forecourt of the defendant's petrol filling station and injured her leg but did not then blame the defendant or refer to any diesel or any other substance on the forecourt floor. The trial judge referred to the seriousness of the injury and the fact that she had to be carried by two men into the payment kiosk and removed by ambulance as a reason why a reasonable man would have realised that there was a likelihood of a claim but this was rejected by the UK Court of Appeal.

As in the present complaint, there was no evidence that the insured knew of anything wrong with the forecourt at the time of the accident and they had not been blamed for the accident at the time. I accept that the notification obligation in *Jacobs* was couched in terms of '*likely*' to give rise to a claim which is a less onerous standard than the '*may*' arise standard which applies here. If the circumstances of the *Jacobs* injury and the present injury were the same, and nothing was said by the injured party about who was to blame for the accident, it might have been objectively reasonable to conclude that a claim '*may*' be made. There is an important distinction to be drawn in the present complaint, however, and that is the injured party's attribution of blame on to himself and his insistence that the injury had nothing to do with the Complainant. In those circumstances, and despite the fact that the injury appeared to be comparatively serious and that it had occurred during an employee's work day, I am not convinced that a reasonable man in the position of the Complainant would have (or would have necessarily) appreciated that the incident may give rise to a claim.

Returning to the scale of appreciation of risk set down by Lord Toulson in *HLB Kidsons (a firm) v Lloyd's Underwriters* [2008] EWCA Civ 1206 in the context of a '*may give rise to*' notification obligation, I do not feel that the present complaint belongs at either end of the spectrum; being neither too remote a risk to be reasonably capable of being regarded as a matter which might give rise to a claim, nor one where any reasonable person in the insured's position would recognise a real risk of a claim. I am satisfied that the present complaint belongs in the middle of the spectrum, where "*different people, possessed of the same knowledge, might reasonably form different views about whether a claim was a real possibility as distinct from a remote risk.*" According to Lord Touslon, in such cases an insurer could not complain if the insured did not notify.

In light of the above, and while acknowledging the case to be a finely balanced one, I am not satisfied that from an objective perspective but armed with the knowledge possessed by the Complainant at the relevant time, that a reasonable person ought to have appreciated that there was a real or meaningful risk that a claim might be brought in the present case as opposed to a speculative risk. I am not satisfied, therefore, that the Complainant was in breach of the obligation under general condition 7(a) to notify the Provider "*if circumstances should exist and/or on the happening of any Event which may give rise to a claim*" under the policy. As there has been no breach of the relevant condition in my view, the fact that the condition is described as a condition precedent is not relevant.

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Furthermore, I am of the view that the conduct of the Provider was unreasonable. There are a number of reasons why I have come to this conclusion.

I accept the general rationale for the need for a notice clause a set out in cases such as *Re Butler* [1970] 1 IR 45. I accept that, in general, a notice clause might enable an insurer to test the genuineness of a claim within a reasonably short period of time of the occurrence and to ensure that immediate steps are taken to mitigate the loss. I accept that, in general, prejudice may result to an insurer if an incident is not reported to it within a reasonable period of time. That does not mean, however, that prejudice will always be suffered nor does it mean that early notification of an incident will always result in ensuring that the Provider can test the genuineness of a claim made. In the present complaint, and as pointed out in the loss adjuster's report, since there was no witness to the alleged incident, the crucial time for investigation was in the immediate aftermath of the occurrence of the injury to see whether or not oil and water were present on the workshop floor.

Since the injured party assured KW that the injury had nothing to do with the Complainant and made no mention whatever of having slipped on any substance, it appears that KW did not take the opportunity to investigate the state of the workshop floor. If the Complainant had notified the Provider within 90 days of the incident, no further light could have been shone on whether or not the injured party in fact slipped on any substance on the workshop floor as I understand that the workshop floor is cleaned at least once a day. It is for this reason that the loss adjuster concluded that the insurer's position has not been unduly prejudiced by the late notification as the same information was probably available in April 2012 as it was in the weeks after the accident. I therefore do not accept the Provider's position that it has suffered any specific prejudice or any general prejudice in the present case as a result of the delay in notification. Since there is no apparent prejudice to the Provider in the present case, its decision to refuse to indemnify the claim appears unreasonable.

Finally, I accept that KW and the Complainant accepted the assurance of the injured party in the aftermath of the accident that the injury was the fault of the injured party and had nothing to do with the business. I note the loss adjustor has described the Complainant as '*naïve*' in accepting the veracity of these statements but that is simply the loss adjustor's own opinion in light of his experience working as an investigator of insurance claims. It is not necessarily reflective of the opinion of a reasonable person without the experience of the loss adjustor, particularly one who does not seem to have made a claim on its employers' liability insurance before. I further note that the loss adjustor accepts the genuineness of the Complainant's 'late' notification of the claim. I accept that, as a matter of contractual interpretation, the appropriate test in determining whether general condition 7(a) has been breached is an objective standard.

When determining the potential unreasonableness or unjustness of the Provider's conduct in refusing to indemnify the claim, however, I am satisfied that the subjective belief or understanding of the Complainant is relevant, particularly where that belief was not an extraordinary one but based on the representations of the injured party in the immediate aftermath of the incident.

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In light of all the above, I am of the opinion that the conduct complained of was unreasonable.

Accordingly, I uphold this complaint.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2) (b) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by reviewing its decision to refuse to indemnify the Complainant's claim in the present case and that the claim be met by the Provider in accordance with the terms of the contract of insurance. For the avoidance of any doubt, the Provider is also to consider, in accordance with the terms of the insurance contract, the Complainant's claim to recover legal fees incurred in the defence of the claim.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20 December 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

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(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.